The social determinants of health (SDOH) in CBL cases

Background: a structural interpretation of the SDOH

Individual and community well-being and health are strongly influenced by the broader context in which patients live. This can be broadly spoken of in terms of social determinants of health, including the structural determinants of health, and related concepts of colonialism, racism, and others.

The World Health Organization defines the social determinants of health (SDOH) as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life." Attending and responding to the SDOH improves **health equity (the absence of unfair and avoidable or remediable differences in health among social groups)** (WHO 2010).

Structural determinants of health are those that cause and operate through intermediary determinants of health—e.g. housing, physical work environment, social support, stress, nutrition and physical activity—to shape health outcomes (National Coordinating Centre on the Determinants of Health). The structural determinants include "all social and political mechanisms that generate … stratification and social class divisions in society and that define individual socioeconomic position within hierarchies of power, prestige and access to resources" (p. 5). The social determinants of health thus include both structural determinants and intermediary determinants.

Colonialism is a key structural determinant of health that persists in Canada through Indigenous-settler health inequities, Black health disparities, and challenges for newcomers in accessing care. Health inequities due to socioeconomic status (SES) are closely tied in Canada to geographic inequities that also reflect the colonial project of occupying and using the land. **Colonialism exists to further the "viability and reproduction of the colonizer," and results in inequities in accessibility and quality of care provided to the colonizing vs. colonized populations** (Amster 2022)**.** Colonization enforces western world views and approaches at the expense of Indigenous cultural, social, spiritual, and physical lifestyles and health.

Reading (2018) represents this structure from an Indigenous perspective as a tree: the structural determinants of health are the trunk, the basic structure that produces the rest. The determinants are also sometimes analyzed as proximal (e.g. individual health literacy; family support), intermediate (e.g. school policy; kinship and relationship to the land and ceremony), and distal (e.g. colonialism) (Loppie, Reading & Wien 2009; Raphael 2016).

All of the dimensions of diversity explored in the diversified CBL cases are relevant to the social determinants of health and to health equity. For example, race and ethnicity point to the role of (e.g.) racism or Islamophobia as structural determinants of health; Indigeneity, settler status, and Black identity point to colonialism as a structural determinant of health. Learning to question one's own assumptions, learning to evaluate medical evidence for bias, practicing the health advocate role, learning to respond in clinically appropriate ways (e.g. trauma-informed care, inclusive and affirming practice) to patients of diverse identities, all serve the goals of addressing the SDOH and achieving health equity.

Structural determinants of health in patient care, in advocacy, and in system change

Why should medicine pay attention to structures, if these are so deeply rooted, difficult to change, and outside the healthcare system?

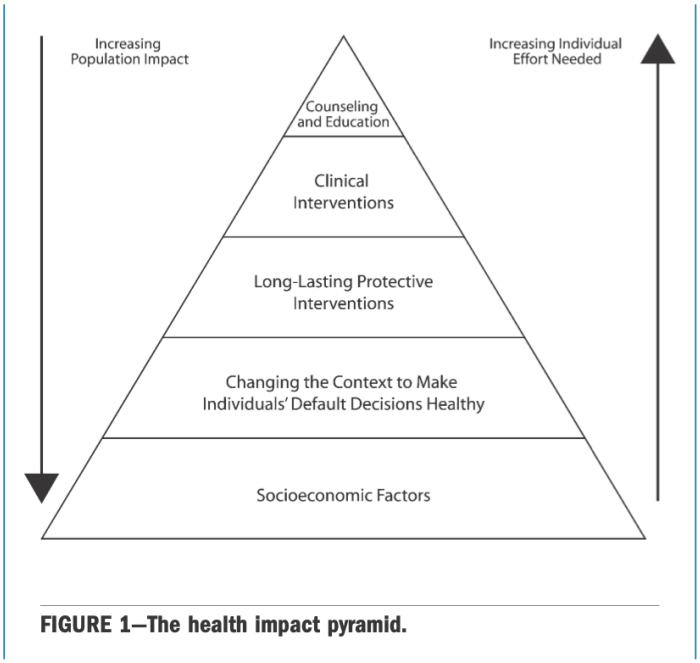

FIGURE 1—The health impact pyramid.

Figure 1 from Frieden 2010

- Canada spends a high proportion of provincial budgets on health care, while fewer tax dollars are available for determinants of health that have an even stronger impact, such as education and housing (FPTACPH 2009).
- Understanding structural determinants **challenges the blame and stigma** that can attach to the proximal determinants of health (lifestyle, behaviour).
- Because understanding them helps us work with community to **design interventions and approaches to care that work** for community.

For example, lifestyle modification recommendations that attempt to convince Indigenous persons to increase their physical activity in the absence of safe and appropriate infrastructure sets unrealistic expectations that can harm the therapeutic relationship. This infrastructure continues to be underfunded in Indigenous communities. Furthermore, asking Indigenous people and communities to adopt a Mediterranean diet or the Lancet "healthy planet" diet will fail, for multiple reasons that are rooted in colonialism: fruits and vegetables key to the Mediterranean diet are in low supply and very expensive, with a high carbon footprint, in remote areas of Canada; healthy diets and food security are closely tied to access to land, which has been systematically destroyed by settler colonial states; asking Indigenous persons to adopt a European diet after centuries of intentional efforts to disrupt traditional Indigenous food systems is a continuation of cultural genocide; producing dietary guidelines without substantive input from the people affected perpetuates epistemic racism (i.e. the concept that one racial group's knowledge system is superior to that of another).

Current best practices in addressing the SDOH in clinical care and in advocacy

Best practices include:

1. **Moving attention from individual "lifestyle" factors to structural determinants.** A "5 Whys" exercise can be used to help us move from intermediary to structural determinants of health (Card 2017).
    - Take the patient's concern (e.g. diabetes) and ask "why?" they have that concern (e.g. "poor diet"). Take the answer to that question and ask "why" again, until (after five

iterations) you have reached social structures in context of people's individual choices or health experiences.

2. **Taking a strengths-based rather than a deficits-based approach**. On a deficits-based approach, intermediary determinants of health are presented as individual failures to adopt healthy lifestyles and are treated as the cause of inequitable health outcomes. On a strength-based approach, we consider the strength people show in achieving their level of health in the face of oppressive structures that work against them.
3. **Using key clinical approaches that support safe and effective care** in the context of social and structural determinants of health, such as trauma-informed care, harm reduction, affirming care (for sexual orientation and gender identity) and inclusive care (for disability).
    - The social accountability of the profession and the health advocate role at the policy level (Meili et al. 2016; Woollard et al. 2016) and at the individual patient navigation level (Goel et al. 2016) support addressing the social determinants of health to advance health equity.
4. **Using the principles of community engagement to work with communities.**

The Social Determinants of Health the CBL cases

In the CBL cases, a wider array of patient socio-economic status (SES) are now portrayed than in the past, by describing education and occupation, including job security or insecurity, source of funding if any for drug and health benefits, housing insecurity, food insecurity, and health literacy.

This is clinically realistic, as well as reflecting Canada's poverty measures. Specifically, we portray people living meaningful lives wherever they are within structures that provide or deny them:

- The basics to **participate** in society with "dignity" (housing, food, clothing, access to information)
- What is needed for "**opportunity**" (with secure housing and food, the resources to participate in sports, leisure, culture, vacation)
    - Persons with secure housing and food can lose either or both through medical events.
- Income and capital that gives them "**security**" (a relatively small number of patients; able to pursue opportunities in a wide range of areas; education and voice to advocate for themselves in healthcare; housing, benefits, savings, and retirement funds to manage medical events and conditions without risking their economic security, housing, etc.) and the ability to give their children help with major life investments (education, housing)
    - Persons who have this level of income and capital security can lose it through medical events.

Cases represent physicians undertaking patient advocacy in these situations, including using tools to assess how patients are impacted by the social determinants of health, to address the hidden curriculum that might imply this isn't part of routine medical practice. Even if the case doesn't focus on the social determinants of health, this adds realism to the case.

Cases also include discussion questions that prompt the group to consider how to address the social determinants of health, e.g. assessing patient financial resources and supporting patients via interprofessional care, navigation, advocacy, social prescribing, etc..

Language and tutorial process notes: reflecting current best practices

- In portraying and discussing the adverse health effects of the social determinants of health, **take a strengths-based approach rather than a stigmatizing deficit-based approach**.
    - Example:
        - Deficit-based: *Andrew and Kara are both very concerned about the on-going disruption of their social, cultural, and spiritual traditions due to colonization.*
        - **Strength-based:** *Andrew and Kara are actively involved in the revitalization of traditional resource management as a means of disrupting colonial harms.*
    - Example:
        - Deficit-based: The Indian Act is a colonial imposition.
        - **Strength-based:** The Indian Act has been amended many times in history in response to the ways that Indigenous communities always found ways to circumvent even the most profound forms of oppression.
    - Examine presuppositions instead of assigning responsibility to patients. E.g.: Does the patient have a limitation in health literacy, or is the provider not speaking to them in their language?
    - If someone's work is poorly paid, or not paid at all (e.g. caregiving in the home), that is a societal structure and not a personal shortcoming.
- As in all dimensions of diversity, **assume that the people being talked "about" in the cases are people who are also in the room.** Do not assume that everyone in the room is of high SES and here to "help" people of lower SES.
    - Even though physicians are in general well remunerated, differences exist between areas of practice, between genders, and across racialized identities; in addition, economic insecurity affects high-income individuals too;
    - Learners have a long career path ahead of them and sometimes substantial student debt before they earn professional incomes.
    - Formal or informal group sharing can exclude lower-income participants when activities or conversation focuses around expensive leisure activities.
- **The language for people experiencing the adverse effects of structural disadvantage is challenging**.
    - "Vulnerable" is still sometimes used, but it can insinuate or imply "blaming the victim." The structural determinants are the factors that people are vulnerable to, and that present barriers to their wellbeing.
    - "Marginalized" is also sometimes used, but it also has limitations—it can be heard as "othering" people who are present. If you are yourself a physician, medical student, or collaborator in patient care, and you and your community is described as "marginalized" when you are in the room, it gives the impression that your colleagues think everyone shares the same ("majority") identity.
    - "Minority" is also problematic if we consider that what we commonly consider "majority" identity is also a numerical minority, when all the dimensions of diversity are taken into account.
    - Some better options include **speaking to the specifics of a given group, or when talking about those experiencing health inequities, using "equity denied" or "equity deserving" groups, or "priority communities."**

- People rarely identify as “poor” or living “in poverty,” given the stigma attached to this language, though some poverty activists do. Talking about specifics with patients is better (“would affording this prescription be a challenge for you?”), as is using the academic language of higher or lower socio-economic status.

Patient identity is not the social determinant of health.

Rather, the structures that disadvantage patients based on their identities are the determinants of health.

Racism, not race or ethnicity, is the social determinant of health.

- Racism includes individual acts of discrimination (individual attitudes), but it also includes structural factors: e.g. historical and current limitations on land ownership, school systems that disrupt families and provide sub-standard education, job segregation, intensive policing of communities and the prison system, etc.

Gender isn’t a social determinant of health: sexism is, including (for example) unequal pay and the unequal distribution of caregiving responsibilities that lead to disruption in women’s earnings.

Sexual orientation or gender identity are not risk factors; transphobia and homophobia and their far-reaching ramifications (such as making patients reluctant to seek care or to share sexual practices with care providers) are the risk factors.

Disability is not a social determinant of health; ableism and the way environments are physically structured to be inaccessible to some disabled persons are the determinants.

Citations

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What Makes Canadians Healthy or Unhealthy?

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian.

"Why is Jason in the hospital?
Because he has a bad infection in his leg.

But why does he have an infection?
Because he has a cut on his leg and it got infected.

But why does he have a cut on his leg?
Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.

But why was he playing in a junk yard?
Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.

But why does he live in that neighbourhood?
Because his parents can't afford a nicer place to live.

But why can't his parents afford a nicer place to live?
Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed?
Because he doesn't have much education and he can't find a job.

But why ...?"

Toward a Healthy Future

Toward a healthy future: second report on the health of Canadians. 1999.

Case Diversification Committee: Keith Brunt (Pharmacology, DMNB), Abdullah Chanzu (Class of 2025; SDIC), OmiSoore Dryden (James R. Johnston Chair in Black Canadian Studies; Community Health & Epidemiology), Jordin Fletcher (Class of 2025), Sarah Gander (Pediatrics DMNB), Leah Jones (Family Medicine; Black Health Academic Lead), Neha Khanna (Class of 2025; DMSS VP EDI), Darrell Kyte (Program Evaluation), Osama Loubani (Assistant Dean Pre-Clerkship), Susan Love (CPDME), Natalie Lutwick (Student Assessment), Anna MacLeod (Director of Education Research; RIM), Eli Manning (Visiting Scholar in Anti-oppressive Practice; School of Social Work), Anu Mishra (Ophthalmology; Skilled Clinician Unit Head), Anne O'Brien (administrative support), Tiffany O'Donnell (Family Medicine, Med 1 ProComp Unit Head), Christopher O'Grady (Class of 2023), Oluwasayo Olatunde (Family Medicine, NB), Sarah Peddle (Community Partnerships and Engagement), Leanne Picketts (EDIA Curriculum Reviewer), Lynette Reid (Bioethics; chair), Jim Rice (Curriculum Refresh liaison), Sanja Stanojevic (Community Health and Epidemiology), Wendy Stewart (Assistant Dean Pre-Clerkship), Gaynor Watson-Creed (Associate Dean for Serving and Engaging Society), Brent Young (Family Medicine; Indigenous Health Academic Lead).