Downstream approaches to the Social Determinants of Health and Tackling Health Inequities

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The Social Determinants of Health (SDoH):

Are the **conditions** in which people are born, grow, live, work and age, including the health system.

These **circumstances** are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

SDoH are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.
How can we reduce these health inequities?

Social and economic inequities are the fundamental causes of health inequities

WHO: Commission on the SDoH:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money and resources
3. Measure and understand the problem and assess the impact of action
Why treat people....

...without changing what makes them sick?

http://www.who.int/social_determinants/en
Global Forces

Policies
- Economic
- Welfare
- Health
- Housing
- Transport
- Taxation

Determinants of Health (social, physical, economic, environmental)
- Education
- Employment
- Occupation
- Income
- Working Conditions
- Housing
- Neighbourhood

Global Forces

UPSTREAM (MACRO)

MIDSTREAM (INTERMEDIATE)
- Psychosocial
  - Demand/strain
  - Control
  - Perceptions
  - Stress
  - Networks
  - Attachment
  - Self esteem
  - Coping
  - Anger
  - Social Support
  - Hostility
  - Isolation

Health Behaviours
- Smoking
- Diet/Nutrition
- Alcohol
- Physical Activity
- Self Harm/Addiction
- Preventative Health Care Use

DOWNSTREAM (MICRO)

Physiological Systems
- Endocrine
- Immune

Health
- Mortality
- Morbidity
- Life expectancy

Biological Reactions
- Hypertension
- Fibrin Production
- Adrenalin
- Suppressed Immune Function
- Blood Lipids
- Body mass index
- Glucose Intolerance

The need to tackle health inequities on a broad front

What role for downstream approaches in responding to the SDoH and tackling health inequities?
Clinician/Practitioner

GPs
Nurses
Midwives
Allied health professionals (e.g. dietician; OT; podiatrist; social work; speech pathologist; optometrist; physiotherapist)
Health promotion/education personnel

Client/Patient

Persons with chronic disease
High risk individuals
Public

Interface
Four challenges confronting “downstream” approaches to the SDoH and tackling health inequities
1. Social and economic factors as fundamental causes of disease

For the individual, downstream efforts might prevent, minimize, and manage the impact of chronic disease, or result in behaviour change, but they cannot alter the underlying social and economic conditions that gave rise to the individual’s health problems
2. The contested contribution of the health care system to health and inequities in health

“Overall health and longevity are determined to a greater extent by whether one falls ill rather than by medical care.

Inadequacies of health care, including lack of access and poor quality care, are estimated to account for only about 10% of premature mortality overall.”

Source: Adler NE, Stewart J. Health disparities across the lifespan: meaning, methods, and mechanisms. Ann NY Acad Sci 2010;1186:5-23.
“Medical care has accounted for only five of the thirty years of life expectancy gained over the course of the twentieth century”....

3. Victim blaming

Individual (lifestyle) interventions which fail to acknowledge and address the underlying social determinants of health inequities are victim-blaming in nature.

‘Lifestyle’ interventions assume individual behaviours are freely chosen and therefore can be altered by providing information, education, or developing skills.

Choice is not free: choice is largely conditioned and determined by social and economic factors operating over the lifecourse.
4. **Widening health inequities**

Disadvantaged groups are often constrained by their social and economic circumstances that make behaviour change difficult.

Individual downstream interventions (e.g. health education programs) may widen health inequities by benefiting the socioeconomiclly advantaged more than the advantaged.

Intervention effectiveness: high-risk individuals (downstream) or whole populations (upstream/midstream)?

**High-risk individuals:**
Clinically oriented, medicalized prevention
Success may be temporary
Large individual benefits, small population benefits
Doesn’t prevent new cases from occurring

**Whole population approach:**
Focus on decreasing population exposure to causes of disease
Often requires a focus on the SDoH
Large population benefits, small individual benefits
Prevents new cases from occurring
Individuals or populations: what does the evidence say?

“For prevention of CVD in Australia it is important to treat high-risk individuals and to reduce the mean risk-factor prevalence in the population”.

Relative contribution of high-risk and population strategies in reducing cardiovascular events (CHD and stroke), persons aged 35-74 years

<table>
<thead>
<tr>
<th></th>
<th>Males (%)</th>
<th>Females (%)</th>
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<tbody>
<tr>
<td>High-risk</td>
<td>12.6*</td>
<td>19.0</td>
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<tr>
<td>Population</td>
<td>19.3</td>
<td>21.9</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>24.1</strong></td>
<td><strong>28.7</strong></td>
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*126 events per 1000 people over 5 years

The involvement and contribution of clinicians and practitioners in the SDoH and health inequities is contentious and contested

The ‘non-supporters’:

Health professionals should focus on providing high quality care

Sceptical about the capacity of health professionals to make a difference

SDoH and health inequities are not within their professional remit
The supporters:

Health professionals have a responsibility to engage with the SDoH and health inequities

Acknowledge that the root-causes of health inequities are structural (SDoH); however, their health effects are experienced at the individual/personal level

Acknowledge that the role and contribution of the health professional is still ill-defined
The characteristics of care received varies by SES

In the GP context patients from disadvantaged backgrounds:

- Receive fewer long-consultations
- Are less likely to be referred to specialist care
- Are less likely to receive appropriate testing
- Are subject to different patterns of prescribing
Clinician characteristics that contribute to poorer quality of care and outcomes experienced by disadvantaged patients

- Stereotypes/generalizations
- Insensitivity
- Discrimination, stigmatization, bias and prejudice
- Pessimism, reluctance, and resistance
- Lack of insight into patients background
- Lack of critical thinking, reflective practice
- Preconceived ideas/assumptions:
  - Question the assumption that the needs of socioeconomically different clients/patients are similar, and that established policies and priorities are equally appropriate for everyone

- Inflexible practice:
  - Commitment to professional uniformity might give the appearance of egalitarianism, however, uniformity doesn’t necessarily encapsulate any meaningful concept of equity
Disadvantaged patients:

- Less likely to adhere to preventive measures
- Poorer knowledge about health and disease concepts
- More misunderstandings about disease susceptibility and benefits of early detection
- Ask fewer questions
Characteristics of clinician – patient relationships that facilitate high quality care and positive outcomes for disadvantaged patients

Imbued with an understanding/appreciation of the client/patient social and economic circumstances

Empowering

Mutual respect and trust

Collaborative communication

Patient centred

Continuity of care

Flexibility of practice
What factors shape or condition the clinician - patient relationship?
Social and economic factors that influence the clinician - patient relationship
## Social and economic factors

- Education
- Employment status
- Occupation
- Income

- Neighbourhood
- Housing
- Transport

- Life-course exposures

- Health literacy/knowledge

- Values, attitudes, beliefs, expectations (culture)

- Private health insurance
- Previous experience with health care system

- Childcare

- Social networks & relationships
How can clinicians more effectively engage with the SDoH and health inequities?

Clinician – training & profession

Client - patient relationship

Community

Polity
Training and profession

Frameworks and models that incorporate a SDoH perspective (not just inequalities in health care)

Curricula: develop competencies in public policy & health care policy analysis and advocacy

Curricula: augmented with a social justice/equity lens

Professional “Codes of Conduct” to include statements about SDoH and equity

Community placements and service
Community

Leadership

Develop partnerships (e.g. schools, welfare organizations)

Engaging in public debate/media advocacy (e.g. articulate the health benefits of policies regarding taxes, housing, transport & education)
Polity

Advocacy

Legislative strategies (e.g. Lobbying, petitions)

Regulatory reform (e.g. Change public policy, health policy)
Barriers to overcome in terms of greater clinician/practitioner engagement in the SDoH and health inequities:

Dominant ideology of individual responsibility for health (biomedical/behavioural/’lifestyle’ discourse)

Pedagogic emphasis on clinician/practitioner – client/patient relationship

Heavy workloads and time constraints
Conclusions

Social and economic factors are the fundamental cause of health inequities, so upstream (and to a lesser extent) midstream efforts are going to have the biggest impact on reducing health inequities.

There is an important role and contribution to be made by downstream efforts; however, the exact nature of the role remains ill-defined, and hence the maximum potential of this level to make a difference to health inequities is someway from being realized.