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Clinical contributions to addressing the social determinants of health

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ABSTRACT – The drive to address social determinants of health is gaining momentum. Appreciating that health outcomes are only partly affected by healthcare, clinicians and clinical communities can play a significant role in this crusade by action at local, regional, national and global levels. A concerted and systematic focus on integrating and industrialising upstream interventions at every healthcare encounter is essential to prevent future illness, thus enabling a paradigm shift in the healthcare service from being one of illness management to health preservation. The evidence base demonstrates the cost efficacy of upstream interventions. The challenge is how this evidence is utilised to implement these interventions in everyday healthcare. Today, with a global economic crisis and challenged public sector funding, the need to address prevention has never been more pressing. Clinical engagement at all levels, from the front line to the boardroom is vital. Clinicians must address access, communication, strategy and commissioning to fulfil a professional responsibility to become and remain the corporate memory of a health service focused on preventing illness while simultaneously delivering cost-effective healthcare.

KEY WORDS: health inequalities, social determinants

Introduction

The review on tackling social determinants of health by Sir Michael Marmot has challenged all individuals and organisations to assess their contributions to this agenda, in its quest to ameliorate health inequalities.[1] Broadly, the commission from the World Health Organization (WHO) highlights three areas for action:

- to improve daily living conditions
- to tackle the inequitable distribution of power, money and resources
- to measure and understand the problem and assess the impact of action.

It is the third area in which clinicians may be able to contribute as well as implement practical reforms to address the consequent inequalities which clinicians manage on a daily basis.

At a macro level, the UK government has established a review with four tasks. It must firstly identify the evidence most relevant to underpinning future policy and action. Secondly, it must show how this evidence could be translated into practice. Thirdly, it must advise on possible objectives and measures, building on the experience of the current Public Service Agreement targets on infant mortality and life expectancy. Finally, it must publish a report of the review's work to contribute to a post-2010 health inequalities strategy. It is clear that a wide range of clinical partnerships involving public health and social care professionals are essential to deliver an optimal strategy with realistic aspirations, transforming rhetoric into practice.

Determinants of health outcomes

It is important for clinicians to appreciate that functionally, the current healthcare system contributes downstream by dealing with health outcomes consequent to a combination of societal and environmental factors. The NHS spends considerable resource and effort in dealing with the health consequences of inequalities, somewhat neglecting its potential contribution in preventing those health consequences. Differential exposure to these 'determinants' or 'causes of causes', in conjunction with differential vulnerability attributed by differential living conditions and access to healthcare, determines disparate health outcomes and the health inequalities witnessed by the medical profession and society at large.[2] The aspiration of the NHS Next Stage Review for the health service to transform from an illness management to a health preserving service is not only beneficent to the individual, but makes considerable economic sense, particularly in the impending economic climate of fiscal famine.[3] Maintaining health not only delivers individual well-being but maintains their contribution to society and the economy, thus avoiding the fiscal consequences of illness and subsequent dependence upon the welfare state.

A real movement to address social determinants of health and disease has rightly gained momentum. Successive secretaries of state for health have highlighted that inequalities in health are

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something we could not afford to ignore, with poverty, unemployment and ill health too often inherited like a gene.

Challenges to the clinician

What are the potential roles of individual clinicians and clinical communities in addressing social determinants of health? How might the individual clinician contribute at levels ranging from the individual to global populations? The clinician has evolved to accommodate many roles and responsibilities ranging from healer and pioneer, to that of manager and leader in today's health service. Many will feel a sense of nihilism at the mere thought of engaging with the social determinants agenda. However, it is a challenge which clinicians must rise to. Without a paradigm shift in the mindset of clinicians to accommodate the need to be at the very least cogniscent of social determinants, healthcare economies will be slow to make the shift from a reactive to a predictive health service and slow to reap the rewards of such a shift.

The evidence base and drivers for tackling social determinants

An evidence base alone is insufficient to tackle health inequalities and the social determinants of disease (indeed, traditional studies lauded within evidence-based medicine usually fail to define social value judgements of interventions), but a robust review of evidence by organisations such as the National Institute for Health and Clinical Excellence (NICE) is vital to guiding policy and strategy. Levers, tools and incentives are essential to translate evidence into practice. Performance management and impact assessments are equally essential to ensure implementation is optimal and sustained. The challenge for clinicians and public health communities is not to replace the armoury of drugs and allied therapeutic interventions which the profession is accustomed to providing, but rather complement these with often neglected upstream interventions to optimise personal and population health gains. Upstream interventions, often considerably more cost effective than downstream interventions, may provide the opportunity costing to facilitate investment within the NHS. Communication and coordinated action between public health and clinical communities must be strengthened in order to define, integrate and industrialise upstream interventions throughout the health service.

Smoking alone accounts for over 50% of the variation in UK life expectancy and up to 30% of all acute hospital admissions are tobacco related. As a single brief intervention, plausible for any healthcare professional to deliver, smoking cessation advice may potentially have a dramatic impact on healthcare resource utilisation.

Strategic challenge

Healthcare strategy must be optimally formulated and deployed to ensure paramount health gains. While NHS targets have undoubtedly improved healthcare by removing deleterious situations, such as two-year waiting times to see a specialist, other targets and drivers can generate perverse incentives with little health gain. Clinicians should professionally challenge strategies and policies which are demonstrably inefficient or which divert attention and resources away from more pressing priorities eg where services are inversely proportional to need such as palliative care in inner cities.

Over their working careers, clinicians contribute to healthcare delivery for three or more decades and therefore must accept the function of being the corporate memory of the health service. Incessant reorganisation of the NHS undoubtedly disrupts focus and communication while creating artificial boundaries obstructive to seamless and equitable healthcare delivery but, with long-term vision, clinicians have an opportunity to underpin intermittent turbulence with strategic stability.

Addressing social determinants in acute care

At the coalface of acute care, clinicians clearly impact upon acute health gains. Coupled to proactive case finding and upstream interventions, such acute activity delivers the preventative healthcare expected of all healthcare staff. Social determinants of inequalities are often covert and therefore awareness is necessary to pursue their detection. One example would be a strategy to ensure that not only cessation of tobacco smoking but also the reduction of passive smoking and smokeless tobacco use be proactively sought and addressed, particularly in areas of deprivation. By leading existing multidisciplinary teams and extending their roles, clinical teams can detect determinants and impart upstream interventions along an entire pathway of care. Newer structures and organisations therefore need not necessarily be developed rather some things should be done differently and different things should be done.

Following the delivery of acute care, clinicians must ensure that pathways reaching into the community are optimised to maximise benefits from secondary prevention. More challenging in an era when the healthcare economy aims to deliver as much healthcare in the community as possible, clinicians must guarantee that they engage with primary care, public health and social care teams to ensure prevention is not only delivered at every opportunity in the acute sector, but also that appropriate strategies are developed to embed prevention services into mainstream primary care. In primary care, clinicians must embrace the concept that not only is more acute care offered closer to home, but entire pathways of care should be delivered covering primordial and primary prevention in tandem with health and social care interventions.

Analysis from WHO demonstrates that the top seven contributors to morbidity and mortality from any cause worldwide are also cardiovascular risk factors and, therefore, cardiovascular disease prevention has much to offer the wider healthcare economy as a starting point in the quest to ameliorate health inequalities.

Improving communication across clinical pathways

Enhanced communication across clinical pathways is essential to influence the root cause of much morbidity and mortality. Preconceptual health lays the foundation for disparities and inequalities and therefore clinicians might wish to influence the upstream agenda of maternal and child health. Childhood, adolescence and early adulthood offer opportunities to entertain primordial and primary prevention strategies across clinical pathways. When treating the consequences of adverse behaviours in one pathway, eg alcohol-related harm, does the clinician intervene to reduce the risks of subsequent admission or the psychosocial consequences of alcohol abuse?

Improving access to healthcare

Simply providing does not ensure access to healthcare, but rather may foster inequalities in access unless individuals are made aware of their existence, the services are acceptable and physically accessible (in time and place) and acquired equitably. Continuous audit and equity impact assessment of services is crucial to ensure inequalities are addressed. Equal access is not necessarily equitable if healthcare needs are disparate. Commensurately, disparities in disease prevalence do not necessarily equate to inequalities and this is an important observation. Disparities may reflect different patterns of disease or presentation. Therefore, informed needs assessment, audit and service development are key to respond to inequalities data from health outcome reports and regional health profiles demonstrating inequalities in care.[4]

Influencing service development and strategy

Clinicians and clinical networks can strongly influence healthcare commissioning but should also aspire to influencing local strategic partnerships to ensure wider determinants of poor health are addressed in local area agreements developed between NHS, local authorities and partners. Therein is an opportunity for clinicians to make a significant impact upon local social determinants of health.

Clinical influence at a regional level

Clinical engagement engineered by the Next Stage review provides an opportunity for clinicians to influence regional strategies, programmes and partnerships.[3] Regions must begin to use knowledge of inequalities to guide strategic developments and define the health and social care workforce, along with the skills required of it to deliver upstream interventions and additionally detect triggers for urgent healthcare utilisation. Peer review of clinical pathways, services and interagency links must be facilitated to optimise the impact upon social determinants at a macro level, cogniscent of the need to focus on mental as well as physical wellbeing.

The current approach in the NHS to improving quality and ensuring value for money in a time of global recession puts innovation, productivity, and prevention at the heart of the healthcare agenda. This is a process underpinned by clinical engagement. Free of thought constraints, healthcare staff will shortly enter into dialogue which aims to define and deliver optimal healthcare in a challenging climate. Concepts of cost effectiveness and its alignment with capacity (greater investment is not always commensurate with better healthcare), equity and an appreciation of the overall healthcare economy within these dialogues will strive to deliver an engaged workforce with wider strategic vision. Collaborative disinvestment and strategic development has the potential to shape healthcare without boundaries in a climate where competition and boundaries have often constrained healthcare development for the overall healthcare economy.

Clinical influence at a national level

At a national level, firstly there is ample opportunity for clinicians to engage in guideline development, particularly at NICE where each guideline commendably has a focus on inequalities and is tailored to meet the needs of groups where the evidence base dictates a need. Clinicians have much to contribute to public health programme guidance development by demonstrating opportunities for upstream interventions at each healthcare interaction. Secondly, a clinical contribution to challenging policies damaging economic growth is essential and communities such as the medical royal colleges and voluntary organisations, by virtue of hosting such debates, are rightly seizing the initiative to ensure developments in the food and drink, alcohol, tobacco and arms industries are fully aware of their health impact at population level. It is a duty of clinical communities to demonstrate the social injustice of inequitably weighted economic growth. Climate change is a prime example of how the carbon footprint of developed countries creates an unequal mortality burden on developing countries and the poor. Consequently, all global summits and policies should accommodate health impact assessments and clinicians, particularly academic clinicians, are invaluable in developing such assessments. The carbon footprint of healthcare should begin to challenge individuals and institutions, starting with the role of the NHS and its employees.

Clinical influence at global level

Clinical contributions to the social determinants agenda at a global level are more challenging. India, for example, is an economic powerhouse celebrated by trade sectors and organisations, yet a quarter of the population survive on less than $2 per day, a third of all deaths occur in children under the age of five years and almost half of three year olds are malnourished. All clinical communities and organisations must be cogniscent of global healthcare challenges and the responsibility developed

world governments have in playing their part in addressing global inequalities.

An awareness of global health inequalities data is often useful in developing local services. For example, globally, 20% of cardiovascular disease (CVD) deaths occur in south Asians. This is projected to rise to 40% by 2025. Local outcomes data, which in England have demonstrated year upon year that proportional mortality ratios are higher in this ethnic group. How might the physician use this information to improve health outcomes locally? An appreciation of such inequalities enables the clinician to tailor not only individual healthcare with a heightened suspicion of CVD in patients from this ethnic group, but proactive case finding might also be influenced at local, regional or national levels.[5] Risk assessment and interventions for primary prevention might be influenced by such epidemiological data too.[6,7] Similarly, knowledge that CVD prevalence and outcomes demonstrate a socioeconomic gradient enables justifiable strategies for proactive case finding, risk assessment and upstream interventions in deprived populations, together with local tailoring of services to improve access and outcomes. Local challenges are thus informed by global, national and regional epidemiological data.

Clinician as sociologist

Finally, for those clinicians who lead communities, one must recognise that while healthcare delivery and social change movements have been challenged to focus on diversity of the populations they serve, we must celebrate similarity to the same extent to which we focus on diversity, to develop more cohesive rather than divided communities, thereby reducing the mental strain of marginalised groups being perceived as 'different' or feeling as such.

Summary

Overall, it is time to appreciate that health outcomes are only partly determined by health services. Doctors must rise to the challenge of having a greater impact on health outcomes by embracing opportunities to influence health inequalities by addressing social determinants of health and disease. Prevention is everybody's business in 21st-century healthcare and clinicians are well placed to be the advocates of their most vulnerable patients.

Conflicts of interest

KP is also chair of trustees for the South Asian Health Foundation and trustee to the National Heart Forum, which have both contributed to the policy dialogue on social determinants of health.

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