INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Commentary

James R. Knickman

Getting Serious About the Social Determinants of Health

Download PDF - 126 KB

Published:May 9, 2013
Type: Commentary
Topic(s):Public Health
Author(s)*:James R. Knickman

*Participant in the activities of the IOM Roundtable on Population Health Improvement

Note: The views expressed in commentaries are those of the authors and not necessarily of the authors' organizations or of the IOM. Commentaries are intended to help inform and stimulate discussion. They have not been subjected to the review procedures of the IOM and are not reports of the IOM or of the National Research Council.

We have long known that factors outside of medical care — race, education, housing, income, and other social determinants — are the most important drivers of how healthy or sick we are. It is not new information that people of color get unequal health care and have poorer health outcomes than their white counterparts; what is new is how solid the evidence is becoming that race and discrimination alone, regardless of income or education, have a direct negative effect on health.

David R. Williams of the Harvard School of Public Health gave a compelling presentation of some of this evidence during the recent kickoff meeting of the Roundtable on Population Health Improvement of the Institute of Medicine (IOM). Most striking is the research he shared on the impact of race on neonatal mortality rates. White women have the highest risk of poor outcomes if they are age 15–19 when they have their first baby, and the lowest risk if they are in their 20s. For African American women, their best chance of having a healthy baby is at age 15–19; neonatal mortality rates are slightly higher for women in their 20s and approximately 50 percent higher for women in their 30s. Why? Because the older African American women have been living longer with disproportionate amounts of stress, disease, and overall poor health than the white women—a phenomenon known as "weathering." They have more breast cancer, higher blood pressure, and babies with lower birth weights.

So what can those of us in the worlds of health care and public health do about these persistent disparities?

Alone, not much.

I've spent more than 35 years in the world of health policy, and it strikes me that many of the same people—or at least the same types of people—have been around the health policy table for my entire career. And rarely are there people outside of the health care sector at the table. Yet that's exactly what's needed! If the biggest problems related to health outcomes have to do with factors outside of health, shouldn't we be widening our circle to include folks who are experts in the worlds of education, community and economic development, housing, and social justice? We have long talked about the effects of these issues on health, but we haven't quite pushed ourselves to the point where we acknowledge that we in the health world are perhaps not the best people to tackle those issues! Surely, we have a role to play, but without the experience, expertise, and leadership of a whole range of sectors, we will never make progress on the social factors that affect health. During the roundtable meeting, IOM President Harvey Fineberg talked about creating a "culture of health," and I think he got it exactly right. Another common rallying cry has been for "health in all policies"— considering the health impacts of policy proposals primarily related to, say, transportation or education or housing.. And the Robert Wood Johnson Foundation is reconvening its Commission to Build a Healthier America, with a focus on the factors that affect health in early childhood and on building healthy communities.

All of these are welcome and important developments in raising the visibility of the nonmedical factors that affect health, and in elevating the conversation. But there has to be action to get advocates outside of health into these conversations.

It's interesting: for years, in the health world, there's been a bit of a divide between those who are primarily focused on medical care and those who are focused on public health and population health. Both medical care and public health interventions are critical to our health, and advocates for both should be on the same team, given a shared interest in keeping people healthy.

So, what's the solution?

This coming together or integration of the two fields, along with engagement of a broader set of stakeholders outside of health, needs to happen state by state and community by community. And the way we pay for both public health and medical care should incentivize this type of cooperation and synergy. But how to make our payment systems create these incentives is a broader topic that deserves more attention as our Roundtable proceeds.
