If social determinants of health are so important, shouldn’t we ask patients about them?
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Patients’ socioeconomic circumstances should be routinely enquired about and documented in their healthcare record, according to Andrew Moscrop, Sue Ziebland, Gary Bloch, and Janet Rodriguez Iraola

Health inequities are worsening across Britain. Data from the Office for National Statistics (ONS) reveals that men living in England’s ‘most deprived areas’ die ‘nearly a decade’ earlier than those in affluent neighbourhoods. The ONS also reports ‘a large fall in life expectancy at birth among women living in the most deprived areas in England’.¹ 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 inequities tends to rely on data relating to geographic areas, rather than data describing the experiences of individuals. In this paper we consider: the limitations of geographic area data; the importance of individual-level socioeconomic circumstances in relation to health and care; and how individual-level socioeconomic enquiries have been incorporated into routine care by some North American healthcare teams. Finally, we consider the potential for doctors to respond purposefully to Britain’s inequities in health and healthcare by asking patients about their socioeconomic circumstances. The purpose of this would be to improve the targeting of social prescribing and other relevant components of care, and to create an enhanced data set for research and monitoring healthcare equity.

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’.² On this gradient, lower socioeconomic position or greater deprivation is associated with increasing incidence of mental health problems,³ and greater mortality from cardiovascular disease⁴ and most cancers.⁵ Recognised social determinants of health such as employment status, occupation, education, housing, and household income, not only affect people’s health⁶ and health experiences,⁷ but also significantly influence healthcare access, outcomes, and engagement with health protection activities.⁸⁹¹⁰¹¹ Yet within Britain’s National Health Service, no system
exists for the routine recording 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 are required, composite deprivation scores are
commonly employed. These scores are based on averaged geographic area data, inferred
from the postcode of the patient’s home address. Area based deprivation scores are then
applied to individuals and used in clinical research, as well as service evaluation (including
the GP patient survey run by Ipsos MORI for NHS England), and even some clinical decision-
making (included in online cardiovascular risk calculation tools, for example). But while
geographic data and area-based deprivation scores are appropriate for comparing groups
(as demonstrated by the ONS statistics above), it is not appropriate to use the data to
characterise individuals from within those groups (the ONS state specifically that their Index
of Multiple Deprivation should not be used for this purpose). This makes intuitive sense:
living in a ‘deprived area’ is not the same as being deprived. For this reason and others (see
Box 1), a patient’s postcode is an unreliable indicator of their socioeconomic circumstances.
So the socioeconomic components of research, evaluation, and clinical decisions that utilise
postcode data have their reliability undermined too.

The duty of doctors to ensure equity and the need for equity data

The lack of robust individual-level socioeconomic assessment in healthcare settings means
that doctors are unable to identify individuals whose socioeconomic circumstances increase
their risk of adverse health outcomes or treatment failures. Accordingly, it is not possible to
identify those who may have most to gain from targeted interventions, including social
prescribing or enhanced follow up. Also and importantly, it is not possible to reliably
monitor socioeconomic inequities in healthcare.

While some may maintain that social inequities lie outside the remit of the medical
profession, and even that socially determined inequities in health are beyond our capacity
to usefully intervene, we cannot shirk a responsibility for inequities in healthcare. There is a
fundamental ethical duty to ensure that patients have equal access, equal experience, and
equal benefit from care. Like much else in healthcare, evidence is a pre-requisite to action.
But present UK systems that rely on patients’ postcodes are simply too blunt for the
purposes of identifying, addressing, and monitoring socioeconomic inequities in health and healthcare.

The aim of reducing inequities in healthcare access and outcomes was repeatedly referred to in the 2012 Health and Social Care Act. That Act was based on the UK government’s white paper Equity and Excellence, but the promise of that title has yet to be fulfilled and the mechanisms for effectively reducing socioeconomic healthcare inequities are yet to be installed. 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 a first step in confronting health inequities. The British Medical Association suggests that doctors should consider patients in the context of social factors, noting the adverse health impacts of poor housing, unemployment, poverty, and low educational achievement. But these recommendations have not been made manifest in policy, nor led to any appreciable shift in practice, and the subject has been largely neglected in the UK research agenda.

The irony is that even when they are not acknowledged overtly, patients’ socioeconomic circumstances and their health effects are unavoidable, especially in 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 or only inconsistently noted in the medical record. Health practitioners’ enquiries and their documented ‘social histories’ continue to focus on socially influenced behaviours such as diet, exercise, alcohol consumption, and smoking habits.

Yet by not asking patients about their social circumstances, by not recording socioeconomic data, and by allowing inequities to remain invisible or obscured by postcodes, doctors may help to conceal these issues from public view, and from the political agenda. These are important, but often unacknowledged, moral choices (see Box 2). 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 inequities we must begin by gathering data: documenting the social contexts that affect patients’ health, their
access and outcomes from care, thereby evidencing inequities, aiding research into their causes, and monitoring changes.

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

The lack of attention paid to social determinants in UK clinical care appears increasingly striking as other healthcare systems begin to take patients’ socioeconomic contexts more seriously. The developments described below may provide a roadmap for changes in practice elsewhere.

In the US, during the Obama-era healthcare reforms, it was recognised that identifying and addressing patients’ social needs could restrain healthcare spending and improve health outcomes. 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. Subsequent research has demonstrated the feasibility of routine assessment of these and other social health determinants in US healthcare settings; clinicians have reported that the knowledge acquired can prompt useful adaptations in patients’ care plans while improving communication; and that patients referred onward through social prescribing networks benefit from improved access to community resources.

Evidence is still awaited on the ultimate health and cost impacts of socioeconomic assessments and social referrals in the US. Nonetheless, UK practitioners 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 address 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. If this initiative is to meet the needs of the most deprived and play a role in tackling inequities, reliable individual level socioeconomic data is needed.

In Toronto, Canada, the routine collection of patients’ social data including information on housing and household income has been introduced in four large health organisations (including the Family Health Team at St. Michael’s Hospital where two of our author team
are located). Doctors have used this data alongside an online tool to identify social benefits for which patients may be eligible;\(^\text{24}\) tackling income and related issues directly in the clinic (see Box 3). The primary stated purpose of the data collection in Toronto is to monitor the association of patients’ socioeconomic characteristics with healthcare access and outcomes; creating an improved basis for reducing healthcare inequities.\(^\text{25}\) 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).\(^\text{26}\) The relevance to the UK is apparent, 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.\(^\text{27}\)

**Proposals for action**

Healthcare teams that are inclined to initiate socioeconomic enquiries may find the learning points from Toronto helpful (see Box 4). They include a single-question screening tool for identifying patients experiencing poverty. More in-depth questions might address occupation, current or recent unemployment, highest level of education, housing (owning, renting, homelessness, etc), and household income (using income brackets). Primary care would seem the appropriate setting to commence asking patients about these socioeconomic factors. Though coordination might best occur nationally, the enquiries could prove valuable even if initiated locally. Patients identified as experiencing socioeconomic difficulties might be referred to social prescribing networks, and across the practice population the information obtained could be used in auditing and resolving healthcare inequities (for example in relation to screening uptake, specialist referrals, or treatment follow-up). Other healthcare teams, including Improving Access to Psychological Therapies (IAPT) services, might also find socioeconomic enquiries useful for the purposes of care planning and service evaluation. Meanwhile, further research may be required to confirm the best approaches, including the most appropriate socioeconomic questions to ask and how often to ask them. It may be important to seek the views of a range of patients on these issues. We also need to ensure that there are adequate electronic record templates and clinical codes to record socioeconomic information. In primary care, QOF incentives could be introduced to motivate socioeconomic data collection (as previously
occurred for ethnicity data), materials and messages developed to communicate the purpose to patients and staff, guidance produced on how best to audit and utilise the data, and the role of socioeconomic enquiries could be emphasised in postgraduate training.

Doctors can make these changes happen. Which may prompt the questions of why they have not done so already, and why socioeconomic enquiries have been so widely neglected. The omission may not be entirely accidental. The social structures that have allowed inequities to arise permit them to persist, and to remain invisible. Our lack of process for asking about and documenting patients’ socioeconomic circumstances may reflect learned professional priorities, limited perceptions of the role of healthcare, and perhaps too the relative socioeconomic privilege of doctors.28

Some cautions and caveats around socioeconomic enquiries appear in the published literature.29 These include concern about a lack of time, reflecting pressures on healthcare staff, but also the prioritisation of biomedical factors over social determinants. Another frequently encountered concern is the supposition that patients would object. Yet we do not need to go as far as North America to witness the 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. It is a collective failing that the children born to some of those mothers will have their life span diminished by as much as a decade due to socioeconomic circumstances. As life expectancy at birth falls for the most deprived in Britain, as socioeconomic health inequities widen, and as inequities in healthcare continue to be overlooked, it is surely time for doctors to act on the knowledge that social determinants impact peoples’ health.
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. So aetiology and potential points of intervention are obscured.
- 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.
- Confounded by area effects: postcodes may be associated with deprivation, but may also be independently associated with other environmental health determinants.
- 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.

Box 2. Implicit moral choices in routine care: QRISK

The routine management of cardiovascular risk in UK primary care provides an instructive example of our problematic clinical response to patients’ socioeconomic contexts. Current NICE guidelines advise clinicians to “use the QRISK2 risk assessment tool to assess CVD risk for the primary prevention of CVD in people up to and including age 84 years.” With a few exemptions, the UK population will be periodically subject to this CVD risk assessment by a GP using an online QRISK tool. The algorithms of both QRISK2 and the updated QRISK3 use the patient’s postcode to determine their neighbourhood deprivation score; and this area-based deprivation score influences the patient’s calculated CVD risk; which then influences clinical decisions including blood pressure medications and statin prescribing for the individual. Leaving aside concerns already described about using postcodes to define individual deprivation, what happens here implicitly is an attempt to ameliorate socially determined disease risk using clinical interventions, with an increased risk of side effects and harms for the more deprived. Despite a recent emphasis on shared decision-making, this typically occurs without a discussion about social health determinants ever occurring between patient and doctor.
Box 3. Patient Perspective, from Toronto Canada

“For me, keeping healthy is a full-time job, and it takes most of my disposable income. When I came to the Family Health Team at St Michael’s in Toronto, I was asked about my physical conditions, my medications, the usual. But the doctor also asked me about my work (I had stopped working for a few years), and then asked about my sources of income, how I paid for my medications, and about my social and emotional life. I left the doctor’s office with all my regular prescriptions, plus an appointment to see a clinical social worker, and another to see a nutritionist. Healthcare providers talk about food with patients diagnosed with Type 2 diabetes, high cholesterol, or after a heart attack: why not have a ‘food’ talk with someone who is un(der)employed or lives on disability income?”

Box 4. Learning points from the Toronto experience

* Choose and modify existing tools to systematize collection of socioeconomic information. One of the simplest approaches uses the single question screener ‘Do you (ever) have difficulty making ends meet at the end of the month?’ Affirmative answers are a good predictor of poverty (sensitivity 98%, specificity 40%). The Canadian Centre for Effective Practice (https://cep.health/clinical-products) provides other online resources for clinicians, including a poverty tool and the IF-IT-HELPS tool for social history-taking.
* Plan for implementation. Information gathering can be done on registration forms or by front line health providers. The whole team need to be involved. Resources and referral pathways should be established in advance for patients facing socioeconomic challenges.
* Ensure that socioeconomic questions are asked with sensitivity and respect, and with confidence - like we ask about other sensitive areas like sexual orientation, drug use, or past trauma - ensuring that the patient feels comfortable and empowered.
* Plan for data analysis. Data needs to be analysed and reviewed to ensure it has an appropriate influence on practice.
* Always consider this process to be imperfect. Engage in continuing quality improvement and critical analysis of both the data collection process and the data collected.
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. Robust individual socioeconomic assessments could identify individuals whose social circumstances leave them at risk of poor health or poor healthcare access, and identify social needs that require intervention.
3. Social prescribing in primary care would be more equitable and effective when combined with routine assessment and documentation of patients’ individual socioeconomic circumstances.
4. Monitoring healthcare access and outcomes using individual-level socioeconomic data would create a basis for fairer healthcare and help to fulfil the ethical duties of doctors.

Contributors and sources

This article was drafted by andrew moscrop following discussion with Sue Ziebland. Sue provided comments, edits and amendments to the final version. Gary Bloch commented on an earlier draft of this article, provided additional material for inclusion, and reviewed and approved the final version. Janet Rodriguez Iraola also reviewed and commented upon an earlier draft and contributed new material for inclusion (see below).

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Report of patient involvement

Janet Rodriguez Iraola is a patient at St Michael’s Hospital’s Family Health Team in Toronto and a Lived Experience Expert Patient Advisor for their Social Determinants Of Health Committee. For over ten years she has been an advocate for people experiencing disabilities and/or poverty in Toronto. She has served as a patient expert advisor for several previous projects based at St. Michael’s. Following peer review and editorial comments on an earlier draft of this paper, we contacted the team at St. Michael’s to ask if anyone among their patient participation cohort might be willing to comment upon our article and / or comment upon the experience of being asked questions about socioeconomic contexts in a healthcare setting. Janet was kind enough to review our earlier draft and
provide comments that we have incorporated, as well as providing a ‘patient perspective’ that we have also included. She reviewed and approved the final revised version. In working with our patient author we sought to follow the guidance contained in the document “What does the BMJ mean by patient involvement and co-production?”.

Conflicts of Interest

The authors have no competing interests to declare.

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