If social determinants of health are so important, why don’t we ask patients about them?

Patients’ socioeconomic circumstances should be routinely enquired about and documented in their healthcare record, according to Andrew Moscrop and Sue Ziebland.

Health inequalities are worsening across Britain. Recent data from the Office for National Statistics (ONS) reveals that men who live in England’s ‘most deprived areas’ die ‘nearly a decade’ earlier than those living in affluent neighbourhoods. These inequalities are widening year on year. Overall improvements in life expectancy have slowed, and have actually reversed for some: the statistics show ‘a large fall in life expectancy at birth among women living in the most deprived areas in England’.¹ Previous reports have described stark differences in health between specific local authority areas. In ‘the Hampshire district of Hart’, Britain’s wealthiest and least deprived area, life expectancy was 83.3 years for men and 85.4 for women; while in Glasgow City, an area with high levels of deprivation, life expectancy was Britain’s lowest: ‘73.3 years for males and 78.7 years for females’.² These statistics confirm the impact of socioeconomic circumstances on health. They also highlight one of the major themes of this paper: that the measurement and description of those health impacts and resulting inequalities tends to rely on data relating to geographic areas, rather than individual level data. In this paper we consider: the limitations of geographic area data in healthcare; the importance of individual-level socioeconomic circumstances to patients’ health and to their engagement with healthcare; how the acknowledgement of that importance has prompted efforts to improve socioeconomic data collection in North American healthcare settings; and the potential for doctors to respond purposefully to Britain’s worsening inequalities in health and healthcare.

Social determinants of health and the problems with postcodes

Between the glaring extremes of life expectancy exposed by the ONS data above, researchers in the UK have described a ‘social gradient in health’ whereby the lower our socioeconomic position, the more likely we are to die sooner and to suffer from disease while we are alive.³ Lower socioeconomic position or greater deprivation is associated with increasing incidence of mental health problems,⁴ as well as greater mortality from cardiovascular disease⁵ and most cancers.⁶ Definitions of ‘socioeconomic position’ and
‘deprivation’ vary, but they commonly include acknowledgement of social determinants of health such as employment status, occupation, education, housing, and household income. These social and economic factors not only affect health\textsuperscript{7} and health experiences\textsuperscript{8}, but also significantly influence people’s healthcare access, healthcare outcomes, and engagement with health protection activities including immunisation and screening programmes.\textsuperscript{9,10,11,12} Yet within Britain’s National Health Service, no system exists for the routine assessment of patients’ socioeconomic circumstances. Social health determinants are not routinely enquired about, documented, or coded in clinical settings.

The health service, in effect, is blind to those social determinants of health and healthcare. Where patient-level socioeconomic data is required, for service evaluation, clinical research, or even some clinical decision-making (included along with ethnicity in online cardiovascular risk calculation tools) composite deprivation scores are employed. These scores use averaged geographic area data, inferred from the postcode of the patient’s home address. But while geographic area data are appropriate for comparing groups (as demonstrated by the ONS above), it is not appropriate to use the data to identify or characterise individuals from within those groups. This makes intuitive sense: living in a ‘deprived area’ is not the same as being deprived; not everyone with a Glasgow postcode experiences deprivation and not everyone in Hampshire is affluent. For this reason, and for several others (see Box 1), a patient’s postcode is an unreliable indicator of their socioeconomic circumstances.

**Developments in the US and Canada: social prescribing and equity monitoring**

Given the scale of their potential impact upon patients’ health (recall the decade of lost life expectancy described by the ONS), the lack of attention paid to social determinants in UK healthcare settings seems strange. The absence of robust socioeconomic assessment is especially surprising because doctors are often concerned with attempting to identify individuals at risk of adverse outcomes, and to quantify as accurately as possible the risks of disease incidence or treatment failures; all of which may be affected by patients’ socioeconomic circumstances. These omissions in the NHS appear increasingly striking as other healthcare systems begin to take patients’ socioeconomic contexts more seriously, making socioeconomic enquiries part of routine clinical care and providing a roadmap for changes in UK practice.
In the US, during the Obama-era healthcare reforms, it was recognised that identifying deprived patients and addressing their social needs before they became clinical ones could restrain healthcare spending and improve health outcomes. Accordingly, the US National Academy of Medicine delivered specific recommendations for practitioners on the assessment and recording of patients’ education level and their experience of financial hardship.\textsuperscript{13} Subsequent research has demonstrated the feasibility of routine assessment of these and other social health determinants in US healthcare settings;\textsuperscript{14} clinicians have reported that the knowledge acquired can prompt useful adaptations in patients’ care plans\textsuperscript{15} while improving communication;\textsuperscript{16} and patients referred onward through social prescribing networks have been shown to benefit from improved access to community resources.\textsuperscript{17,18}

Even while evidence is still awaited on the ultimate health and cost impacts of socioeconomic assessments and social referrals in the US, practitioners in the UK should take note. Social prescribing is already part of the NHS Long Term Plan for England. Characterised as embracing everything from debt counselling for the insolvent to dance classes for the lonely, social prescribing is intended to link patients with suitable non-medical resources or services from the voluntary or community sector. The aim is to benefit people by addressing their social needs, while reducing pressures on primary care services. The NHS Long Term Plan describes the intended recruitment of hundreds of social prescribing link workers and anticipates the benefits to millions of patients.\textsuperscript{19} If this initiative is to meet the needs of the most deprived and play a useful role in tackling inequalities, patients’ individual socioeconomic needs would require to be identified and interventions would preferably be based on reliable data evidencing those needs.

In Canada, four large health organisations in Toronto have already introduced routine collection of patients’ social data, including information on housing and household income. Doctors there have used this data alongside an online tool to identify social benefits for which patients may be eligible; tackling income issues directly in the clinic.\textsuperscript{20} The primary stated purpose of the data collection in Toronto though is to monitor the association of patients’ socioeconomic characteristics with healthcare access and outcomes; creating an improved basis for reducing healthcare inequalities.\textsuperscript{21} Researchers have used the data to demonstrate social disparities in cancer screening, showing that those on low income are
significantly less likely to be screened. Notably, this association was not revealed when only neighbourhood-level geographic area income data was used for the analysis.\textsuperscript{22} Again, the relevance to the UK is apparent. Here, despite healthcare being free at the point of service, socioeconomic barriers to healthcare exist and healthcare inequalities persist. The consequences are evidenced by the greater cancer mortality among patients from deprived areas attributed to ‘healthcare system factors’, including later diagnosis and impaired access to optimal treatment.\textsuperscript{23}

**The duty of doctors to ensure equality, and its negation in politics and policy**

While some may maintain that social inequalities lie outside the remit of the medical profession, and even that socially determined inequalities in health are beyond our capacity to usefully intervene, the responsibility for inequalities in *healthcare* cannot be shirked. There is a fundamental ethical duty to ensure that patients have equal access, equal experience, and equal benefit from healthcare. Where this is not so we must take steps to ensure it. But like much else in healthcare, evidence is a pre-requisite to action. Present systems in the UK that rely on patients’ postcodes are simply too blunt for the purposes of identifying, addressing and monitoring socioeconomic inequalities in health and healthcare.

The aim of reducing inequalities in healthcare access and outcomes was repeatedly referred to in the 2012 Health and Social Care Act. That Act was based on the government white paper Equity and Excellence, but the promise of that title has yet to be fulfilled. When the 2010 Equality Act was brought before Parliament by Harriet Harman during the final days of the last Labour government, it included a ‘public sector duty regarding socioeconomic inequalities’. Public bodies, including health authorities, would be required to consider how best to ‘reduce the inequalities of outcome which result from socio-economic disadvantage’.\textsuperscript{24} Monitoring healthcare access and outcomes according to accurate socioeconomic markers might have been a logical response. But the legislation has never been implemented. Soon after the Conservative-led coalition took office Theresa May, then Home Secretary, dismissed Harman’s socio-economic duty as ‘ridiculous’, and scrapped it.\textsuperscript{25}

Professor Michael Marmot, one of the UK’s leading public health researchers, has proposed that the ‘monitoring of all health and health-care measurements by socioeconomic position, sex, geographical distribution, or other relevant markers of health equity, such as education’
would represent an important first step in confronting health inequalities. The British Medical Association has suggested that doctors should consider patients in the context of social factors that affect their health, noting the adverse health impacts of poor housing, unemployment, poverty, and low educational achievement. But these recommendations have not been made manifest in policy, no significant effort has so far been made to bring about a shift in practice, and the subject has been largely neglected in the UK research agenda.

**Feasibility and acceptability**

The irony is that even when they are not addressed directly, patients’ socioeconomic circumstances and their health effects are unavoidable in healthcare settings, especially primary care. Patients frequently present to their GP with problems relating to welfare benefits, housing, or unemployment, and significant amounts of consultation time are spent talking about these non-medical issues. Yet though socioeconomic circumstances and difficulties are commonly witnessed and discussed, they are rarely coded in the medical record. Health practitioners’ enquiries about patients’ ‘social’ factors and their documented ‘social histories’ continue to focus on socially-influenced behaviours such as diet, exercise, alcohol consumption, and smoking habits.

Our omissions do not occur by accident. The social structures that have allowed inequalities to arise permit them to persist, and to remain invisible. Our blindness to social determinants and our lack of process for asking about and documenting patients’ socioeconomic circumstances may reflect learned professional priorities, perceptions of the role of healthcare, and perhaps too doctors’ positions of relative socioeconomic privilege. But by not discussing social determinants with patients, by not collecting socioeconomic data, and by allowing inequalities to remain invisible or obscured by postcodes, we help to conceal these issues from public view, and from the political agenda. The loss of ‘nearly a decade’ of life expectancy represents a deficit owed to the most deprived. To end the complicity of the medical profession with existing health and healthcare inequalities we must begin by gathering data: documenting the social contexts that affect access and outcomes of care, evidencing inequalities, aiding research into their causation, and monitoring their improvement. Why do we not do this already in Britain? The most commonly cited answer is that patients would object. But we do not need to go as far as North America to witness the
feasibility and acceptability of systematic socioeconomic enquiries in healthcare settings: midwives in the UK routinely ask every expectant mother about their financial security, employment status, occupation, education, and housing.

No child deserves to be born with their life span diminished by as much as a decade due to socioeconomic circumstances. But as life expectancy at birth falls for the most deprived in Britain and as socioeconomic health inequalities widen, it is surely time for doctors to acknowledge the social determinants that impact peoples’ health. The roll out of social prescribing and the importance of ensuring an equitable healthcare system make it timely to consider the need for socioeconomic enquiries in clinical settings.

Box 1. Problems with using socioeconomic data derived from postcodes

- ‘Postcode data’ is actually drawn from larger geographic areas for which statistics are available, such as Lower Layer Super Output Areas (LSOAs). An average postcode contains 15 households; an average LSOA contains 672. So ‘postcode’ data includes far greater averaging effects than might be supposed, making it much less accurate and more liable to blunt extremes of affluence and deprivation and their effects.
- Composite deprivation scores (including Indices of Multiple Deprivation, Townsend Scores, Underprivileged Area Scores, and the Carstairs Index) derived from postcodes mask the lived experiences of deprivation and conceal the actual social causes of health effects; obscuring aetiology and potential points of intervention.
- Interpretation may be confused by ecological fallacies: when inferences about individuals are deduced from inferences about the group to which they belong. Area data may reveal an area of deprivation, but does not reveal the deprivation of an individual from that area.
- Unreliable where populations are heterogeneous or undergoing rapid demographic change.
- Inapplicable to the estimated 320,000 people who are homeless or vulnerably housed in Britain and who represent some of the most deprived and vulnerable members of our society.

Key messages

1. Socioeconomic factors (including education, employment, occupation, housing, and household income) are known to impact patients’ health, as well as their healthcare access and outcomes, but these socioeconomic factors are not routinely documented in UK healthcare settings.
2. Consequently, it is not possible to identify individuals whose social circumstances leave them at risk of poor health or poor healthcare access, or to identify social needs that require
intervention.
3. Social prescribing in primary care would benefit from introduction of routine assessment and documentation of patients’ individual socioeconomic circumstances.
4. Using individual-level socioeconomic data in monitoring healthcare access and outcomes would create a basis for fairer healthcare and help to fulfil the ethical duties of doctors.
**Contributors and sources**

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**Report of patient involvement**

Patients were not involved in the writing of this article.

**Conflicts of Interest**

The authors have no competing interests to declare.

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