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Informing adoption of a social model of health and wellbeing

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Informing adoption of a social model of health and wellbeing: A systematic review of literature

Dr Rachel Rahman, Dr Caitlin Reid, Professor Reyer Zwiiggelaar & Professor Andrew Thomas

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1. Executive summary

Hywel Dda University Health Board (UHB) have identified a strategic ambition to work towards a social model of health and wellbeing. In doing so, the health board have recognised the need to ensure that the overarching approach and ambition is working towards a defined and recognised model underpinned by academic rigour.

To achieve this, a strand of work by Aberystwyth University has been commissioned to conduct a systematic review of the academic literature, designed to identify, and inform future strategic development. Aberystwyth University have a long tradition of research expertise in social and physical sciences, rural policy, and economics. More recently the university have developed an increased health focus through the development of their Centre for Excellence in Rural Health Research and increased taught provision of a variety of allied health and nursing programmes. The academic team for this programme of research comprise expertise from the Departments of Psychology, Computer Science and the School of Business and Management in recognition of the diverse body of research likely to comprise the literature in question. The team therefore contribute knowledge of a variety of methodological approaches and offer insights to organisational change and community development to guide informed recommendations.

The review seeks to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

Through a systematic process to search and review the literature, 222 eligible papers were identified for inclusion in the final review and data synthesis. Data was extracted to explore the country of origin of papers, the methodological approach taken, and the health and social care contexts within which they were set. The papers were then coded using NVivo software and later themed into commonly occurring topics in relation to the research questions.

In summary, papers were predominantly from America, the UK, Australia, Canada and wider Europe. The majority were narrative reviews with a smaller number of empirical research studies comprising qualitative, quantitative and mixed methods set in a wider range of health and social care settings. Five overarching themes were identified: 1) the lack of a clear definition of a social model of health and wellbeing; 2) the need to understand context; 3) the need for cultural change; 4) integration and collaboration towards a holistic and person centred approach; 5) measuring and evaluating a social model of health.

Key conclusions of the review centre on the need for organisations such as Hywel Dda UHB to decide how a social model will be defined within the organisation, how this dovetails with the current biomedical model, and whether the model will act as a descriptive framework or

will require further development to become a measurable operational model. The review highlights the importance of engagement and collaboration with end users and multidisciplinary health and social care staff to ensure that transition towards a new model is done with holistic needs of end users and organisational staff as a central value. Finally, the review highlights the challenges associated with the lack of a clear linear pathway to transitioning to a new model of care, emphasising the complex and unstandardised approaches to the implementation and evaluation of a social model that are likely to be necessary and in potential contrast to the current biomedical approach.

2. Introduction

2.1 Background to the review

Following years of sustained and increasing pressures, followed by unprecedented challenges of the Covid-19 pandemic, the UK NHS health system is facing significant challenges in terms of the sustainability of the current model of care (British Medical Association (BMA,2022). The incidents of chronic disease continue to increase alongside an ageing population with more complex needs, whilst recruitment and retention continue to be insufficient to meet the demand (BMA, 2022). The Covid-19 pandemic has only served to exacerbate pressures, resulting in delays in patient presentation (Nuffield Trust, 2022), poor public mental health (NHS confederation, 2022) and strain and burnout amongst the workforce (Gemine et al., 2021). However, preceding the pandemic there was already recognition of a need for a change to the current biomedical model of care to better prevent and treat the needs of the population (Iacobucci, 2018).

The biomedical model has been the dominant model in western healthcare systems and takes the perspective that ill-health stems from biological factors. Application of the model therefore focuses treatment on the management of symptoms and cure of disease from a biological perspective. However, despite its contribution in advancing many areas of biological and health research and understanding, the biomedical model has come under increasing scrutiny (Pedgorski, 2021). This is in part due to the growing recognition of the impact of wider social determinants on health, ill-health and wellbeing (Marmot, 2005; World Health Organisation (WHO), 2010). The continuing and arguably increasing inequalities amongst society provides a stark view of the role that social and socioeconomic deprivation play in predicting health outcomes. Life expectancy is over 18 years lower for individuals considered most deprived compared to those considered the least (The King's Fund, 2021). The social determinants at play are far reaching, including economic stability (access to quality education and employment), housing quality, access to transport and neighbourhood safety, access to quality nutrition, physical activity and health services, air and water quality, and social inclusion and non-discrimination to name but a few (WHO, 2010).

2.2 The semantics of models

The use of the term 'model' poses its own challenges and debates. Different disciplines attribute differing parameters to what constitutes a model and this in turn may influence the interpretations or expectations surrounding what a model should comprise or deliver (Stanford Encyclopaedia of Philosophy, 2006, 2020). According to numerous authors a model has no ontological category and as such anything from physical entities, theoretical concepts, descriptive frameworks or equations can feasibly be considered a model (Callender & Cohen, 2006; Contessa, 2010). At a basic level, a scientific model typically represents a physical or mathematical representation of a system, process or idea. The model identifies patterns within data to support prediction or explanation of association or causal outcomes. Whilst this scientific approach is frequently utilised in social science research, social sciences may also use the term model to demonstrate theoretical or descriptive associations or concepts. Whilst these are often developed and guided by

empirical data, models in this context often take the approach of *idealised models* aiming to simplify or conceptualise something complicated in reality with the view of communicating the principles in a more understandable way (Stanford Encyclopaedia of Philosophy, 2006, 2020; Clarke & Primo, 2012).

Systems models such as business process models or business reengineering models consist of a multi phased approach towards developing the 'model'. The initial phase is to develop and construct an accurate representation of the system or process in order to be able to characterise of 'model' the overall functionality of the system. This is normally termed a Current Reality Model and is used frequently in health care models and business modelling where the model represents or characterises the existing system and attempts to 'model' the inputs and outputs of that system. The second phase of a systems model considers the development of a future state model. In essence, this model is what the systems analysts would like to see as the new, improved or optimised model going forward. Generally, the future state model is an attempt to provide a solution towards improving the current system. Finally, this new or future state model should then have the capability to allow the model to be simulated. Simulation involves the inputs of a number of 'what if' scenarios that will enable the system analyst to determine and as accurately as possible, what the outputs of that model should be. It can be argued that 'systems modelling' represents a full cycle of modelling from developing a conceptual model of the current state to defining a future state model and then to use this model for simulating whether the model will provide the desired outputs from a given set of inputs.

2.3 Social models and frameworks in health and wellbeing

Numerous theoretical models and frameworks have been developed in order to capture the ethos of the wider contribution of social determinants of health. These include, but not exclusively, the biopsychosocial model (Engel, 1977), the social model of disability, social-ecological models of health (e.g., Dahlgren & Whitehead, 1991; McLeory et al.'s ecological model of public health, (1988), and the WHO's framework for action on social determinants of health (2010). These are briefly outlined below.

2.3.1 Biopsychosocial model

The biopsychosocial model was first proposed by Engel in 1977, challenging the biomedical model of health as inadequate to address the '*social responsibilities of medicine or psychiatry*' (Engel, 1977, pg. 129). In an attempt to better explain the subjective experience of an individual's illness the biopsychosocial model promotes the interaction between the biological, psychological and social-environmental factors that contribute to an individual's development of an illness. For example, highlighting the connection between the biochemical defect of diabetes, the psychology of when an individual may perceive or accept themselves as being ill and the social interaction between the physician and patient in modifying the behavioural response to the illness or treatment options. The model has been widely accepted as a conceptual framework in health and medicine; however, it has faced criticism about the lack of specificity regarding the interactional processes between the model's components (e.g., Farre & Rapley, 2017).

2.3.2 Social model of disability

Following reference to the social construction of disability outlined in a report by the Union of the Physically Impaired Against Segregation (UPIAS, 1976) the social model of disability has been developed by individuals with disability to challenge the exclusion of individuals from society, and to oppose the dominant medical model which approached the individual with the disability as a medical problem to be resolved (Inclusion London, 2022). The social model of disability moved this perception of disability away from the physical impairments of an individual to propose that disability is socially constructed and more broadly encompasses the physical and social environments that create a sense of disability for an individual. The model proposes disability less as a personal attribute instead highlighting the potential barriers that physical and social environments pose for an individual, and which contribute to the disability experienced. For example, an individual may experience a physical impairment, but it is only when that impairment is exacerbated by limitations of the physical environment, such as negative attitudes or inappropriate access to facilities that an individual will experience 'disability'. The model therefore challenges society to recognise how its structures and environments could be adapted to be more inclusive of individuals with impairments, thus removing this sense of disability and without placing the individual as a central cause of the 'problem'.

2.3.3 Social-ecological models of health

Models such as Dahlgren-Whitehead's model of health determinants and McLeroy et al.'s Ecological model of public health (Dahlgren & Whitehead, 1991; McLeroy et al., 1988) provides an illustrative representation of the societal impacts on an individual's health and wellbeing. They emphasise the individual as part of wider societal ecology of varying levels which interact and have reciprocal influential relationships. Dahlgren and Whitehead (1991) for example, place the individual at the centre of their model (e.g., attitudes, gender), with the role of lifestyle factors, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental being illustrated as influential factors. McLeroy et al. (1988) also place the individual at the centre of their model with similar layers of interpersonal processes (e.g., close social networks and support systems), institutional factors (e.g., organisational processes and practices), community factors (e.g., relationships among organisations) and public policy as surrounding influences.

2.3.4 World Health Organisations' (2010) conceptual framework for action social determinants framework

The World Health Organisations' (2010) framework, demonstrates how social determinants of health influence health inequalities. The framework categorises social determinants into 'structural determinants' and 'intermediary determinants'. Structural determinants include the interplay between the socio economic and political context and an individual's socioeconomic position, gender and ethnicity. Whilst intermediary determinants refer to material circumstances (e.g., housing, and environment), behavioural factors (such as lifestyle, nutrition and access to social groups) and psychological factors (such as psychosocial stressors and social support). These concepts are used to develop a conceptual framework for analysis and action with the intention of reducing health inequalities.

2.4 Political context of social model of health and wellbeing

Public policy is also bringing awareness to the need for better recognition of social determinants of health. Following an independent review into health inequalities in England, Marmot (2010) highlighted the important role that social determinants can play in creating health inequalities. The review highlighted how previous approaches to target individual behaviours such as smoking, or diet are unlikely to be effective without wider societal change. The importance of early year's education and intervention, improving quality of housing, strengthening community resilience, and investing in the prevention of health were key focuses of the review. Although not framed directly within a Social Model for health, the review's recommendations align with the principles of a social model, highlighting a need for individuals to have autonomy over their lives, the need for sustainable and healthy communities, and strengthening the role and impact of ill-health prevention. The review specifically tasks the NHS with engaging people and communities in co-production of multi-disciplinary services designed to meet their needs, engaging with multisector agencies to improve service integration, and moving the balance of spend from acute care to primary and preventative care.

Policies such as *The First 1000 Days: Foundations for life* (2011) and the Welsh Government's Framework on embedding a whole-school approach to emotional and mental wellbeing (Welsh Government, 2021) have focused strategies on improving the social determinants of health and wellbeing for young children, recognising the importance of preventive health and social initiatives for this societal group. The framework for a whole school approach (2021) also recognises that schools alone are not responsible for children's health and wellbeing calling for wider sector collaboration to meet the complex needs of children and young people. Similarly, policies such as Welsh Government's *Connected Communities: Loneliness strategy* (2020a) have recognised the broad social determinants that contribute to how connected people feel, including digital literacy, transport infrastructures and use of community spaces, and emphasise the wide ranging sector collaboration that is needed to address such wide ranging determinants.

A number of policies have recognised that in order to meet the needs of communities and regions, health and social care partners need to consider where and when care is delivered, and by whom. The launch of the *Six Goals for Urgent and Emergency Care* policy handbook (2021-2026) sets out a need for integrated working across sectors to enable the coordination of rapid and appropriate responses for care, and discharge of individuals from emergency care back into their communities. Similarly, the call for improved integrated working is a central component of *A Healthier Wales* (Welsh Government, 2018), and the *Strategic Programme for Primary Care* (NHS Wales Primary Care One, 2018). The *A Healthier Wales* plan for health and social care calls for seamless working between health and social care to the extent that the organisations providing the care be indistinguishable to the end user. The importance of individuals being cared for through services in their local communities also features heavily along with the need to better measure and understand the values and needs that are important to individuals and communities.

The important role of cohesive and connected communities is a feature of policy documents, such as the Welsh Government's *Connected Communities: Loneliness strategy* (2020a). The strategy outlines 'Our Vision, The Wales we Want', which sets out a vision for a compassionate society, seeing care as a societal civic mission with the aim of developing a more connected and inclusive nation. The strategy emphasises the commitment of stakeholders ranging from the individual, to the deliverers of public and voluntary services, and government and highlights the need to create opportunity for shared working and collaboration. Importantly and in line with other policy

documents, the strategy emphasises the need for partnership working, placing individuals at the centre of decision making to help create a society without shame and stigma.

The key principles within the Well-being of Future Generations Act (2015) and the Social Services and Well-being (Wales) Act (2014) focus on improving well-being, and also place people at the centre of decision making about their lives. Specifically, the Well-being of Future Generations Act outlines five ways of working towards sustainable development, which include the need to balance short term and longer term needs, to involve wider society in developing and achieving well-being goals and working more collaboratively in communities and across sectors. The Health and Social Care Act (2020b) has also emphasised the need for improved voice of the public and has legislated for a citizen's voice body to represent the voice of the public in health and social decisions. The need to be open and honest with end users about their care is also emphasised. Similarly, the principles of Simply Prudent Healthcare (Bevan Commission, 2013) promotes the ambition to meet the needs of individuals through improved understanding of value and emphasises a need for a rebalance in the relationship between health professionals and patients towards improved co-production.

A number of policy documents emphasise the need for public bodies to better reduce inequality, improve equality and improve social relationships between individuals from differing characteristics. For example, The Equality Act (2010) sets out the Public Sector Equality Duty and places a duty on public bodies to eliminate discrimination, harassment, and victimisation and to advance equality of opportunity and relationships in society. The Social Model of Disability (see section 2.3.2) is well-established in the United Nations Convention on the Rights of Persons with Disabilities. The National Assembly adopted the model in 2002, making Wales one of the first countries in the world to do so. The Action on Disability framework and action plan (Welsh Government, 2019) aims to embed the model visibly across all areas of work, including Welsh public services and agencies. As noted above, the Social Model of Disability makes an important distinction between 'impairment' and 'disability' and recognises the social and organisational barriers that exist and which can prevent people's inclusion and participation in all walks of life.

It appears therefore that, whilst policy, with the exception of the social model of disability, may not specifically legislate or vocalise implementation of a specific social model, the principles and ambitions outlined align with the principles of social ecological and biopsychosocial models. The advocating for recognition of social determinants of health and wellbeing, embedding individuals and community at the centre of their health decisions and empowering communities to be resilient and inclusive with a view to reducing health inequality align with a number of the social models discussed. However, whilst ambitions, goals and targets are welcomed, there is less evident guidance about how complex organisations such as the NHS and its allied partners move strategically towards a more social model of health and wellbeing.

2.5 Aims and research questions

It appears therefore, that whilst providing commendable recommendations for a move towards a social model of health, less attention has been given to the practicalities of transitioning and delivering a social model in health and social care. As a result, this review seeks to explore the academic literature in order to better understand how a social model of health and wellbeing is conceptualised, implemented, and evaluated in the health and social care sphere.

The review seeks to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

3. Methods

A systematic search of the literature was carried out between January 6th, 2022 and January 20th, 2022. Using the search terms in Table 1 below, a systematic search was carried out using online databases PsycINFO, ASSIA, IBSS, Medline, Web of Science, CINAHL, and SCOPUS. English language and peer-reviewed journals were selected as limiters. No cut-off date was selected for the searches to provide a comprehensive picture of the current literature on the use of the social model of health and wellbeing.

3.1 Search criteria

Through discussion with Hywel Dda UHB and the preliminary reading of the literature around the social model of health and wellbeing, the search terms in Table 1 below were compiled to provide a comprehensive search strategy to capture papers on and related to the social model of health and wellbeing. The search terms aimed to capture the broad definitions of a social model of health and interventions based on this and related models. The search terms were also informed by the World Health Organisation's definition of health and wellbeing and Card's (2017) definition of health which states that good health and poor health occur as a continuum rather than a dichotomy and is based on physical and psychological wellbeing.

Table 1 Search terms

"social model* of care" OR "social model* of health" OR "social model* of healthcare" OR "social model* of health care" OR "social model* of health and wellbeing" OR "social model* of health and well-being" OR "social model* of wellbeing" OR "social model* of well-being" OR

"biopsychosocial model* of care" OR "biopsychosocial model* of health" OR "biopsychosocial model* of healthcare" OR "biopsychosocial model* of health care" OR "biopsychosocial model* of health and wellbeing" OR "biopsychosocial model* of health and well-being" OR "biopsychosocial model* of wellbeing" OR "biopsychosocial model* of well-being" OR

"community model* of care" OR "community model* of health" OR "community model* of healthcare" OR "community model* of health care" OR "community model* of health and wellbeing" OR "community model* of health and well-being" OR "community model* of wellbeing" OR "community model* of well-being"

3.2 Selection and extraction criteria

The search results from each database search can be found in Table 2 below. After an initial sift through the database search results, 535 papers were identified.

Table 2 Search results

Database	Hits	Initial sift
PsycINFO	103	63
ASSIA	270	74
IBSS	31	7
Medline	225	62
Web of Science	206	97
CINHAL	170	70
SCOPUS	650	162
Total	1655	535

Given the potentially diverse range of research that could be considered as encompassing the ethos of a social model of health and wellbeing the search strategy adopted the approach that the review would specifically consider research that had explicitly self-identified as including, framing, or adopting a 'social model of health and wellbeing'.

Each paper was checked for relevance and screened. Papers that explicitly used the search terms outlined in Table 1 within the main body of the paper were included and all others excluded. Figure 1 shows the PRISMA flow chart of the systematic search process.

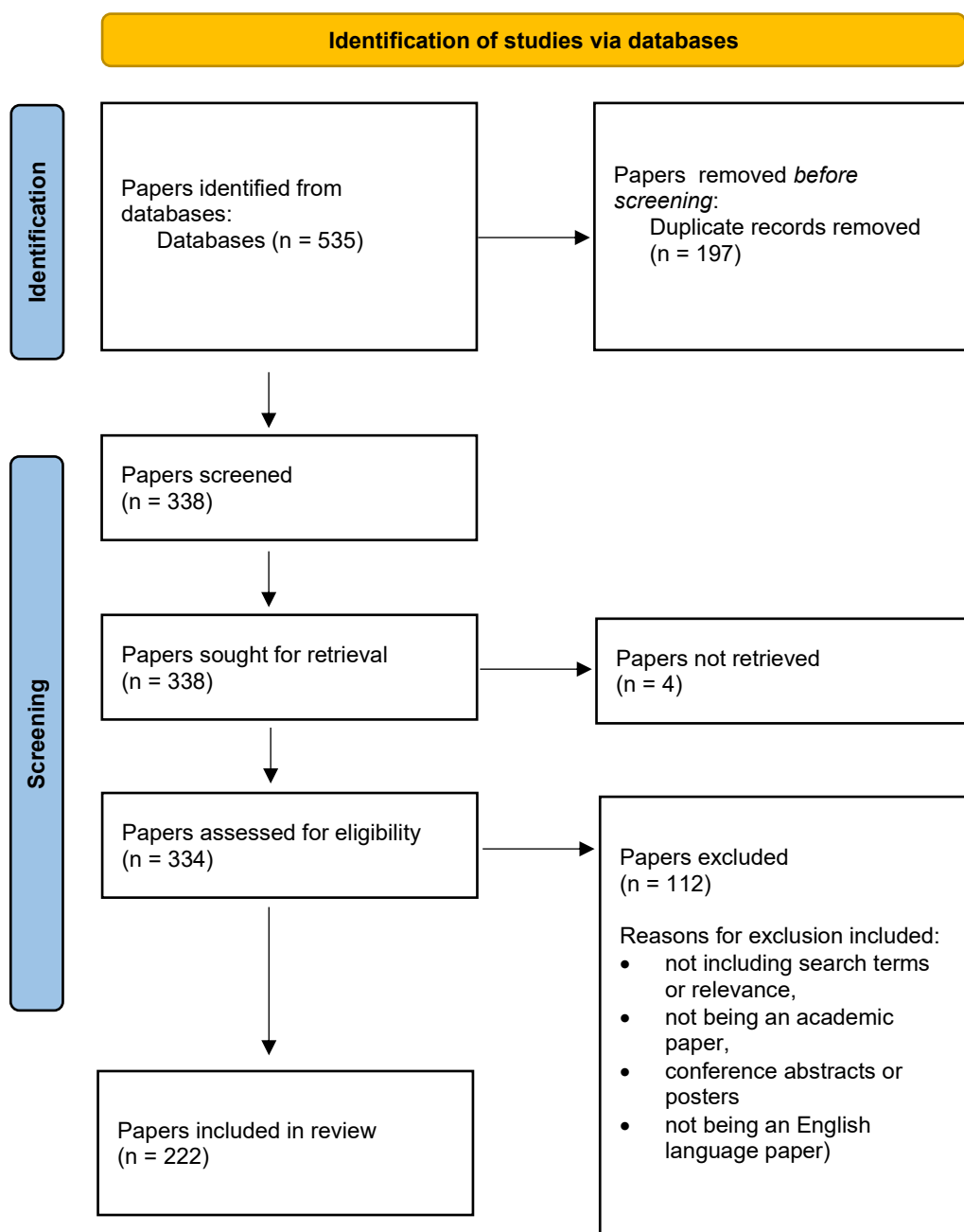


Figure 1 PRISMA 2020 flow chart of the systematic search process adapted from Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71

3.3 Data Extraction

A systematic search of the literature identified 222 eligible papers for inclusion in the final review. A data extraction table was used to extract relevant information (as outlined in Table 3).

Table 3 Data extraction table example

Aim of the paper	Focus and location of the research	Method	Service or specialty	Intervention or non-intervention	Type of paper	Model definition in practice	Key findings

3.4 Data Analysis

Quantitative studies were explored with a view to conducting a quantitative meta-analysis; however, given the disparate nature of the outcome measures, and research designs this was deemed unfeasible. All included papers were therefore coded using NVivo software with the identified research questions in mind, and analysed using Thematic Analysis (Braun & Clarke, 2006) to explore common themes of relevance.

4. Results

4.1 Summary of included research

Figure 3 shows the breakdown of papers according to country of the research. The majority of included papers were from America (34%), with the UK (28%), Australia (16%), Canada (6%) and wider Europe (10%) also contributing to the field. The 'other' category (6%) was made up of single papers from countries such as Nigeria, South Korea, UEA, Zimbabwe, Singapore, South Africa, Puerto Rico, Kenya, India, Hong Kong, China, and Brazil.

Most of the papers are reviews, with the majority being narrative reviews (n=90) and some systematic reviews (n=9). A smaller number of empirical research studies were included comprising qualitative (n=47), quantitative (n=39) and mixed methods (n=14) research. The remaining papers were comprised of small samples of, for example, clinical commentaries, cost effectiveness analysis, discussion papers, and impact assessment development papers.

Medical specialty or services of the papers include cardiology, mental health services, paediatric oncology, primary healthcare, urology, community services, public health interventions, disability prevention and rehabilitation, urban planning, long-term care, diabetes, gerontology, pain management, midwifery, health equity, nursing, paediatrics, orthopaedics, general practice, physiotherapy, arts, adult education on healthy behaviours, home-care, COVID 19, pandemics and health outbreaks, health psychology, neuroscience, gastroenterology, psychotherapy, and perinatal care.

The majority of papers referenced the guiding principles of a social model of health or care (n=73) or the biopsychosocial model of health (n=122). However, none of the papers included in the data extraction included a complete definition or implemented a functional model of a social model of health and wellbeing. Instead, papers tended to focus on a how a social model of health and wellbeing could be applied to or implemented within specific contexts of health and care, for example, in health promotion, resident-centred care,

mental health, integrative working, patient-centred care, environment, and patient-clinician relationships.

4.2 Meta-synthesis findings

The qualitative meta-analysis identified five overarching themes in relation to the research questions, some with underlying sub-themes. These are outlined in Figure 2.

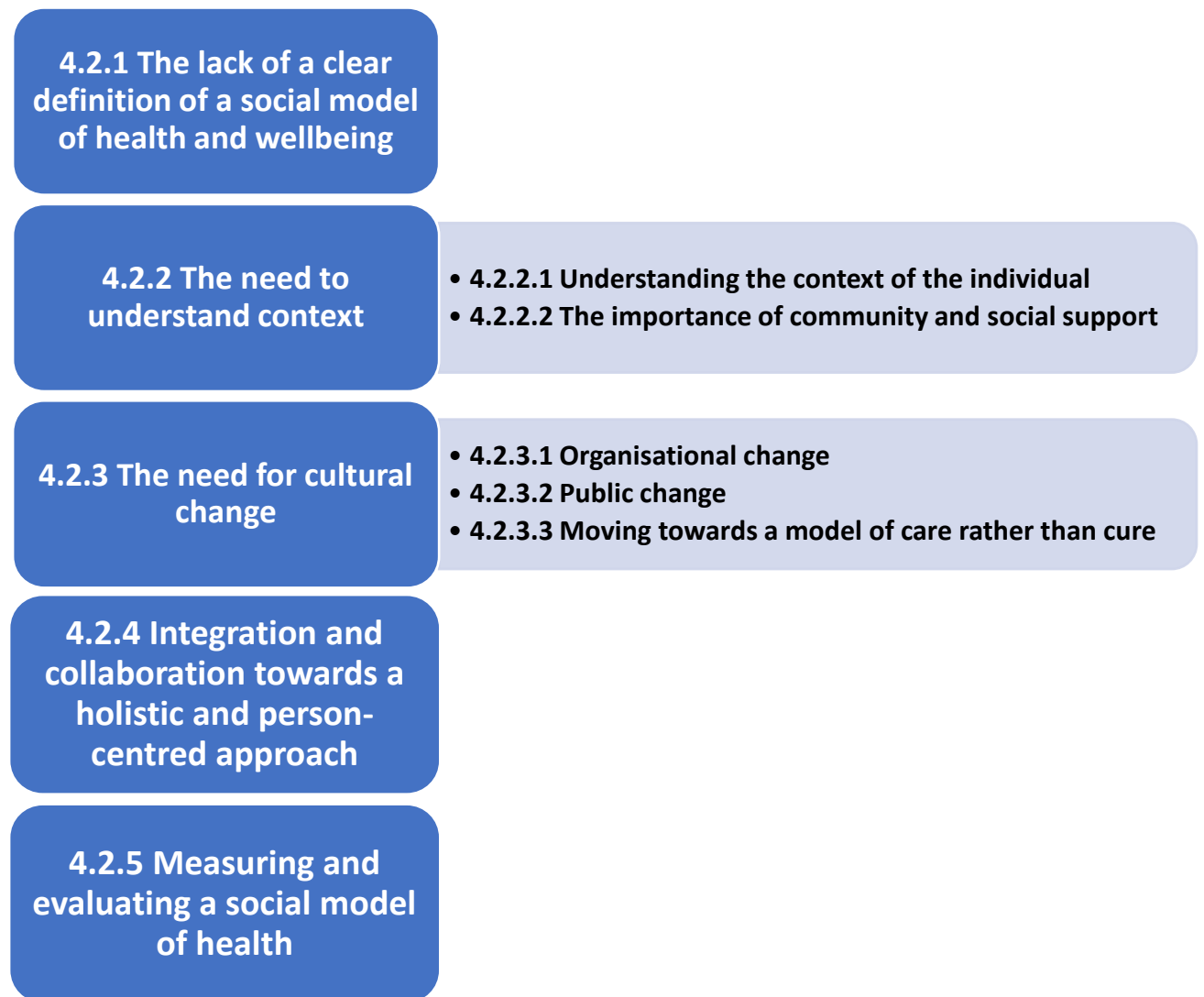


Figure 2: Overview of meta-synthesis themes and subthemes

An overview and discussion of themes follow with supporting extracts. To note that where extracts have been used, reference is given to the paper from which the extract was taken at the end of the extract; however, references to any citations incorporated within the extract have been left as per paper formatting and not referenced in addition.

4.2.1 The lack of a clear definition of a social model of health and wellbeing

There was common recognition amongst the papers reviewed that a key aim of applying a social model for health and wellbeing was to better address the social determinants of health. Papers identified and reviewed relevant frameworks and models, which they later used to conceptualise or frame their approach when attempting to apply a social model for health and wellbeing. Amongst the most commonly referenced was the World Health Organisation's framework (Solar & Irwin, 2010) and Brady provided an explanation for the importance of its consideration in regards to addressing health inequality.

The WHO framework highlights the importance of policy-based interventions as part of a multi-level population-based prevention strategy. Insufficient attention to policies that impact the conditions in which people live and their opportunities to be healthy could inadvertently generate or widen health inequities over time and across generations. This can occur even when the health of all communities is improving. (Brady et al., 2018, pg. 2954)

Namely, a society stratifies its population according to income, education, occupation, gender, race, ethnicity, and other factors. From these social stratifications, social hierarchies result. Position within the social hierarchy in turn shapes specific social determinants of health. Thus, the WHO framework separates structural determinants of health inequities, the distal factors rooted in a society's political, economic, and social structures (eg, macroeconomic and public policies), from social determinants of health, a more commonly understood term that refers to proximal factors rooted in one's social position (eg, living and working conditions). The WHO framework asserts that a society produces health and disease among its citizens. The framework also asserts that policymakers bear responsibility for creating and maintaining health equity among populations, as well as redressing the structural factors that produce under-resourced communities and health inequities. (Brady et al., 2018, pg. 2956)

Engel's bio-psychosocial model was referred to as a seminal framework by many of the papers, but was also critically evaluated for its lack of ability to fully address social needs. As a result, a number of papers reported using the biopsychosocial model to frame their 'social model' approach but with the addition of other supporting models to better emphasise the social elements (e.g., Robles, Kuo & Tobin, 2021). Supporting models referred to included the Social ecological model (McLeroy et al., 1988), Glass and McAtee's Society-Behavior-Biology Nexus (Glass & McAtee, 2006), and the Environmental Affordances Model (Mezuk, 2013),

In what follows, we begin by describing how Engel's model falls short in addressing the needs of the person in the context of their lived experience of dementia. Then we

move on to illustrate how the social ecological model allows us to better understand the person with dementia within their family relationships and social networks, which helps to capture a more comprehensive picture of the person's individual and relational needs regarding dementia care. (Pedgorski,2021, pg. 3)

Papers made reference to specific models which they classed as 'Social Models' including Wilkinson and Marmot's (2002) Model of Social Determinants of Health which framed specific determinants of interest (namely social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport). Similarly, Dahlgren and Whitehead's 'social model' (2010) which illustrates social determinants via a rainbow of influential factors from the individual to the wider cultural and socioeconomic influences.

Other papers conceptualised the ethos of what constituted a social model. This included being patient or client centred (e.g., Cooney & McClintock, 2006), maintaining individual autonomy and services being organised around quality of life rather than symptom management (e.g., Wilson & Malmberg, 1993)

Long-term care for older adults is shifting away from the traditional, medical model to new, more social models, including such examples as client-centered (Keating et al., 1997) resident-centered (Bond et al., 1996) or person-centered care (Rantz & Flesner, 2004), and the "pioneer movement" (Gold, 2001). (Cooney & McClintock, 2006, pg 71).

Healthcare problems are seen as an interaction among personal, physical, environmental, and societal factors. The healthcare goal in the social model is to create positive change, even when a cure is not possible. (Elman, 2007, pg. 302)

However, of the papers reviewed, none formally developed a working *definition* of a social model of health and well-being, instead applying guiding principles and philosophies associated with a social model to their discussions or interventions. For example, Rogers (2008) outlines their work to develop 'social model thinking' in their drug prevention programme arguing that this provides a guiding framework that is key to articulating its benefits.

Adoption of social health thinking also gives a multidisciplinary health care workforce an effective conceptual framework to work within. A clearly articulated model is crucial in allowing us to explain our work, and why it is effective, to others. This is especially important given the increasing need to collaborate across service systems. (Rogers, 2008, pg. 57)

Blout & Bayona (1994) called for the translation of social models, in this case the biopsychosocial model, into a set of organisational practices that made the functional elements of integrating a model into routine service delivery more transparent.

In the field of health care, these elements are: a model (biomedical), an organization (a network of primary care physicians as gatekeepers to more specialized physicians, mental health providers, and the "high-tech" hospital), and a practice (the basic

routines of interaction between health care providers and their patients). The replacement of the biomedical model by a more integrated model, such as the biopsychosocial model, will be successful only when it is translated into an organization and a set of practices that will support and validate it. We believe the biopsychosocial model must be joined with integrated biomedical and psychosocial services, integrated both in the network of providers and at the level of the patterns of interaction in the consulting room, before a true alternative to the present system can evolve. (Blout & Bayona, 1994, pg. 173)

Health Impact Assessments (HIAs) were proposed as one method of integrating better consideration of social determinants into service organisation and formalise the adoption of a social model or social thinking. HIAs required assessments of how any policy or practice change would impact health outcomes such that decisions were considered alongside the wider social implications.

The aim of health impact assessment (HIA) is to assist policymakers and other decision-makers to formulate “healthier” decisions and thus maximize population health gain and, where possible, reduce health inequalities. In 1999, the WHO Regional Office for Europe published the Gothenburg Consensus Paper (GCP), establishing a general framework for HIA based upon a social model of health and the values of democracy, equity and sustainability (1). HIA can be undertaken at the project, programme, and national or even supra-national policy level. (Wright, Parry & Scully, 2005, pg. 471)

4.2.2 The need to understand context

4.2.2.1 Understanding the context of the individual

Numerous papers discussed that in order to move towards a social model of health and wellbeing it was imperative to understand the context of the individual, such as the complex interaction of social determinants of health and their influence on health and wellbeing outcomes.

The literature identified the complex multidisciplinary nature of a variety of conditions or situations involving medical care. These included, but not exclusively, chronic pain (e.g., Berger, 2007), diabetes (e.g., Baun & Freeman, 2021), cancer (e.g., Berrios-Rivera et al., 2008), childbirth and motherhood (e.g., Brand et al., 2014), mental health (e.g., Ning, 2010), older adult care (e.g., Mark, 2006) and dementia (e.g., Kùmpers et al., 2005).

If lifestyle and behavioral risk factors were not influenced by societal factors, then they should be randomly distributed throughout the population, without regard to social class. They are not. National surveys conducted in the US and Europe have demonstrated striking gradients in smoking, diet, and physical activity by social class (Marmot et al., 1991; Uitenbroek et al., 1996; Lynch et al., 1997; Lantz et al., 1998). (Chin, Monroe, & Fiscella, 2000, pg. 318)

Many acknowledged that the frequently used biomedical models failed to fully capture the holistic nature and need of patients as a data extract from a review by McCullough shows.

A social perspective on health Nurses referred to providing care from a social perspective as 'holistic care' (NP3) 'complete care' (NP3) and looking at 'the whole picture' (NP1). NP3 explained, "... we're looking at the psychosocial needs of the patient, [as well as] the physical needs of the patient." For NP2, nursing care included: ... saying: "What about their social stuff?" People didn't automatically think of that. Have they got money? Have they got transport? Where are they living?... have they got someone to live with? Is their Centrelink [welfare payments] sorted out? (McCullough, 2021, pg. 538)

Papers outlined some of the key social determinants of health affecting the specific population of interest in their own context, highlighting the interactions between wider socioeconomic and cultural factors and health and wellbeing outcomes.

The outbreak (referring to Covid-19) will expose so many families to extreme levels of poverty and malnutrition. There is need to learn from this pandemic and strengthen food security programmes in communities and nations. (Chigangaidze, 2021, pg. 104)

Homeless individuals are more prone to many factors including malnutrition to perhaps lowered immunity to catch infectious agents including COVID-19 due to waste disposal, weather extremes, contamination, increased prevalence of infections, and substance abuse with overall poorer quality of physical and mental health (Banerjee & Bhattacharya, 2020, p. 2). (Chigangaidze, 2021, pg. 108)

Socioeconomic and other environmental challenges complicate or compound pain and limit access to pain management. Conditions of poverty, isolation from family, friends, or health care professionals, inadequate accommodation, physically demanding labour, and limited access to support and work increase the likelihood of inadequately managed pain. (Craig et al., 2020, pg. 261)

Access to, and, availability of, public transport, irrespective of car ownership, had salience for all age groups. The availability of public transport was linked to health for it was seen as facilitating social contact. For instance, the Metrolink, an innovative and expanding light railway system, enabled people to visit relatives and friends who lived in different parts of Greater Manchester. Changes in the rail network had allowed shopping trips to be made to the open-air produce markets which are a feature of urban areas in Greater Manchester. (Fairhurst, 2005, pg. 34)

As a result of this recognition, papers advocated and highlighted the importance of end users, patients or clients being included in the development of social models, such that their social needs and determinants were correctly accounted for.

In Designed to Involve it is argued that participation and involvement through the use of community development methods can lead to better communication, and assist in the development of better targeted and more appropriate services, as well as helping

communities to tackle health inequalities from the bottom up (Scottish Consumer Council, 1999). Fisher et al. (1999) argue also that community development can provide a voice for marginalised groups, for example by empowering lay people to participate productively as local representatives on the management bodies of primary care groups. (Black, McKie & Allen, 2003, pg. 69)

The lack of understanding or consideration of wider social determinants of health and their implications for health conditions was believed to result in the increased risk of bias or stigma towards certain groups who did not fit the traditional explanations of a biomedical model. This was acknowledged to have implications for treatment options, patient perceptions and access to health care services. A move towards a social model was proposed to require a change by services to be more inclusive of wider society.

There is evidence of devaluing and discrediting practices directed at people with chronic pain who are socially marginalized... Charges by patients of racist, classist, heterosexist, cissexist, transphobic, sexist, and ableist biases by health care providers and others are not uncommon...uncertainty about sources of pain are likely when pain is not medically understood or diagnosable, leading to discounting reports of pain,28,50,76 and health care providers report they are less inclined to help, feel less sympathy, dislike patients, and suspect deception under these circumstances. (Craig et al., 2020, pg. 262)

In contrast, and in line with the philosophy of the 'social model of disabilities' description of a social model, some countries, organisations or interventions had attempted to overcome these stigmas and biases through improved community engagement and a change of discourse around 'blame' and 'responsibility' in at risk communities.

An examination of the routine practices and philosophy of ACCHS (Aboriginal Community Controlled Health Services) reveals that they locate the sources of Indigenous ill health in the wider power relations, processes, and structures of Australian society. The dismal status of Indigenous health is viewed as a social product; they argue that it is important to note that the poor health status of Indigenous people emerges from the social and material conditions of their existence and not from their "race," biology, or culture. ... To blame Indigenous cultural traits, lifestyles, and personal habits for their high mortality and morbidity rates overlooks the vast pressures and incursions imposed upon Indigenous communities. The data and figures referred to previously in this article cannot be attributed to Indigenous laziness, lack of motivation, or personal irresponsibility, as some have suggested. Factors such as racism, discrimination, lack of employment and educational opportunities, criminal persecutions, and impoverished housing and living conditions, to name a few, are derivative of a legacy of dispossession and colonialism. (Khoury, 2015, pg. 477)

Interventions that had successfully addressed individual needs and successful embedded services in communities reported improved outcomes for end users and staff in the form of empowerment, agency, education and belonging.

Nonetheless, they described the Leg Club as a hospitable environment for staff and clients. Common emerged themes derived from staff members included 'education', 'camaraderie' and 'empowerment', signifying a collaborative learning environment allowing both patients and staff to grow. (Abu Ghazaleh, Artom & Sturt, 2019, pg. 6)

A sense of belonging and safe place to share and reflect on their own stories and learn from each other provided these young mothers with an opportunity to move beyond the socially scripted deficit narratives typically assigned to teenage mothers. Over months of field work, many of the young women identified new attributes and capabilities by opening up their life stories to fresh hopes, dreams and possibilities and beginning the journey of actively rescripting their story. (Brand et al., 2014, pg. 501)

Nurses working in clients' own homes perceived that in their work, in sharp contrast to the hospital setting, the locus of control is with the client, rather than the nurse: '[in hospital] a lot of them feel threatened that they have to agree to whatever treatment you suggest, in the community they're part of the actual process of deciding what course is best'. (Oberski et al., 1999, pg. 458)

4.2.2.2 The importance of community and social support

The role of the community was seen to be key in how social models were implemented. Elman discussed the varying definitions of 'community' with consideration of how these differing interpretations had relevance to service implementation.

The dictionary definition of community includes three separate notions...One definition is that a community is a unified body of individuals with common interests, a common location, common characteristics, a common policy, and/or a common history....A second dictionary definition of community includes the notion of society at large or the "bigger community." ... The third dictionary definition of community includes the notion of joint ownership or participation, common likeness, fellowship, or social state. (Elman, 2007, pg. 303)

In line with the varying definitions, papers discussed community in different ways. Some reflected on embedding services within communities and the importance of community voice in developing services to meet their needs, thus improving ownership, access and engagement. Others discussed how building a sense of community through a social model had positive implications for health and well-being through fostering improved perceptions of social support and empowerment. The importance or success of locating traditionally clinical services within communities was considered to be important for a variety of reasons.

it is argued that participation and involvement through the use of community development methods can lead to better communication, and assist in the development of better targeted and more appropriate services, as well as helping

communities to tackle health inequalities from the bottom up (Scottish Consumer Council, 1999). (Black, McKie and Allen, 2003, pg. 69)

Examples included Brune's overview of developing initiatives to instil community cohesion amongst adults in long term care. Discussion included 'eldershires' to empower older adults to have more ownership and autonomy in terms of their care within an intergenerational community. Similarly, discussion of 'Eden facilities' centred on intergenerational opportunities and engagement with the natural environment and animals to combat loneliness and boredom.

The Eldershire Community ...is a planned intergenerational community designed to promote an active and ongoing exchange among the generations. An Eldershire Community contributes to bettering the quality of life by strengthening and improving the means by which (a) the community protects, sustains, and nurtures its elders, and (b) the elders contribute to the well-being and foresight of the community ("Basic Tenets of the Eldershire Community Concept," 2008). An Eldershire is a community where residents work together to effect the realization of well-being, the elements of Culture Change in Long-Term Care Services which include identity, autonomy, security, connectedness, meaning, joy, and space ("Basic Tenets of the Eldershire Community Concept," 2008). Eldershire residents are empowered to collaborate in the design and ongoing development and management of their communities. (Brune, 2011, pg. 518)

Children, from pre-schoolers to high-schoolers, are often a key feature in Eden facilities, allowing residents to interact and share life experiences and knowledge including playing games, sharing stories, helping with homework, and working together in the garden "A home that opens its doors to pets, children, and the community has little room for boredom . . . Life in an Eden home is spontaneous" ("An Eden Alternative: Life Worth Living," 2003). (Brune, 2011, pg.512)

Building communities of individuals with common needs, either physically or through community groups, was considered to be an important way to foster a sense of social support, empowerment and connectedness and remove bias and stigma from certain groups. However, whilst community engagement was recognised as being central to developing a successful service or initiative, this involvement was not without it's challenges. The make-up of groups representing communities was critical for fostering a good working relationship and achieving the goals of the community. Authors and participants warned of the risk of vocal individuals with the communication skills and confidence to engage, pushing a personal agenda rather than representing the views of their wider communities.

The effectiveness of some approaches, including focussing community development on local organisations and non-health settings, was questioned. Some professionals working with community managed organisations believed that most decisions were made by vocal people with their own personal agenda ('bossy professionals' and

'vocal locals')...who did not really typify the community they were supposed to represent. (Hogg & Hanley, 2008, pg. 23)

There was also recognition that the transition to more community based care could be challenging for health and social care providers who were having to work outside of their traditional models of care and accept a certain level of risk. Many respondents viewed this opportunity to take increased risk positively. However, additional challenges were also faced when community preferences did not align with policy agendas. This required certain community level roles acting up as community 'advocates' or 'catalysts' brokering between communities and policy makers.

A key theme emerging in this study was the importance of relationship to facilitate the identification of community agendas and develop appropriate responses. The respondents of this study emphasised the importance of equity and partnership as key in their relationships with communities. They perceived this, together with working to the communities' agendas, as power sharing with the community ...However, it was those ways of working that were also described as 'risky' and challenging as they attempted to work outside of 'traditional' professional boundaries. (Forester, 2004, pg. 143)

4.2.3 The need for cultural change

4.2.3.1 Organisational change

A number of papers referred to the need for a 'culture change' or 'cultural shift' within organisations in order to move towards social model of health and well-being. For example, in their paper exploring the change from a biomedical model to a more social model of health in long term care, acknowledging the benefits afforded to organisations that fully embraced the cultural change.

Interestingly, the authors also found that "the more a nursing home has adopted culture change principles, the greater the benefits that accrue to it, in terms of staff retention, higher occupancy rates, better competitive position, and improved operational costs" (Doty et al., 2008, p. 20). (Brune, 2011, pg. 515)

Papers identified how 'culture change models' were implemented as way of adapting to a social model. These were deemed to have had limited success but recognised that for culture change models to be effective, staff needed to be fully engaged with the entire move towards a social model, informing and shaping the mechanisms for the cultural shift as well as the application of the model itself.

it seems that what is most important is achieving the correct balance between the desired cultural change and the environmental and social realities within LTC (long term care) facilities. Our findings suggest that this may be best achieved through the development of mutually agreed upon culture change initiatives between staff and managers rather than attempting to implement a pre-defined CCM (culture change

model). (Caspar et al., 2009, pg. 174)

The medicalisation and ‘power’ within professional relationships was seen to be one area that had the potential to hinder effective collaboration towards a successful social model of health and wellbeing (e.g., Baldwin, 2019; Mark, 2006). These involved organisational imbalances of political or professional power which had the potential to diminish the ability of allied health, social and community professionals to work in a fully integrated way. This was also seen to impact how some physicians were able to relate to the holistic needs of their patients with Crowley-Matoka et al. (2009) highlighting the need for improved understanding of the biomedical culture currently in operation.

...our exploration of the role of biomedical culture in pain management problems suggests the need for another form of cultural competence as well; that is, for physicians to become more self-reflectively aware of the culture of biomedicine in which they themselves are immersed. To reduce the cultural distance between physicians and patients—and thereby enhance clinical communication, assessment, and management—physicians must unpack their own cultural baggage and examine its contents and the ways in which it affects their responses to and care of patients in pain (Crowley-Matoka et al., 2009, pg. 1318)

Authors advocated the need for reflection of the organisational values, such that these became central to the movement towards cultural change and supporting organisational staff to consider how their own roles could contribute to the wider organisational values of a social model.

To begin the change process, providers need to explore their current organizational culture including organizational values, norms, and artifacts. This exploration will help staff evaluate how their own organization’s culture promotes or hinders the ability of residents to live their lives as fully as possible. It is very difficult to look at long-term care objectively while working in the system day-to-day. (Brune, 201, pg. 521)

Our statement of values has been guided by the ideas and work of speech-language pathologists as well as by individuals in psychology, sociology, and medicine. We intend neither to prescribe exact methods for achieving specific outcomes, nor to provide a quick fix to the challenges facing our profession. Rather, we offer a statement of values and ideas relevant to assessment, intervention, policy making, advocacy, and research that we hope will stimulate discussion related to restructuring of services and lead to innovative clinical methods for supporting those affected by aphasia. (p. 279) (Elman, 2016, pg. 158)

Others felt that education was the critical route to implementing a cultural change at an organisational level. There was a recognition that medical education continued to take a predominantly biomedical approach, focusing on symptomology and ill-health.

The contemporary curricula for Health Sciences (medicine, nursing, allied health professions) are focused on the instruction of clinical expertise, especially to diagnose individuals' biological or psychological problems (medical model of health). While knowledge about social aspects of health is essential, skills such as communication or advocacy skills are necessary to tackle health inequalities. Taking a social history, for example, should be embedded in any health professional curriculum, but is currently often neglected in the formal education of health professionals. (Schoeb, 2006, p.g 58)

The consequence of this biomedical training was believed to be a profession who failed to fully consider or adopt the importance of wider social contributions and such were susceptible to bias and negative attitudes toward certain behaviours and members of the community.

In our view, health professions education has too often interpreted the biopsychosocial model as focused on biological and psychological factors, with insufficient attention given to social context. When implemented, this educational approach has produced health providers with enhanced compassion toward individual patients, but insufficient awareness of social causes of disease. Such providers may overemphasize the role of patient's lifestyle choices. A focus on health behaviors can generate negative attitudes, not only about unhealthy behaviors but also about the people who practice them. These negative attitudes may contribute to conscious or unconscious biases about working with the poor, and can interfere with establishing trust and rapport between providers and low-income patients. (Chin et al., 2000, pg. 321)

Based upon international research and experiences from both Norway and the United Kingdom, it is clear that shifting from a professional control to service-user orientation is crucial. Within this focus, allowance must be made for a shift in culture, helping the health professionals in their development and practicing of skills and competences from education to personal formation, by supporting them in maintaining, preserving, and furthering their professional focus and involvement. It is central to encourage and develop the ability to hope, be creative, caring for and showing compassion, with the intentions of creating conditions for living meaningful lives while struggling with mental health challenges. (Damsgaard, & Angel, 2021, pg. 2715)

4.2.3.2 Public change

Organisations were not the only consideration when it came to the need for a change in culture. Some papers made reference to the culture change required amongst the general public to move away from a biomedical model.

On a more strategic or discipline specific level, they identified the invisibility of midwifery (being seen) which was due in part to the medicalisation of childbirth and medical representation in all levels of politics, current workforce shortages and the poor public understanding about the role and scope of practice of midwives... That is,

perceptions of power limit how different specialty areas and specialised practitioners refer and collaborate on care. (Baldwin et al., 2019, pg. 201)

Patients who adamantly reject any psychological or behavioral approaches to pain treatment out of a belief that such approaches imply that their pain is not “real,” for instance, are also operating with the hierarchical mind–body distinction characteristic of biomedical culture. (Crowly-Makota, 2009, pg. 1318)

Despite this, authors recognised the need to achieve this through the general public being at the core of cultural change rather than being recipients of intervention or change. The importance of engaging with end users and including them fully in the design and organisation of structures was seen to be key to removing power imbalances and increasing the potential success of new models of service delivery.

Hence, participation and inclusion do not involve changing people to fit in, but changing the (health care) system and society to be inclusive....Within this context, a change can only happen by confronting and challenging health care systems to reduce barriers that impede and thwart people’s efforts to live independently and gain control over their lives and the resources needed. (Damsgaard & Angel, 2021, pg 2712)

Examples from community interventions highlight the important role of patients as part of the multidisciplinary collaboration, where enabling patients to collaborate with each other and with staff members aided a culture shift towards shared learning thus improving knowledge, access and reducing stigma and bias.

Collaborative working is the foundation of Leg Club culture. Patients and nurses work together in an open environment, where interactive learning is paramount. Treatment is undertaken collectively in an area where two or three people can have their legs washed and dressed in the same room, giving them the opportunity to compare healing and treatments. They are encouraged openly to discuss treatment issues with the care team, carers and other patients, and this offers them control over their own leg ulcer destiny. Treatment is undertaken with, rather than on, the patients. This shared treatment also provides an open forum where excellence in practice can be observed, recognized, critically evaluated and mirrored by all the nursing staff (Lindsay and Hawkins, 2003). (Lindsey, 2010, S.18)

Open spaces and nonjudgemental learning areas for young people can contribute to skills and values being caught and taught. Within the social context of the community service, the process of becoming and learning was organic and spontaneous, providing an intangible social and cultural resource in the young mothers’ life, which is in stark contrast to the transmission model that all too frequently occurs in traditional health educational exchange (Banks-Wallace 1999). This learning process not only mitigates the effect of isolation and the wider community stigma but also inspires the construction of empowering narratives, especially for the young women who have no clear plan and require supportive scaffolding to help map out a desired life path. (Brown et al., 2014, pg. 503)

4.2.3.3 Moving towards a model of care rather than cure

The move towards preventative care and the need to better consider the determinants of health and illness ahead of reacting to symptom or illness was seen to be central to a social model. Discussions about a return to delivering quality of life rather than quality of care were used to refer to the changing focus towards the holistic individual.

With the advent of antimicrobials and technological advances in imaging and surgery, American medicine in the 20th century transformed from a discipline concerned primarily with “caring” for patients to one concerned more with “curing” diseases [76,77]. This shift has resulted in a bias favoring conditions and patients with a clinical story for which a parsimonious diagnosis can be made and for which efficacious treatments exist (Crowly-Matoka et al., 2009, pg.1315)

Ultimately, we hope social health thinking and primary health practices continue to encourage staff, clients, funding bodies, and the communities they serve, to offer “care-based” responses to client needs, rather than simply treating symptoms without first attempting to understand their genesis. (Rogers, 2008, pg. 57).

An overarching distinction between these two approaches is that the medical model emphasizes quality of care, whereas the newer social models stress quality of life (Kane et al., 1998). Though quality of life is valued in traditional nursing homes, it is heavily influenced by safety concerns (Kane, 2003). Technical competency of medical services assumes priority in delivering quality care under a medical model (Wiener, 2003), but such factors as resident choice and autonomy, comfort, meaningful activity, opportunity for growth, and maintaining relationships all matter in social approaches centered on the resident (Lustlader, 2001) (Cooney & McClintock, 2006, pg.73)

However, the complexity of these social interactions was acknowledged, with recognition that addressing social determinants as part of a more holistic model required different approaches. Authors highlighted how the methods of evaluating application of a social model did not always relate clearly to methods of adoption in clinical practice, limiting the translation from research to applied policy and practice.

Participants highlighted that social interventions were inherently more complex compared with medical interventions yet this complexity was not reflected within the current evidence base, which tended to focus on disease prevention rather than health promotion. This created a challenge for practitioners ‘to adapt the “scientific evidence” to the real world!’ (James et al., 2007, pg. 582)

There was recognition that whilst health professionals might be aware of the interactions of various determinants of health, there was a lack of understanding or systems in place to help them to address them.

The findings show that physiotherapists recognised the centrality of patients’ psychosocial context and the ‘social’ mediators of back pain, such as work absence, which played a key part in affecting patient recovery. The implications of these

findings are that in order to achieve concordance with patients physiotherapists will need to use best practice recommendations in ways that take account of patients' pain experiences [30]. In other words a balance between patients' psychosocial issues and biomedical approaches to managing patients' pain problems are needed, though as yet physiotherapists may struggle to adopt strategies to identify and manage both the biomedical and psychosocial aspects of non-specific back pain that patients present with. (Sanders et al., 2014, pg. 9)

In the United Kingdom, there are very few interactive educational opportunities that focus on supporting changes in practice toward biopsychosocial models. In the United States, different states have different continuing education requirements, but based on our anecdotal experiences, few of these offerings are related to psychosocial models and how to integrate psychosocial principles into routine management of patients with low back pain. Uncertainty about effective interventions for patients who have psychosocial obstacles to recovery may well mean that clinicians do not see the value in routine assessment of these factors... Some of these psychosocial obstacles to recovery (eg, pain-related distress, perceptions of poor personal control, catastrophizing, fear of movement) are likely to be modifiable using physical therapy treatment approaches. Other factors, such as unemployment, low levels of perceived job control, and social isolation, may be much more challenging to address within the context of physical therapy services alone. (Foster & Delitto, 2011, pg. 794).

4.2.4 Integration and collaboration towards a holistic and person-centred approach

The importance of integration and collaboration between health professionals, wider organisations, services users and patients were emphasised in the ambition to achieve best practice when applying a social model of health and wellbeing. A number of papers identified the reported benefits of improved collaboration between, and integration of services which included improved continuity of care throughout complex pathways (e.g., Bambridge et al., 2012), improved return to home or other setting on discharge (Blount et al., 1994), and social connectedness (Agarwal & Brydges, 2018).

Numerous papers discussed the importance of multi-disciplinary teams who were able to support individuals beyond the medicalised model. One such example came from Baum & Freeman (2021) in their review exploring why Australian Community Health Systems have not flourished in high income countries. Despite the challenges identified, the benefit of multi-disciplinarily came across strongly.

One strength that did persist at all services was a focus on multi-disciplinarity. Staff reported generally much less hierarchical dynamics than would be typical in other health services such as hospitals, and enacted a range of strategies to provide holistic, coordinated care to clients, including joint appointments, case conferencing, and team planning for clients. This allowed, for example, a client with diabetes to see a dietitian, exercise physiologist, diabetes nurse educator, and podiatrist at the one service, to support many different aspects of their management of their diabetes. This provided a more whole-of person approach to care than can be achieved in more

selective primary medical care services.’ (Baum & Freeman, 2021, pg. 53)

A number of papers suggested specific professional roles or structures that they felt would be best placed to act as champions or integrators of collaborative services and communities. Suggested roles included nurse practitioners (Davis et al., 2015), psychologists (Negri et al., 2021), network therapists (Blout et al., 1994) and referral centres (McLeod, Baker & Black, 2006). For example, the role of ‘network therapists’ in research by Blout et al. acted as a link between secondary, primary and community level care helping to identify patient needs and supporting the integration of relevant services.

In many cases, the network therapist assembles and helps to organize the primary care system of a patient. This involves identifying the agency personnel and community helpers who are involved with a particular patient or family, and arranging a meeting to review the problematic situation. In this meeting, a common goal can be denned and the group can agree on the function and accountability of each person in relation to the goal. The network therapist also tries to identify community people, self-help groups, and former patients who are willing to be involved as resources for patients and for team members in situations where additional help may be needed. (Blount & Bayona, 1994, pg. 177)

Some papers also advocated the need for better integration of service organisation and funding such that a holistic approach to procurement and coordination of services and goods could be achieved, proposing that this would improve health outcomes and cost savings.

Instead of accessing multiple entities and funding streams to procure health services such as mental and behavioral health, home health, physical and occupational therapy, nutritious food, warm clothing, and transportation, this can all be coordinated by one entity, which is managing the coordination of services and a more coordinated payment on the back end. There is an opportunity for cost savings and a reduction of a duplication of services wherein this funding structure could help align costs with health outcomes needed in value-based care. (Barilla, Shah & Rawson, 2019, pg. 83)

Importantly, the role of the patient as an active voice in multidisciplinary working was also seen as an essential feature of patient centred care, where patients were fully integrated into the multidisciplinary approach.

A key to living well with any condition involves incorporation of the patient and family experience into the therapeutic plan. Therefore, the process of systemic healing is a collaborative endeavor (sic) among the patient with the condition, their family, the healthcare professionals, and the larger community, society and culture, with the overarching objective of ‘living well with the medical condition.’ All professionals and perspectives are included and are ‘equal partners’ with patients and families in the systemic healing model. (Goetz & Caron, 2005, pg. 57)

The participation of patients and their families is the lynchpin of any multidisciplinary

approach to chronic diseases. In fact, it is impossible to achieve the proposed aims when this is absent. (de Oliveira, 2009, pg. 185)

However, papers emphasised how for collaboration to work effectively there was a need for clear definition of roles amongst the team in question such that each member had clarity regarding their own responsibilities towards achieving the wider objectives.

'For each member of the interdisciplinary team to work effectively, an understanding of one's own role and the role of others is required. In this way, an understanding of the contribution of each team member allows for better functionality of the team which in turn will lead to more positive outcomes. (Baldwin et al., 2019, pg. 200)

4.2.5 Measuring and evaluating a social model of health

Individual papers applying and evaluating interventions based on a social model used a variety of differing methods to evaluate success. Amongst these, some of the most common outcome measures included general self-report measures of outcomes such as mental health (e.g., Cullen & Solomon, 2013), perceptions of safety (e.g., Cullen & Solomon, 2013), well-being (e.g., Davies, Knuiman & Rosenberg, 2016), life satisfaction (e.g., Smedemear, 2017), health related quality of life (e.g., Dent, Davison & Wilki, 2021), social networks & support (e.g., Fried, 2004). Some included condition specific self-report outcomes relevant to the condition in question (e.g., pregnancy-related anxiety (Duberstein et al., 2021), pain inventories (Geyh, 2012), rheumatoid attitudes scale (Geyh, 2012).

Objective clinical or economic outcomes, for example, number of healed ulcers (Gordon, 2006), blood pressure, weight (McKenzie, 2013) and attendance at services or interventions (e.g., Duberstein et al., 2021) were also considered.

Other papers considered the more in-depth experiences of users or service implementers through qualitative techniques such as in-person interviews (e.g., Duberstein et al., 2021; Nevin et al., 2018).

However, the complexity of developing effective methods to evaluate social models of health were recognised. The need to consider the complex interactions between social determinants, and health, wellbeing, economic and societal outcomes posed particular challenges in developing consistency across evaluations that would enable a conclusive evaluation of the benefits of social models to wider health systems and societal health.

The outcomes of complex interventions include a range of attributes (including health) that are diverse and potentially of value to stakeholders, society, and/or the individual. These attributes, as in our social prescribing example, often, according to Sen²⁹ contribute to all the possible functions for a person...Complex interventions with multiple outcomes require new methods of evaluation.⁶ These evaluation methods, tied to benefit measurement from causal inference, mean moving away from the traditional model of health economic evaluation alongside a clinical trial. Proper evaluation of complex interventions will be expensive and will require extensive data collection.⁴⁷ Nevertheless, putting the task into the "too difficult and too expensive" box risks funding interventions that are not cost-effective (or failing to

fund those that are). (Wildman & Wildman, 2019, pg.512)

In many settings, complexity is considered a vice. However, the biopsychosocial model demands that complexity be viewed as a virtue, albeit a challenging one. Funding agencies and review panels prefer impeccable methodologies and nonmessy samples. The appreciation that new problem areas inevitably are messy needs greater recognition by review panels and policymakers. (Suls & Rothman, 2004, pg. 123)

Evaluation of community initiatives did not always show improved health outcomes; however, they did reportedly improve access to hard to reach groups. The example below warns of the length of time that may be required to see a change in health outcomes amongst populations who have faced health inequality for a significant period of time, which may not be feasible within the timeframe of shorter term evaluations.

This study demonstrates that the interdisciplinary, community outreach midwifery-led model introduced in the Fitzroy Valley increased access to antenatal care for Aboriginal women living in a very remote area. Although increased access and screening for risk factors is the first step, there was limited data on the quality of the increased services provided, and as yet, no change in outcomes. This may reflect the impact of the multifactorial, long-standing socioeconomic determinants on health and the long time frame required to see changes in health outcomes. The continuous quality improvement approach to providing antenatal care enabled the identification of improvements needed to achieve best practice care, highlighting the importance of embedding research and continuous quality improvement into routine health service delivery. (Reeve et al., 2016, pg. 205)

Some criticised the methods of research with a focus on quantification and evidence based practice highlighting how this approach could fail to capture the complexity of human behaviour and the manner in which their lives could be affected. Similarly, there was recognition that evaluation of social models would be unlikely to meet the requirements of standardisation typically expected of scientific research.

The few examples previously outlined in this paper, however, highlight inherent problems with the attempt to 'technologize' human issues related to health and illness. This is because the quantification of responses (and in this way the determination of 'at risk' contingents), fails to address the 'reflective' and meaningful manner in which human beings typically respond to the events taking place in their lives. This is especially the case in terms of traumatizing events such as those often associated with health and illness. To get a person simply to tick a box about how they are feeling or coping misses the reality of how people actually deal with such experiences. (Corrley, 2001, pg. 252)

A further concern regarding the application of an evidence-based framework to health promotion was the perception that the parameters of 'evidence' were too narrow and not consistent with the diverse forms of knowledge that were required in

the delivery of effective health promotion interventions in favor of 'science'. (James et al., 2007, pg. 582)

Critical theory is vital to health equity work; it calls scientists to acknowledge the extent to which the prioritization of specific methods, epistemologies, and competencies in public health maintains and exacerbates health inequities by requiring that health, health care, and health behaviors be defined, understood, and valued according to dominant ideologies and norms. Like most systems, science has been constructed via the prioritization of specific values and ways of knowing that have historically privileged specific persons and populations (10, 24, 33). As a result, scientific practice has often marginalized or erased knowledges and lived experiences that lay beyond its scope: placing them "low down on the hierarchy, beneath the required level of. . . scientificity" [(34), p. 82] (Golden & Wendel, 2020, pg. 5)

5. Discussion

The aim of this systematic review was to better understand how a social model of health and wellbeing is conceptualised, implemented and evaluated in the health and social care sphere. The review sought to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

Analysis suggests that whilst the ethos, values and aspirations of a social model for health and wellbeing appears to have consensus, there is no single definition or operational model of a social model of health and wellbeing applied to the health and social care sector. Authors have consistently referenced models such as the biopsychosocial model, and social ecological models to help frame and guide service delivery. The decision about how best to conceptualise a 'social model' is important both in terms of its operational value but also the implication of the associated semantics. For example, use of the term 'social model' arguably loses site of the biological factors that are clearly relevant in many elements of clinical medicine. Similarly, there is no discussion in the literature about what would not be considered a social model of health and wellbeing, challenging the boundaries within which health and social care sectors may be required to function in addressing their wider social remit. This raises questions and requires decisions about whether implementation of a social model of health and wellbeing conceptually works alongside or, perhaps less likely, is intended to replace the existing biomedical approach. The need to reflect the biological determinants of health may raise questions about what a 'social model' can achieve that the 'biopsychosocial model' does not. Regardless, questions about how health and social care sectors practically work to this broad remit will continue to be challenging and decisions about a working definition that meets the needs of health and social care organisations will be needed.

Authors have advocated that a social model provides a way of 'thinking' or articulating an organisation's values (e.g., Rogers, 2008), as opposed to presenting an operational model for organisational implementation. Common elements of the values associated with a social model amongst the papers reviewed included recognition and awareness of the social determinants of health, increased focus on preventative rather than reactive care, and similarly the importance of quality of *life* as opposed to a focus on quality of *care*. However, whilst this approach enables individual services to consider how well their own practices align with a social model, we suggest that this does not provide large organisations such as the NHS, with multifaceted services and complex internal and external connections and networks, sufficient guidance to enable large scale evaluation or transition to a wide spread operational model of a social model of health and well-being. This suggests that the current use of the term 'model' in this context represents an idealised meaning of a model, simplifying a complex reality in a way that conceptualises ways of thinking about service delivery as opposed to modelling or evaluating implementation, as may be the case in organisational or systems models. This raises questions about how health and social care organisations wish to utilise the model; whether its function is to support communication of a complex ethos to encourage reflection and engagement of its staff and end users, or to develop the current illustrative framework into a predictive model that can be utilised as an evaluative tool to inform and measure the success of widespread systems change. If the latter, then further identification of the appropriate input, process and output measures relevant to the implementation of a model of health and social care will be needed. The three phased approach of systems models may be helpful when investigating and analysing healthcare models that are currently in existence, and to characterise models in one of three states namely: a) models that characterise existing methods of operation and functionality i.e current state models, b) models that describe existing functionality but also model the future state in order to propose a new or improved solution, and c) a model that not only models current and future states but also allows for simulation of the model to determine the quantifiable benefits that emerge from adopting the new approach.

Given the lack of an operational model, no papers that we identified evaluated complex wide spread organisational implementation of a social model of health and wellbeing, instead focusing on individual services, or specific organisational contexts such as long-term care in care homes or residential services. Despite this, common elements of successful implementation did emerge from the synthesis. This included the need to wholeheartedly engage and be inclusive of end users in policy and practice change in order to fully understand the complexity of their social worlds and to ensure that changes to practice and policy were developed with, as opposed to created for, the wider public. This also involved ensuring that health, social care and wider multidisciplinary teams were actively included in the process of culture change from an early stage such that the move to transition and develop novel approaches to care were done with the engagement, support and advocacy of the teams responsible for delivering them. The need for improved multidisciplinary, inclusive of varied roles, both internal and external to traditional health services were also emphasised. This was proposed to support improved continuity of care, and better opportunities to consider and address the holistic needs of a patient or client.

Finally, the move towards more community based delivery was advocated. Embedding services more evidently in the community enabled improved attendance and engagement, improved opportunities to increase social support and empowerment, and reduce inequality and stigma. This clearly proposes a significant change of mindset and removal of perceived and actual hierarchical structures that are historically embedded in health and social care structures amongst both organisational staff and the wider public. Whilst unpicking and removing socially embedded hierarchies will pose significant challenges in practice, this may also open opportunities to promote the appreciation and significance of previously undervalued roles enhancing their attractiveness as career pathways.

The evaluation of social model interventions or services were varied and widespread and were mixed in terms of the social and health related improvements reported. Whilst this echoes the complexity of social and ecological perspectives, the lack of standardisation of outcomes measured and methodological approaches limits the ability to evaluate social model implementation at scale and in line with traditional scientific rigor. This challenges the ability to conclusively demonstrate the economic, and health benefits of a shift towards a social model of health and wellbeing. However, many authors argued that the benefits of a social model in term of its societal impact was not necessarily achievable using the dominant 'scientific' tools, and timeframes of traditional clinical research which were typically designed to be aligned with traditional biomedical approaches. They advocated for the complexity and 'messiness' of a social model calling for different approaches to assessing and evaluating success that better reflected the holistic complexity of end user environments and experiences. It is evident therefore that transition towards a social model, in whatever form that might take, is unlikely to follow a clear linear pathway. The transition is likely to be staged, gradually cumulative and iterative which is likely to be uncomfortable, unpredictable and disconcerting in an organisation that is steeped in scientific rigor, and evidence based practice. The focus of a social model around quality of life as opposed to cure may form a central point of focus enabling a consistent outcome of interest that draws together the wider remit of service delivery.

In conclusion, the evidence of the review demonstrated consensus regarding advocating for a move towards a social model of health and wellbeing. However, further discussion is required about how this dovetails with a biomedical perspective and what mechanisms and processes are required to transition to a functional systems model if this is deemed favourable. There is therefore a need for complex organisations such as the NHS and allied organisations to agree a working definition of their model of health and wellbeing, whether that be a social model for health and wellbeing, a biopsychosocial model, a combination of the two, or indeed a new or revised perspective. Many of the principles associated with a social model outlined in this review could be useful point of consideration to support the development of their approach with further consideration about whether there is a need to develop a workable systems model or whether the guiding principles of an idealised model is sufficient to inform system change. Considerable work will be required to engage on a more equal footing with the general public, health and social care staff as well as wider supporting organisations in developing workable principles and processes that fully embrace the equality of a social model and challenging the 'power' imbalances of the

current biomedical model. Acceptability of a degree of risk and insecurity will also be required with careful consideration of how organisations will evaluate and assess the long-term impacts of such a transition.

6. References

*A full table of references for studies included in the review will be provided as a supporting document. The references below refer to citations in the report which are in addition to the included studies of the synthesis.

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