Social Determinants of Health and the Affordable Care Act

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ABSTRACT

Healthy living is mainly seen as a product of good genetics and holistic healthcare in the United States, but a growing field of research is also attributing well-being to social determinants of health (SDH), which are the compounded effects that arise from the concentration or lack of social capital. The Affordable Care Act (ACA) was enacted to promote the overall health of the country and its clauses are calling to attention the health disparities that come from social inequalities, the main sources for SDH. The ACA acknowledges that SDH affects marginalized communities in different ways, and to mitigate their effects, it localizes funding in hopes of empowering individuals and communities, but there is no integrated, multi-prong system for addressing SDH.

KEYWORDS: Social determinants of health, marginalized populations, mitigation techniques, integrated models of care

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INTRODUCTION

Historically, improvements in living environments have ushered in higher levels of good health. The creation of a modern sewage system in London during the 1800s was instrumental in curbing the rate of infection for cholera.[1] However, the benefits of the new systems were not equal and the poorer residents were still at disadvantages; the latrine systems for the wealthy had flush-control valves, whereas the latrine systems for the poor were flushed manually, which continued to spread disease.[2] This trend of unequal benefits to health improvements within a region has continued into the present day, with the least socially advantaged populations confronted with many more health problems. Realistic efforts to improve public health on the whole necessarily should include policies that are designed to mitigate the health disparities that arise from social inequality.

WHAT ARE SDH?

Overall health improvements, such as advances in vaccines, have been beneficial to people across the board, but the social determinants of health are still preventing many groups from reaping the fullest benefits of such advancements.[3] Although health is primarily seen through a biomedical perspective, the conditions in which people live, work, and play (social determinants of health) act not only to influence one's access to healthcare, but also largely determine the health and rate of illness within communities. Social determinants of health refer to the context in which health arises: the economic, political, social, and cultural conditions of communities and institutions that perpetuate them.[4,5] Racism, poverty, unsafe neighborhoods, and lack of education are some of the many SDH that create health inequity through effects such as elevated stress levels, higher rate of uninsured patients, and less access to healthy foods.[6-8]

Social determinants of health disproportionately affect already marginalized populations, exacerbating the material and psychosocial inequalities that they may already face. Wealth and income are main contributors to SDH; they are important to preventative measures, such as living in safe neighborhoods, as well as curative measures, such as being able to afford medical attention for illnesses. Social inequality not only prevents people from treating their current illnesses, but also creates health problems in itself. The rate of mortality among different social classes is stark; many of the working poor are in manual labor jobs and research has shown that the health of manual workers declines more rapidly during the working years than does the health of non-manual workers.[6] Some SDH, however, are indirectly associated with wealth, but also compound the stresses

of working and living conditions. In Rhode Island, many undocumented immigrants (estimated at 35,000 people in 2007) face a unique combination of working low-wage positions, encountering language barriers to health care, and fearing detection from deportation agencies, all of which compound with other SDH to create conditions that exacerbate undiagnosed illnesses and poor health.[7]

There is increasing interest in the field of SDH and a growing body of evidence that demonstrates the roles of SDH in creating health inequity.[8] Consequently, because the SDH are also contributors to social inequality in general, research has discussed the importance of the government in promoting social capital and equity by way of mitigating SDH.[9] Unequal social capital continues and compounds through the effects of SDH, and disease prevention can arise from the promotion of social justice. Healthcare services – that is, direct medical attention – function both as curative and preventative biomedical strategies, but equitable healthcare access alone does not overcome the complex ailments that stem from SDH. Mitigating social determinants of health, in addition to improving equitable access to health care, are keys to promoting healthy communities.

SDH MITIGATION: THE AFFORDABLE CARE ACT

The Affordable Care Act intends to bring about healthcare reform for the United States and it addresses aspects of SDH in a two-pronged approach that emphasizes both individual and community responsibility for well-being. The act outlines different classes of resources for these two scopes of responsibility: Its efforts to encourage desirable actions at an individual level include funding allotments for public information campaigns to help people make informed choices. Additionally, to contextualize health improvement efforts, grants are given at a community level for local organizations.

INDIVIDUAL RESPONSIBILITY

The goal of reducing health disparities is central to the ACA's efforts of increasing healthy choices, but the nuances of SDH – in particular, its community-specific disparities – are unaddressed at the individual level. In Section 4004 of Title IV (Prevention of Chronic Disease and Improving Public Health), there are provisions related to the dissemination of disease prevention tips and techniques.[10] Additionally, the act will dedicate funds for the creation of an Internet portal that allows individuals to track their own health. Although they are improvements overall, without targeting specific at-risk populations through such efforts as language translation and rural dissemination, even higher overall population health may not translate to higher health for communities already affected by SDH.

While individual empowerment is an important cornerstone of health, the ACA public information campaigns and Internet health portals rely almost entirely on personal choices to overcome the institutionalized social determinants of health. This practice follows what Baum et al describe as "a long-standing Western biomedical and individualistic concept of health."[11] By placing the responsibility of obesity reduction, for instance, on the individual to make more informed diet choices, the ACA fails to recognize that many low-income neighborhoods are food deserts, where fresh fruits and vegetables are scarce. In contrast, processed and shelf-stable foods are more abundant, which can lead to poor nutritional health.[12] This approach falls short, as the ACA's individualized efforts are not prioritized for especially disadvantaged populations, but for the average American.

COMMUNITY EMPOWERMENT

For the disadvantaged populations, however, the ACA has taken a larger community-level scope to mitigate SDH. The Secretary of Health and Human Services is enabled with the authority under Subtitle C to award monetary grants to community organizations and departments that are able to address healthy living in certain areas that have "racial and ethnic disparities, including social, economic, and geographic determinants of health."[13] The Community Transformation Grants, while created primarily to address community-specific health concerns, also serve as a tool to improve the holistic well-being of marginalized communities. The grants' guidelines call for neighborhood safety as well as infrastructure for healthy living, among others.

Although the Community Transformation Grants do reflect a national acknowledgement of SDH, the ACA does not create comprehensive programs to address mitigation techniques for SDH. The grants, while aimed at localized solutions, are not part of a larger, integrated system that seeks to prevent SDH, as well as monitor their salience. Without a cohesive system that strategically targets SDH from many angles, the ACA's main line of SDH mitigation will be through the Community Transformation Grants. While it is most likely the case that all cities have populations that are more susceptible to SDH than others, these relatively small grants are not standard for all states and their communities; instead, communities with the resources to apply for the grants and are not guaranteed to have a winning application.[14] Compared to the complexity of the integrated-care model that the ACA mandates for healthcare reform, the simplicity in which the ACA addresses SDH reveals that mitigating social determinants is not a main priority for the legislation.

Even if there were an integrated model for SDH mitigation, Rhode Island faces a uniquely challenging position to alleviate effects of SDH because the state has several communities of resettled refugees, in addition to dense minority urban cores. Its refugees potentially face language barriers as well as psychological trauma due to the events that led to their emigration from their home countries. In particular, many Cambodian Americans in Rhode Island are refugees

due to the reign of Pol Pot and his genocidal mission. As such, migration woes of small communities can compound with inequalities faced by ethnic groups on the whole and result in many more SDH affecting them. The ACA's reliance on community organizations and local departments to implement SDH mitigating policies may not address the full SDH spectrum that affects marginalized populations within even larger marginalized communities.

CONCLUSION

The development of an American healthcare system that works to eliminate health disparities rests on the importance of action aimed specifically at the social determinants of health. In particular, integrated policies should be explicit in mitigating SDH through many channels. Additionally, SDH policies ideally should integrate local involvement of community-based organizations, which can elucidate problems plaguing specific communities and provide health assessments of the policies. In its fullest, the healthcare system and its policies that aim to create healthy communities must also be synergistic to policies already in place that promote education, economic justice, and equitable services. Social determinants of health are as much related to the health of communities as they are to the general well-being of its populations.

References

1. Halliday S. *The great stink of London: Sir Joseph Bazalgette and the cleansing of the Victorian capital.* 2nd ed. Shroud, UK: Sutton; 2007:XI.
2. Hassan J. *A history of water in modern England and Wales*. Manchester, UK: Manchester University Press;1998:14.
3. Tarlov AR. Social determinants of health: the sociobiological translation. In: Blane D, Brunner E, Wilkinson R, eds. *Health and Social Organization: Towards a Health Policy for the Twenty-First Century*. London, UK: Routledge; 1997;157(3):79.
4. Baum FE, Bégin M, Houweling TA, Taylor S. Changes not for the fainthearted: reorienting health care systems towards health equity through action on the social determinants of health. *American Journal of Public Health*. 2009;99(11):1967.
5. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs*. 2002;21(2):81.
6. Case A, Deaton AS. Broken down by work and sex: how our health declines. In: Wise DA, ed. *Analyses in the Economics of Aging*. Chicago, IL: University of Chicago Press; 2005:204.
7. Kullgren JT. Restrictions on undocumented immigrants' access to health services: the public health implications of welfare reform. *American Journal of Public Health*. 2003;93(10).
8. Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annual Review of Public Health*. 2011;32:382.
9. Baum FE, Bégin M, Houweling TA, Taylor S. Changes not for the fainthearted: reorienting health care systems towards health equity through action on the social determinants of health. *American Journal of Public Health*. 2009;99(11):1968.
10. 111th Congress. The Patient Protection and Affordable Care Act. Section 4004. 2010. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Accessed February 11, 2013.
11. McLeroy K, Holtzman D. Framing health matters. *American Journal of Public Health*. 2009;99(11).
12. Hendrickson D, Smith C, Eikenberry N. Fruit and vegetable access in four low-income food desert communities in Minnesota. *Agriculture and Human Values*. 2006;23(3):381.
13. 111th Congress. The Patient Protection and Affordable Care Act. Section 4201. 2010. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Accessed February 11, 2013.
14. Community Transformation Grants (CTG): States and Communities Program Descriptions. Centers for Disease Control and Prevention Web Site. http://www.cdc.gov/communitytransformation/funds/programs.htm. Accessed February 8, 2013.

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Disclosures

The authors have no financial disclosures to report.

Disclaimer

The views expressed herein are those of the authors alone.

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