The Social Determinants Of Death

Alan Weil, Health Affairs, June 3, 2020

I raise my voice in support of those demanding a response to the consequences of institutional racism that are being laid bare before us. I speak as an individual, but as the editor of Health Affairs I feel the need to place my response in the context of health care and health policy.

I have long been skeptical of the notion that the health care system can address social determinants of health. After decades of direct action and advocacy with the goal of achieving living wages, affordable housing, paid leave, a safe environment, and other conditions conducive to health, why, exactly, would we imagine that the health care system can achieve results when others with far more expertise in these matters have had limited success?

The reasons for my skepticism are many, but they mostly revolve around the implausibility of the powerful and resource-rich health sector serving as a catalyst for change by transferring resources and power to the social sector and engaging authentically and equitably with resource-poor communities. I find support for my skepticism in empirical work we published just a few months ago.

I understand that paying for health outcomes, not health care services, creates financial incentives for health systems to address underlying social needs when doing so is less expensive than providing the excess health care required when those needs go unmet. Surely, this is better than ignoring social determinants, and it has yielded some real creativity and supported mission-driven institutions that were trying to tackle social determinants anyway. But, as explained in more detail in this blog post, tackling individual needs one patient (or member) at a time is not the same as addressing social determinants.

Unpacking the Determinants of Health: Economic, Political, And Social

Broad definitions of social determinants of health, for example the "conditions in which people are born, grow, live, work, and age," are useful in affirming that health care services provided to individuals are not the primary drivers of health. But such broad definitions also obfuscate.

People who are sick because they cannot afford healthy food or safe, stable housing are suffering from the economic determinants of health. And our failure to translate our nation's more than $60,000 of GDP per capita into an actual living wage, or a high-quality education for everyone, reflects policy choices. I would call these political determinants of health.

If by "social" we mean the relationships among people, in my view the primary social determinant of (poor) health is the absence of relationship, or, to be more precise, the separation of the self from the "other." The most virulent form of defining one's self in contrast

to others is racism. Ableism, sexism, gender norms, and similar types of "otherness" are powerful in and of themselves; and they interact with racism to multiply the harmful consequences. Denying the humanity of others paves the way for those in power to adopt laws, policies, and practices that perpetuate the economic and political determinants of poor health and racism itself.

I wrote this as the COVID-19 pandemic was raging, with emerging data showing a "consistent pattern of racial/ethnic differences"—namely a disproportionate burden borne by Black and Latinx people. As I put the finishing touches on this piece I, along with the rest of the world, witnessed the murder of George Floyd, a Black man.

It is impossible to miss the cruelty and callousness apparent in a human being's murder when it is captured on video. But it is the same cruelty and callousness that ignores (or laments and then does nothing about) the daily premature death and disability of people of color.

These deaths are all socially determined.

Racism and Power

I appreciate the response of many in the health care sector denouncing the racism that underlies the murder of Mr. Floyd and others whose names are known, as well as the murder of countless others whose names have never received media attention.

While I hear a lot about racism, I hear little about power. But the two concepts are closely intertwined, and speaking of one without the other leaves me concerned that nothing will change.

The health care sector holds tremendous power. If it were a country, the US health care sector would have the fifth-highest GDP in the world. Individual leaders and investors throughout the sector—at insurers, hospitals, physician practices, and biopharmaceutical companies—command salaries and returns orders of magnitude larger than the average person.

In true American fashion, the health care sector uses much of its power to sustain its power. We fight to protect our entitlements, our favorable tax treatment, our "reimbursement rates" (which normal people call prices), and, ultimately, our incomes. In its pursuit of growth, the health care sector has become responsive to the needs of those with wealth in the same manner as the broader political and economic system. Investment, institutions, professionals, and talent flow to where financial returns are greatest.

Payment reform has changed the health care conversation, facilitated new relationships, and shows promise for improving patient care. I applaud those pushing the boundaries of payment reform so that it supports the transfer of wealth and power from heavily capitalized institutions to the under-resourced social sector, locally accountable institutions, and communities. But payment reform, the promised formula for transforming incentives to promote health, can

achieve only so much. No number of ACOs or bundles or risk-based payments will fundamentally alter the calculus of health care resource allocation, or—perhaps it would be more appropriate to say—the imperative of health care resource accumulation. Indeed, when policies tiptoe up to the edge of doing so, they are quickly withdrawn in the face of withering attacks from those in power.

I am not optimistic that the health care sector will address the real social determinants of health. That simply is not in its self-interest. At best, it will nibble at the edges of the economic determinants of health. After all, when you control $3.6 trillion, sharing a bit to buy food for patients is not that heavy a lift.

I do not share the view that the COVID-19 pandemic, by laying bare inequities in health, will inexorably lead to health system transformation. Those inequities have been obvious for decades to anyone who wished to open their eyes.

In the face of current events, it is time to speak not only of the social determinants of health, but also of the social determinants of death.

Racism has long been a central tool in the toolbox of those who wish to hold onto power. Medicine has been complicit over the years—consider brain size, the US Public Health Service Syphilis Study at Tuskegee, general intelligence, segregated hospitals, to name only a few examples. It is facile to pretend that these are merely historical phenomena that we have moved beyond. Their legacy remains and is baked into our institutions, our thinking, and our policies.

The Test We Face

It is not enough for health care institutions to stand against racism or with those who protest it. The test of the day is whether those institutions will use their power to fight racism. Will they cede wealth and power accumulated over decades to those who have been excluded? Will they engage in meaningful dialogue designed to break down barriers to a well-functioning society—one in which people engage in authentic relationships and learn of their shared humanity? If no one else is leading that dialogue, will they initiate it and include others as equals? Will we? Health Affairs is eager to be a part of this change and these conversations.

This is how we will eliminate the social determinants of death.

And then we can get serious about improving the social determinants of health.