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

Response to BMJ comments. 3 December 2019

First, the argument isn’t being made clearly enough, judging from the fact that several of us had different interpretations (and were generally a little hazy) as to what you’re arguing. Some thought the piece was about improving the way in which individual doctors make decisions with the patient in front of them. Others thought it was an argument about better granularity of data to respond to population health needs or inform clinical decisions.

The fact that different readers had different interpretations of our argument certainly suggests a need for greater clarity. In fact, both interpretations of our argument are correct – it is about improving the way in which doctors deal with the patient in front of them AND about improving data quality. I have aimed to resolve ambiguity early on by specifying at the end of the introductory paragraph that the proposed socioeconomic enquiries would facilitate targeting of social prescribing and other components of care while creating an improved data set for monitoring healthcare equity and research.

If it is about the former (doctors and the patients in front of them), how would an uncoordinated data collection effort by healthcare teams help?

I understand your questioning of the value of uncoordinated data collection. However, I would respond by suggesting that the coordination could occur at various levels and still prove useful. Perhaps ideally it would be coordinated nationally in order to ensure consistency across services and a comprehensive data set for monitoring national trends. However, even if data collection were only coordinated within a single GP practice this would still be valuable – doctors could still use the information to target their social prescribing, and they could still use the data to conduct equity-focused audits of their care (identifying and seeking to resolve socioeconomic inequalities within their practice population in relation to specialist referrals, for example). I have added this point to the concluding remarks on implementation.

There was not space to discuss at length in the text, but it is interesting to note that this point and the examples that we cite in the paper reflect the different ways in which change can happen in healthcare settings: top-down with national guidance in the case of American socioeconomic data collection; bottom-up with local initiatives in the case of Toronto. We have sought to suggest the possibility of either approach.

The example you provide (QRISK2) is a problem for researchers so they can validate different deprivation questions (other than postcode) rather than healthcare teams. Doctors are still left with the questions specified by the instrument to calculate risk.

Regarding the comments about QRISK... I have contacted the creators of QRISK to ask why/how they rationalise the inclusion of the patient’s postcode in their tool despite the problems that we describe about the use of postcode data to infer characteristics of individuals – but I have had no reply. Validated questions for identifying individuals who experience poverty already exist and we mention one in our paper - in Canada, Brcic and colleagues found that the question ‘Do you (ever) have difficulty making ends meet at the end of the month?’ was a good predictor of poverty (sensitivity 98%, specificity 40%); also, in Switzerland, Bodenmann and colleagues found that the single question ‘Did you have difficulties paying your household bills during the last 12 months?’ identified patients at risk
of forgoing healthcare for economic reasons (sensitivity 74.1%, specificity 79.9%). There is abundant potential to validate other questions relating to other areas of deprivation, but this has not yet happened. I may have misunderstood your comments, but it is apparent to me that if, as you suggest, this is a problem for researchers, it has either not been acknowledged as such or its resolution has not been prioritised. Meanwhile, I DO consider QRISK to create a problem for healthcare teams because of the ethical issues described in the paper, even if these too are generally unacknowledged.

Many of us felt you need to cut to the chase sooner - the introduction/rationale are needlessly long. With the space gained, provide more detail on (a) exactly what extra data they want front line health professionals in general practice and also presumably secondary care to routinely record, alongside the current data and (b) what action they suggest is taken when this data suggests socioeconomic factors are underpinning (or exacerbating or may result in) health problems. Should there be a dedicated member of staff in GP practices who have the skill to talk sensitively and constructively to those at risk or in trouble and work out how social prescribing and other measures of support in the community might help them? Doesn’t the IORA model of general practice in the UK employ a cadre of staff to help in this respect?

In order to eliminate unnecessary preamble and cut to the chase I have shortened the first two paragraphs.

I have expanded the concluding section, ‘Proposals for action’, in order to provide greater detail on the sort of information that could be asked about and how the data could be used by healthcare teams. I have suggested that primary care is the most appropriate place to commence these routine enquiries, but said that they could also be utilised by other healthcare teams, such as IAPT services, where the information would also be valuable in care planning and service evaluation. I have not suggested that additional staff members should be employed to deal with these issues, partly because this work will be within the remit of the social prescribing link workers referred to previously in the text. I am afraid that I am not familiar with the IORA model of general practice mentioned.

We are not clear why you suggest that the route to getting this information should be via QOF points. Why not through routine/standard data collection?

The proposal with QOF points was that these should be used to motivate data socioeconomic collection in primary care. A precedent exists for this: some years ago QOF points were awarded for the collection of patient ethnicity details, leading to much improved ethnicity data sets. I have aimed to clarify the role of QOF incentives in the text.

You write that midwives are already collecting data on financial security, employment, occupation, education and housing on pregnant women. Is this policy and observed practice in all parts of the UK? if so it suggests there are lessons to be learnt about how do this for all patients? And what are midwives doing with this data when at risk women are identified? Again maybe we can learn from them re better/earlier use of social prescribing. It does indeed seem rather daft that we have policy to push the latter but not to collect the sort of data which would inform a rational and more effective approach to this form of prescribing.

Regarding the practice of midwives. I absolutely agree that it demonstrates the feasibility and acceptability of socioeconomic enquiries. A set of standard maternity notes are
produced by the Perinatal Institute, available here:
Page two of the Perinatal Institute pregnancy notes is routinely completed by the midwife at
the ‘booking’ appointment and includes a ‘social assessment’ that contains the following
questions: occupation; employment status; age leaving full time education; housing;
entitlement to benefits. According to details on the Perinatal Institute website, these notes
were initially introduced into clinical practice in the West Midlands in 2002 and have since
been rolled out across the country so that they are now used for over 60% of all maternities
in England. Even in places where the standardised Perinatal Institute notes are not used (like
here in Oxford), a ‘social assessment’ is still routinely conducted.
Midwives also demonstrate how the information obtained from socioeconomic enquiries
can be utilised. I have previously been in contact with our local community midwife lead
who tells me that, in Oxford, women identified on the basis of the above enquiries as being
of High Social Risk are referred and signposted to relevant agencies; safeguarding alerts are
made when necessary; the woman’s care plan is adjusted accordingly; and the issue is
followed up at subsequent pre and post natal appointments. Social prescribing, as you point
out, could absolutely follow this approach.

We also suggest that you include a brief comment on recommendations for medical education re
essential information students should learn to ask as part of taking a patients history.

On the subject of medical education, it may be worth noting that generations of medical
students have already been told to enquire about patients’ social contexts. In 1976,
Macleod’s Clinical Examination (a standard undergraduate text, available here:
https://archive.org/details/clinicalexaminat00univ/page/6) was advising that hospital
doctors needed to understand patients’ “normal background, not only in relation to
diagnosis, but also in the planning of rehabilitation”, mentioning employment, occupation,
and housing. The current 14th edition of Macleod’s gives a long list of enquiries that might
be directed at patients, including schooling and educational attainment, occupation
including exposure to hazards and attitude to work, financial circumstances including debts
and social security benefits, details of housing including size, ownership, and so on.
However, there is evidently an important disconnect between undergraduate precepts and
actual clinical practice. I have added a recommendation that socioeconomic enquiries should
be focused on in postgraduate education, especially in the training of GPs.

You may explore - if it works - whether taking some of the practical suggestions from the boxes and
putting it in the body text might work.

Final note, is QRISK2 appropriate to discuss given QRISK3 is out?
https://www.bmj.com/content/357/bmj.j2099

The NICE guidelines quoted refer only to QRISK2. QRISK3 uses the same postcode data in its
algorithm as QRISK2. I have made this point clear in the text.