Social determinants of health are critical, so why don’t we ask patients about them?

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Social determinants of health are critical, so 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. New data released by 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 Britain. In ‘the Hampshire district of Hart’, Britain’s wealthiest and least deprived area, life expectancy was found to be 83.3 years for men and 85.4 for women; while Glasgow City, an area with high levels of deprivation, had the lowest life expectancy: ‘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; the importance of individual-level socioeconomic circumstances to patients’ health and to their engagement with healthcare; how the acknowledgement of these issues has prompted efforts to improve socioeconomic data collection in North American healthcare settings; and the potential for changes in routine practice that would facilitate a response to Britain’s worsening inequalities in health and healthcare.

Between the glaring extremes of life expectancy exposed 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. Definitions of ‘socioeconomic position’ and ‘deprivation’ vary, but they commonly include acknowledgement of social health determinants such as employment status, occupation, education, housing, and household income. Those social and economic factors not only affect health and health experiences, but also significantly influence people’s healthcare access, healthcare outcomes, and engagement with health protection activities including immunisation and screening programmes. If health care professionals were more aware of patients’ circumstances, healthcare encounters could be better tailored to them. Yet within Britain’s National Health Service, no system exists for the routine assessment of our patients’ socioeconomic circumstances. Social 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 example, in the context of service evaluation, clinical research, or even some clinical decision-making (included along with ethnicity in online cardiovascular risk calculation tools, for example), that data takes the form of deprivation scores. These scores use averaged geographic area data, inferred from the postcode of the patient’s home address. But while 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; not everyone in Hampshire is rich. For this reason, and for several others (see Box 1), a patient’s postcode is an unreliable indicator of individual deprivation.

Directions for change

Given the scale of potential impact upon patients’ health, the lack of attention paid to social determinants seems strange. The absence of robust socioeconomic assessment in healthcare settings 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 routine and providing a roadmap for changes in practice. For example, during the Obama-era healthcare reforms in the US, it was recognised that identifying deprived patients and addressing their social needs had the potential to restrain healthcare spending and improve overall health outcomes. Accordingly, the US National Academy of Medicine has delivered specific recommendations for practitioners on the assessment and recording of patients’ education level and their experience of financial hardship. The issue of addressing patients’ social needs is, or ought to be, equally important in the UK. The integration of health and social care makes it prudent to start linking health and social care data: routine socioeconomic enquiries in healthcare settings would be a good place to start. As well, the growing interest in social prescribing (referring primary care patients to local community resources) and concern to make this a fair and effective intervention should suggest the aptness of routine assessment of patients’ social needs, before they become clinical needs.

In Canada, four large health organisations have introduced routine collection of patients’ social data, including information on housing and household income. The purpose is to monitor the association of these characteristics with healthcare access and outcomes in order to create an improved basis for reducing healthcare inequalities. Again, similar concerns might be expected in the UK. 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.

**Duties of doctors**

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, inequalities in healthcare are indubitably our responsibility. We hold an ethical duty to ensure that patients have equal access, equal experience, and equal benefit from services. Where this is not so we must take steps to ensure it. But like much else in healthcare, inequalities must be evidenced before they can be addressed. They must be monitored before efforts to ameliorate them can be evaluated. The present systems that
use patients’ postcodes to define deprivation are too blunt a tool to evaluate interventions
to improve health and healthcare access for those individuals who are socio-economically
deprieved. A health service that is blind to patients’ individual socioeconomic contexts
cannot contribute effectively to resolving the resulting inequalities.

The 2012 Health and Social Care Act made repeated (though non-specific) reference to
reducing inequalities in healthcare access and outcomes. 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’. Monitoring 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.

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 and no significant effort has so far been made to
bring about a shift in practice.

Feasibility and acceptability

The irony is that even when they are not addressed directly, patients’ socioeconomic
circumstances and their health effects are often 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, 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 our learned professional priorities, our perceptions of the role of
healthcare, and perhaps too our own positions of relative socioeconomic privilege.22 But by
not discussing social determinants with our 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 our 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. As
socioeconomic health inequalities widen in Britain and life expectancy falls for the most
deprived, it is time for us to take social health determinants seriously in our clinical work.
### 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 less accurate and more liable to blunt extremes of affluence and deprivation and their effects.
- Composite deprivation scores 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.
- 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.
- Unreliable where populations are heterogeneous or undergoing rapid demographic change.

### 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 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 recognise social needs that require intervention, or to adequately monitor equity in healthcare use.
3. The research and rationales supporting routine socioeconomic enquiries in Canada and the US should encourage reflection on current practice in the UK and elsewhere.
4. Using socioeconomic data in healthcare monitoring would provide 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.

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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14 Wray R, Agic B, Bennett-AbuAyyash C, Kanee M, Lam R, Mohamed A, Tuck A. We ask because we care: the tri-Hospital and TPH health equity data collection research project report September 2013. Toronto: Toronto Public Health; St. Michael's Hospital, Centre for Addiction and Mental Health; Mount Sinai Hospital; 2013.
24 Butler P. At least 320,000 homeless people in Britain, says Shelter. The Guardian. 22 Nov 2018.