All Policies

Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper)

Introduction

Social determinants of health (SDoH) are the conditions under which people are born, grow, live, work, and age, and include factors such as socioeconomic status, education, employment, social support networks, and neighborhood characteristics.[1] These have a greater impact on population health than factors like biology, behavior, and health care.[2,3] SDoH, especially poverty, structural racism, and discrimination, are the primary drivers of health inequities.[4-6] Reducing health inequities is important because they are pervasive; unfair and unjust; individuals affected have little control over the contributing circumstances; affect everyone; and can be avoided with existing policy solutions.[7]

The purpose of this position paper is to outline prevalent health inequities; describe how social factors impact health; discuss the role family physicians can play in addressing SDoH and reducin health inequities; and state the American Academy of Family Physicians (AAFP) stance on relevan policy interventions.

Definitions

Social Determinants of Health: The conditions under which people are born, grow, live, work, and age.[1]

Structural Determinants of Health Inequities: The social, economic, and political mechanisms which generate social class inequalities in society.[8]

Health Equity: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[9]

Health Disparities: "A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability."[10]

Health Inequities: "A difference or disparity in health outcomes that is systematic, avoidable, and unjust."[10]

Health Inequities

The most prevalent and severe health inequities occur where there is poverty, systematic racism, and discrimination.[6] Some of the most common and well-researched health inequities are experienced between groups based on socioeconomic status, race and ethnicity, sexual orientation and gender expression, as well as geographic location.[11,12] Information is provided in the following sections to help characterize these health inequities. However, this is not intended to be comprehensive or cover all health inequities.

Socioeconomic Status

Socioeconomic status refers to the social and economic factors that influence the position individuals hold in society. This includes factors like occupation, class, education, income, and wealth.[11,12] Individuals with higher socioeconomic status consistently experience better health outcomes than those with lower socioeconomic status, and this occurs across a social gradient.[11] It is not just the very poor who are affected. Research has shown that:

- Nearly as many deaths are caused by social factors as by behavioral or pathophysiological factors.[13,14] One group of researchers found that in the year 2000, more than 244,000 deaths could be attributed to low education (less than some college education); more than 133,000 deaths could be attributed to individual poverty (household annual income of ≤$10,000); and more than 39,000 deaths could be attributed to area poverty (live in a county where ≥20% of the population lives below the poverty line).[13]

- The death rate in 2007 was more than 2.5 times greater for individuals without a high school diploma compared to those with at least some college, and the disparity had increased since 1989.[15]
- Income inequality is associated with greater health care expenditures, health care use,[16] and death from cardiovascular disease and suicide.[17]

Race, Ethnicity, and Discrimination

Race and ethnicity are associated with many indicators of health status, even after considering socioeconomic status, behavior, and other characteristics. Systematic, persistent, and long-felt discrimination is thought to be the main contributor.[11] Research has shown that:

- Life expectancy is consistently lower for non-Hispanic black individuals compared to non-Hispanic white and Hispanic individuals of the same sex (Figure 1).[18]
- The infant mortality rate is more than double among infants born to non-Hispanic black wom compared to infants born to non-Hispanic white and Hispanic women (Figure 2).[19]
- Typical drivers of infant mortality do not fully explain the variation. Research has shown that

1. The infant mortality rate is greater among infants born to non-Hispanic black women across age groups and all socioeconomic levels.[20]
2. The infant mortality rate is greater among infants born to non-Hispanic black women across educational levels, and the disparity increases for those with a master's degree or higher. In fact, the infant mortality rate is highest for black women with a doctorate or professional degree.[20]
3. The prevalence of alcohol use during pregnancy is roughly the same among non-Hispanic black and non-Hispanic white women, and non-Hispanic white women are more likely to smoke cigarettes.[20]

Sexual Orientation and Gender Expression

Lesbian, gay, bisexual, and transgender (LGBT) people also experience higher levels of discrimination, stigma, stress, and worse outcomes for a variety of health status indicators. Research has shown that:

- All-cause mortality rates were found to be greater among gay men compared to heterosexual men. However, this was driven almost entirely by differences in HIV-related mortality.[21]
- Current alcohol use was greater among gay and bisexual men compared to heterosexual men, as well as greater among lesbian women compared to heterosexual women.[22]
- Heavy drinking was also greater among lesbian and bisexual women compared to heterosexual women.[22]
- Current smoking was greater among gay men and lesbian women compared to heterosexual men and women.[22]
- Delaying health care due to cost was greater among gay and bisexual men and lesbian and bisexual women compared to heterosexual men and women.[22]
- LGBT individuals are more likely than cisgender or heterosexual people to experience violenc victimization, harassment, and discrimination.[23]

Neighborhood and Place

The physical features of an area can impact people's health. Physical features like air and water quality and climate, as well as housing, parks, and other recreation areas all play a part in physical activity and life expectancy.[11] Research has shown that:

- There is more than a 20-year gap in life expectancy between U.S. counties with the highest and lowest life expectancy and this gap has continued to grow since the 1980s.[24] Life expectancy gaps of up to 25 years have also been identified between different neighborhoods within the same city (Figure 3).[25]
- Improving features of the built environment, such as sidewalks and streetscapes, the density of parks, and recreational facilities have been shown to be associated with greater levels of physical activity in children and adults.[26]

How Social Factors Impact Health

Health equity scholars use a metaphor of a "stream" of causation to illustrate how social factors impact health. The "downstream" factors include issues that medicine and public health typically deal with—morbidity and mortality, access to health care, behavioral risk factors, and living conditions. The questions that arise from this illustration are why are so many people sick and why are there such great differences among groups? The answer lies in the "upstream" factors, which include governance, culture, and societal values. These, as well as economic, social, and public policies, are the factors that lead to long-held social inequities (Figure 4).[8,27] To understand how social factors impact health, it is important to understand how risk factors are shaped upstream, and how differences in living conditions and exposures are physically embodied by individuals.

Upstream Factors: The Structural Determinants of Health Inequities

The structural determinants of health inequities are the social, economic, and political mechanism which generate social class inequalities in society.[8] These are macro-level factors that impact larg numbers of people. Examples of structural determinants of health include the degree that government subsidizes health care or education; decisions about pollution, including minimum standards or where toxic substances are stored or released; and decisions about the built environment, which can benefit or harm communities. These all contribute to social class inequalities. Jim Crow laws and redlining are more specific examples. These laws and corporate policies legislated segregation, restricted access to good housing from black Americans, and reduced their ability to influence governmental decisions or live in a healthy neighborhood. This had a substantial negative impact on the health of black Americans. Data showed that life expectancy and infant mortality improved for black Americans after these policies were eliminated.[24,28]

Downstream Factors: Opportunities and Constraints to Health Promoting Resources

Social factors also influence health by providing or constraining opportunities for people to access resources that promote better health. Individuals with low socioeconomic status are less likely to be able to acquire health care, nutritious foods, good educational opportunities, safe housing, or safe spaces for exercise.[29] Negative health behaviors, like tobacco, alcohol, or explicit drug use are often pervasive in disadvantaged communities. These types of behaviors are then socially patterned in children, who have not fully developed their ability to make rational decisions.[30] These factors are shaped by more upstream factors.

Chronic Stress and Embodiment

The upstream and downstream factors shape the conditions under which people live. Differences in living conditions and opportunities to make healthy decisions result in differentials in exposures and chronic stress. Embodiment is "a concept referring to how we literally incorporate, biologically, the material and social world in which we live..."[31]Social factors are embodied as individuals are exposed to repeated and chronic stress.[32] The autonomic nervous system, the hypothalamic-pituitary-adre axis, and the cardiovascular, metabolic, and immune systems protect the body by responding to internal and external stress. Over time, chronic stress can increase the allostatic load, or the "wear and tear" that accumulates on the body over time. This "wear and tear" has health damaging effects.[32,33]Historically-disadvantaged groups have been found to experience greater allostatic loa more "wear and tear" than more advantaged groups.[34] Embodiment and allostatic load are though explain why social factors are linked with almost every measure of health status throughout time.[31,33]

Call to Action

The AAFP urges its members to become more informed about the impact SDoH have on health and health inequities, and to identify tangible next steps they can take to address their patients' SDoH and reduce health inequities within their scope. The AAFP also urges hospitals and health care systems to consider the SDoH in their strategic plans and to provide their staff, including family physicians, with opportunities to engage with and advocate on behalf of their community to advance health equity. In addition, the AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess, and address SDoH.[35]Finally, since health inequities arise outside of the health care sector, the AAFP urges funders, including the federal

government, to provide sufficient funding to address the SDoH and reduce health inequities. In addition to other interventions, this includes robust financial support for the nation's public health infrastructure to support their efforts to facilitate cross-sector community collaboration, strategic planning for health, Health in All Policies, and the core public health functions.[36]

The Role of Family Physicians in Reducing Health Inequities

Family physicians can play an important role in addressing both the upstream and downstream SDoH. They provide high-quality health care for underserved populations more so than other medical specialties.[37] Family physicians can also work with their practice teams and community members to address SDoH in any of the following ways:

- Knowing how patients are affected by SDoH and helping address their needs to improve their health.
- Creating a practice culture that values health equity by addressing implicit bias in your practi and using cultural proficiency and health literacy standards.
- Understanding what health inequities exist within your community and helping raise the prominence of these issues among the public and policymakers.
- Knowing which organizations are working to improve health equity in your community and w your community's health agenda includes.
- Advocating for public policies that address SDoH and reduce health inequities.

The AAFP has created resources to assist family physicians and their health care teams at The EveryONE Project Toolkit.

Policy Recommendations

The AAFP supports the following types of public policies for their ability to address SDoH and reduce health inequities.

- Access to Health Care: The AAFP recognizes that health is a basic human right for every person and that the right to health includes universal access to timely, acceptable, and affordable health care of appropriate quality.[38] All people of the world, regardless of social, economic, or political status, race, religion, gender, or sexual orientation should have access to essential

health care services.[39] The AAFP also urges its members to become involved personally in improving the health of people from minority and socioeconomically disadvantaged groups. The AAFP supports: (1) cooperation between family physicians and community health centers to expand access to care; (2) regulatory and payment policies that encourage the establishment and success of physician practices in underserved areas; (3) programs that encourage the provision of services by physicians and other health care professionals in underserved areas and that meet the unique health needs of those communities; and (4) public policies that expand access to care and address SDoH.[40]

- Health in All Policies: The AAFP supports adoption of a Health in All Policies strategy by all governing bodies at the local, state, and federal levels. Health in All Policies strategy aims to improve the policymaking process by incorporating health implications, evidence-based information, and community input. This is intended to help inform policymakers about how their decisions about laws, regulations, and policies will impact health and health equity.[41]
- Federal Nutrition Programs: The AAFP supports federal nutrition programs as a matter of pu health. Access to affordable and healthy food significantly affects an individual's health, education, and development.[42] Food access also supports medical treatment that requires patients to take medications with food. In 2015, more than 42 million people in the U.S. were living in food insecure households, including more than 13 million children.[43]
- Anti-Poverty Programs: The AAFP supports programs that lift people out of poverty and has issued the position paper, Poverty and Health – The Family Medicine Perspective.[44] Poverty h been defined as the inability to acquire goods and services that are viewed as necessary to participate in society and negatively affects almost every indicator of health status.[12,45] The poverty threshold in the U.S. was $12,752 for an individual under age 65 and $25,094 for a family of four in 2017,[46] with 12.3% of individuals in the U.S. considered living in poverty.[47] Examples of policies that are effective at lifting people out of poverty include: the earned income tax credit, Social Security, unemployment insurance, and rental assistance programs.[48,49]
- Support for the Homeless: The AAFP supports Housing First programs that offer rapid access to permanent, affordable housing integrated with health care and supportive services. Housing First is a model defined by the U.S. Department of Housing and Urban Development (HUD) as a method to "quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry..."

Preconditions and barriers can include, but are not limited to sobriety, treatment, or service participation requirements.[50] Housing impacts health care. Access to safe and affordable housing is a SDoH. Homelessness may exacerbate existing health conditions and lead to the development of new health conditions. Persons who are homeless frequently experience co-occurring severe physical, psychiatric, substance use, and social problems.[51] Health care services are more effective when a patient is housed, and maintaining housing is more likely when comprehensive primary health care services are available. Effective strategies to end homelessness must address this complexity of health conditions and disability faced by persons who are homeless.

- Civil Rights and Anti-Discrimination: The AAFP opposes all discrimination in any form, including, but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, or national origin.[52]
- Educational Achievement: The AAFP supports programs that improve equitable access to hi quality education and equitable educational achievement. Education is associated with man health behaviors, and therefore affect health status. Individuals with lower education are mo likely to smoke, have an unhealthy diet, and lack exercise.[53] They also have a lower life expectancy.[54] Despite this, school funding, teacher-to-pupil ratio, and other important indicat of educational quality are not distributed evenly by state and community.[55] All schools shoul have sufficient funding to meet the educational needs of its students and promote success. Special attention should be paid to inner city and rural schools that are often under-resourced and may need increased resources to meet their students' needs. Based on strong evidence showing improved educational, social, and health-related outcomes (especially in low-income or racial and ethnic minority communities) the AAFP supports funding for center-based early childhood education,[56] full-day kindergarten,[57] and out-of-school-time academic programs.[58] The AAFP also supports funding for grants, scholarships, and other means of financial support for low-income college students.
- Built Environment: The AAFP supports improvements to the built environment, such as designing walkable neighborhoods, complete streets, and mixed-use zoning as a means to improve community health.[59] The AAFP also supports equitable improvements to the built environment, with a special emphasis on disadvantaged communities, and community input

into these decisions to ensure that current residents are not displaced or otherwise negatively impacted.[60]

- Home Visitation Programs in Pregnancy and Early Childhood: The AAFP supports home visitation programs in pregnancy and early childhood where trained professionals visit families and provide information and training about health, development, and care of children. These programs offer families the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.[61]
- Alternate Payment Models: The AAFP supports alternative payment models that ensure SDoH are appropriately accounted for in the payment and measurement design so that practices have adequate support to improve quality and outcomes for all patients, eliminate health disparities, and reduce costs for the health care system.[35]
- Medical Education: The AAFP supports education on SDoH and their impacts on health inequity to be integrated into all levels of medical education. Physicians should be knowledgeable about the impact of SDoH and have the ability to work with patients to address SDoH by tailoring treatment to address patients' barriers to better health.[62]

Conclusion

Social determinants of health have a substantial impact on the health of many Americans and are key driver of health inequities. Family physicians have an important role in addressing both upstrea and downstream SDoH and reducing health inequities by providing high-quality health care for the underserved and advocating to raise the prominence of health inequities among the public and policymakers. The AAFP urges its members to work with their practice teams and community members to address SDoH and urges government, health care systems, and public health organizations to develop policies and practices that address SDoH to help reduce health inequities.

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