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Commentary

Addressing social determinants of health in the wake of the COVID-19 pandemic: urgent need to consider policy and practice in relation to pharmacy's contribution.

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Abstract:

World Health Organization reports highlight health inequalities and social determinants of health (SDoH) and the need for their consideration in strategic health plans. The coronavirus pandemic has exacerbated these issues and government imposed COVID-19 restrictions may have prolonged healthcare consequences including effects on SDoH. Seventy percent of health outcomes are attributable to socio-economic factors, whereas medical care accounts for only 10%-15% and so there should be a focus on upskilling all health and social care practitioners. Clinical pharmacists are uniquely positioned to contribute to reducing health disparities but current foci are around upstream interventions such as addressing polypharmacy and deprescribing. Given the 'positive care law' for pharmacy, with high accessibility to services even in deprived areas, social prescribing training and intervention pathways could have significant impact. Limited evidence shows there is enthusiasm for this but there is a need for further research to influence policy and practice including; pharmacy roles, training needs, intervention and evaluation of impact.

Keywords: Health inequalities, social determinants of health, COVID-19, social prescribing, personalised care, community pharmacy

Paper

The World Health Organization (WHO) has highlighted the importance of ensuring that health inequalities and social determinants of health (SDoH) are fully integrated into international and national strategic health plans [1]. The coronavirus pandemic has acted as a multiplier for such issues and their effect on health with evidence showing younger individuals in deprived areas are four times more likely to die of COVID-19 [2]. Despite the necessity of government imposed COVID-19 restrictions there are likely to be prolonged consequences on population health and healthcare provision and a need to refocus efforts on SDoH [2].

The WHO defines SDoH as conditions in which people are born, live, learn, work, play, worship, and age affecting a wide range of health risks and outcomes [1]. There are five categories of SDoH: economic stability, education, social and community context, health and healthcare, and neighbourhood and built environment. All are increasingly recognised as drivers of healthcare use and costs [3]. Such SDoH particularly affects deprived communities with a noted lack of funding and provision of healthcare services resulting in perpetuation of the inverse care law [4].

Public Health bodies often outline policy approaches based on human rights in relation to health. Health inequalities have been defined as 'unjust and avoidable differences in people's health across the population and between specific population groups' [5]. Inequalities are often socially, economically, and politically determined beyond individuals' control and are influenced by the actions of governments, health authorities and communities. Interventions that aim to reduce health inequalities should reach beyond health, to its social determinants [6].

Socio-economic determinants such as poverty and food insecurity are particularly relevant to pharmacy practice given the direct impact they have on medication use and efficacy [7], health care utilization [8, 9, 10], and health outcomes [11].

Internationally, the WHO also reports that research shows that SDoH account for 30-55% of health outcomes [1]. In the UK, the Marmot Review indicated that up to 70% of health outcomes are attributable to socio-economic factors, whereas medical care accounts for only 10%-15% [12]. Clinical interventions often have less impact in supporting change in health outcomes than a focus on SDoH and health inequalities [13] but there is a need to consider the further development of a workforce with skillsets capable of effectively addressing SDoH [12].

Braveman & Gottlieb have stressed that despite the lack of coverage of social work-related training within healthcare degrees this issue must be considered by all. They advocate inclusion in training, as a minimum, of awareness and understanding of the importance, influence and impact of SDoH on outcomes. The authors also advocate for the development of interventions that recognise relative skillsets aimed at synergistic collaborative working to achieve more effective outcomes [3].

What does this mean for pharmacists and clinical pharmacy practice? Internationally, the pharmacists' role in addressing health inequalities and SDoH has recently been summarised [7] and concluded that 'Pharmacists are uniquely positioned to lead the charge in transforming current health systems to create a reduction of health disparities within our societies.' In a linked paper Osae et al reviewed the strategies for development of pharmacy services to address health inequality and concluded that '.. seeing past medications to the individual to identify potential barriers, pharmacists can bolster the movement toward health equity' [14].

There is currently and historically been much policy and practice focus on addressing the downstream effects of inappropriate medication use and patient safety with a significant focus on

intervention monitoring, polypharmacy management and deprescribing [15]. Perhaps the time has come to shift the balance and for pharmacists to further consider their role in the wider agenda around SDoH and health inequalities. This is entirely compatible with international agendas around person-centred health systems [16] and policy within the NHS Long term Plan in the UK with a focus on personalised care. Key aspects of personalised care include 'shared decision making' and 'community-based support and social prescribing'.

Social prescribing is a term used to describe the process of connecting patients with non-medical services to improve their health and well-being. It received brief consideration in a policy report on reducing overprescribing from the Chief Pharmaceutical Office of England [17]. Social prescribing interventions should particularly be developed and implemented with a focus on the community pharmacy sector but it has been shown, despite enthusiasm, that further research is required to enable pharmacy to be full participants in social prescribing pathways [18, 19]

In the UK, in contrast to the inverse care law in community based general medical practices [5], 89.2% of the population is estimated to have access to a community pharmacy within a 20-minute walk, and access is greater in areas of highest deprivation highlighting that there is a positive pharmacy care law [20]. In many countries, community pharmacies now provide enhanced services around minor ailments, common clinical, and long-term conditions thus moving away from supply of medicines to more patient-centred services. Additionally, community pharmacies are highly accessible and remained so throughout the COVID-19 pandemic.

Thus, there is scope for community pharmacies to further develop local partnerships with social prescribing practitioners / Community Link Workers health professionals, public health providers, and community organisations. They could more effectively work together to improve patients' medical and social care. Foster et al have proposed roles directed at addressing SDoH that could be provided from community pharmacies including: service co-ordination, informal counselling, health education, community advocate, care management [21].

In view of the above there is potential for a significant contribution to patient care that pharmacists in general and specifically those that are within community pharmacy could make to addressing SDoH. However, a paucity of work has been done in this area and the limited evidence shows there is there is scope and enthusiasm for a role for pharmacy in SDoH. This would be complementary to the current policy and practice focus on overprescribing and rational medicines use. Further research is required to develop an evidence base that will influence policy and practice as it relates to pharmacy's contribution to health inequalities and social determinants of health. This work could focus on; defining pharmacy roles, training needs, intervention development and implementation and evaluation of impact.

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