Transcript of the Socially Determined Podcast

"Defining Socially Determined"
with Dr. Gabriel Kaplan, NACDD Board President (2018-2019)
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ANNOUNCER:
Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Dr. Kaplan speaks with Paige Rohe, Director of Communications at NACDD, about the terms and definitions used to describe his president's challenge, addressing the social determinants of health.

PAIGE ROHE:
Welcome, Dr. Kaplan. Thank you for joining us today for Socially Determined, the podcast that you named. We're so happy to have you.

DR. KAPLAN:
Thank you so much. It's my pleasure to be here.

PAIGE ROHE:
So as NACDD board president, the board president is invited to create a challenge that calls attention to an emerging issue or topic in the field of public health and chronic disease prevention. And this year, you chose upstream factor, something you coined the term "Socially Determined" for your podcast and for the article that you wrote for NACDD's Insights Magazine. So let's start with unpacking some of the general theories and definitions of these terms and why you chose them. We hear a lot about different terms called social determinants, adverse childhood experiences and upstream factors. These all sound very related. What do these terms have in common and how do they relate to public health?

DR. KAPLAN:
Well, so a lot of our understanding and our interest in all of these issues grows out of our long commitment and desire to explore issues related to health equity. I think one of the things that we can be quite proud of in public health is that we have had some real successes: water fluoridation, mandatory seat belt laws, tobacco control, immunization programs. All have rendered the world a safer place and given people the benefit and ability to enjoy much greater health over much longer periods of their life span. But what we've noticed as we've watched our success unfold is that not all groups have benefited equally, and some groups have lagged behind. And in an effort to understand what are the reasons for our failure to lift all boats in the sea, I think public health has gained an appreciation that there is a difference between equality and equity. And that's very often visually represented by a variety of different metaphors. One is giving everybody the same size bicycle, which, if you're a small child or a very large adult, is not necessarily going to be easy to ride. There's other visual images like people watching a baseball game of different heights behind a fence and only one person can see over the fence.

So the fence is at an equal height, but it's not equitable because not everybody is being able to enjoy the baseball game. And so this really, I think, led the field to drill into what are these factors, the injustices and inequities that reside in society. Where do they come from, and then how do they relate to and shape people's experience of life and health across the life span?

And so people began to ask questions about the etiology of chronic disease and what's more, the etiology of the behaviors that can lead to chronic disease, such as smoking, physical activity, obesity, nutrition. And people began to have an appreciation of poverty, of stress, of different kinds of factors that exist in the landscape, marketing people's background, where they grew up and their kinds of connections to each other and how all of that feeds into the behavior decisions that we make in our life. And so people began to understand that we can't really pretend that the decision to smoke is a simple, conscious decision that people make at a certain point in time, fully cognizant of the risks and benefits of such a decision. And informed of all the information when they are very often experiencing life in very different ways, with respect to the amounts of stress that they have, with respect to the amounts of different levels of income and such, that they have. And so, the field really began to want to struggle with this, and I think that's really where concepts like the social determinants of health, adverse childhood experiences and upstream factors kind of grew up to really capture those experiences that lie at the root of the inequities that exist across American life.

PAIGE ROHE:
Thank you. I think that, that's a really good way to set the tone for when we get into some of these other topics. How and why they have risen to the top of conversations in chronic disease prevention and control programing. So, let's actually get to some brass tax. You really define equity force very well, but how would you define the social determinants of health, specifically?

DR. KAPLAN:
So, I take a pretty narrow view of the social determinants of health. I think that there are a lot of people who have a temptation to sort of want to lump all of these ideas under the social determinants of health. And I think the social determinants of health for me, the really important word in that phrase is social. And it's the things that shape our health that are rooted in our social environments, in our upbringing. So, it's not just the physical environment, but it's that social [inaudible] in which we grow up and live, and make choices every day. And so, I think that for me, it's not just a function of a family's income, but it's a function of where that income positions a family and allows a family to live in our society. It's not just income, but it's also wealth, and what kinds of assets does the family have access to. And then, when families don't have wealth, and they don't have income or high levels of income, they tend to get thrown together in our society, to live in the same kinds of neighborhoods. And so, those neighborhoods, because of the way local financing of government tends to operate tend to be under resourced. And so, for me, the really important phenomena are these sort of sociological phenomena that grow out of environments where people live together and experience very similar conditions that are structured by society. So, what are the levels of education that are available to people? What kinds of educational resources do people have available to them?

And so, it's not just a function of their immediate family or themselves, but it's a function of the environment in which they are functioning. And so, it's one thing to say, "Well, my family doesn't smoke," but if the people around you, who play a very important role in shaping your understanding of what is valued and what is not valued, are smoking, whether that's the

neighbors or the people taking care of you after school, or the stimuli that exists in your neighborhood because of the kinds of food that are present in the stores, or the kinds of play opportunities that you have—those are all these social determinants, these social factors beyond your control, that really shape that environment in which you live. And then, begin to influence the kinds of choices that you make.

PAIGE ROHE:
So, you've touched on them a little bit, about the adverse childhood experiences, and it sounds to me like maybe social determinants of health lead into the likelihood that someone may experience an adverse childhood event. Could you talk a little bit then about what the difference might be between an adverse childhood event and a social determinant of health?

DR. KAPLAN:
So, there are a variety of adverse childhood experiences that are important in understanding that concept. The state of Michigan has done a variety of work in this. And so, they are very interested in understanding and educating people about those sorts of things. So, there is physical abuse, there could be physical neglect, there can be mental illness, there can be emotional instability in the family. There can be witnessing household dysfunctions such as substance abuse, mothers being treated violently by their partners, the breakup of families through divorce or family separation. So there can be exposure to violence in a neighborhood. A lot of the adverse childhood experiences, because it's through the lens of childhood, are going to be experiences that are somehow connected to one's family experience. And so I think with the social determinants of health, we're really talking about a broader set of social forces. But there is an understanding that families exist in that broader environmental context, and so the kinds of experiences that they share in a family are very much going to be driven by what is going on around them. And so if the family is experiencing high levels of stress because of income deprivation or because of housing instability, then that stress can manifest itself in various challenges that then get exposed and visited on the child such as substance abuse, or violence, or breakup of families.

If the family lives in a neighborhood where violence levels are higher than in other communities, then that increases the probability that the child will be exposed to that adverse childhood experience. So I think there's a strong relationship between these social determinants such as the safety of a neighborhood, or the quality of an education, or the economic security that a family can enjoy growing up, and then the kinds of experiences that children themselves have. But we tend to think of these as somewhat different contexts and circumstances because the social determinants don't necessarily lead to adverse childhood experiences. Some children can grow up in those environmental contexts and not be exposed to as many adverse childhood experiences as others. What we know is that the more adverse childhood experiences that a child is exposed to, the greater the probability later in their life that they will manifest a variety of problems such as poor health, or addiction, or mental and behavioral health issues. And so there's a relationship, but they are somewhat separate driving factors, the experiences and overall health of an individual.

PAIGE ROHE:

I just want to put in a plug that we will be interviewing, as part of this podcast series, Jody Spicer who is the adverse childhood experiences consultant within the Michigan Department of Health and Human Services. So keep an eye out for that podcast as well for digging a little bit deeper on this topic of adverse childhood experiences. It does sound to me like there is a bit of a sweet spot between what an adverse childhood experience might correlate to with a likelihood for substance misuse or, even some studies are suggesting, cancer, to the social determinants of health and the environment in which they're growing up and that there might be some areas that are easier to target on the public health side than others because there seems to be more of a correlation. One example might be the environment and asthma in areas that are more income-deprived than others or things like that. Would you say that that's true or how would you define getting at both of those issues at the same time?

DR. KAPLAN:
I think that's really one of the challenges. I think one way to think about it is what are the factors that create stress on a family, for instance. If we know that stress on a family can lead to household dysfunction or to increase probability of abuse and neglect, then the factors that elevate stress for that family are going to be important to address. So housing stability, income security, food security, those are going to be essential components in lowering the levels of stress that that family experiences. Now, if the people in that family themselves experienced adverse childhood experiences of their own, then we know that that increases their likelihood of manifesting the kinds of behaviors that then compound the potential for adverse childhood experiences of their own children and so in addition to providing the kinds of economic and social support that a family might need to lower their levels of stress, I think that one of the other things that we've found is very important for those families is to be able to provide them psychosocial supports as well, to help people who may have experienced trauma as children, to cope with that trauma and to find ways of dealing with stress that don't, sort of, spread that stress on others but allow them to more productively process and manage it individually without, sort of, socializing the way that they're manifesting it.

PAIGE ROHE:
Which leads us to our next term in our list, upstream factors. So you've talked a little bit about housing security and some of these other items. Could you talk about the term upstream factors? What is it referencing and what does it mean in the context of these two other terms, social determinants of health and adverse childhood experiences?

DR. KAPLAN:
I think of upstream factors, really, as sort of the umbrella concept that really encapsulates all of these different ideas. If we think about, sort of, a crude model of chronic disease, it might say that chronic diseases such as cardiovascular disease, diabetes, cancer, and others emerge from a variety of choices related to health and behaviors and actions that people will take. For instance, the decision whether or not to exercise, the decision whether or not to eat healthy foods, and the decision whether or not to smoke. And then the frequency with which one smokes, the frequency with which one, sort of, organizes their diet around healthy food or unhealthy food. And what we've begun to understand is - and have understood now for almost a decade - is that those decisions don't really just come out in a vacuum. And then not all people experience their access to those opportunities and to those choices in the same way. And so understanding the things that drive those choices is really critical. And so we think of those as

further upstream from that process. If cardiovascular disease is downstream from the decision to smoke, well, what lies upstream from the decision to smoke?

Is it the fact that your parents smoked? Is it the fact that you were exposed, in your neighborhood, to all kinds of advertising and promotional strategies from the tobacco industry? Is it because you, yourself, had an adverse childhood experience which left you with a level of trauma and stress which you find is eased by using a substance like tobacco? Does your lack of family income and does the lack of nutritional options like healthy fruits and vegetables in the grocery store curtail the kinds of dietary options that are available to you and your family growing up? And so we think of those as further upstream from those initial behaviors that we used to think were just simply the precursors to disease. We now understand that there are these precursors to the behaviors themselves, which need to be understood.

PAIGE ROHE:
So why did you choose this broader topic of the social determinants of health and upstream factors as your President's Challenge? It sounds like it's a pretty complex, even some might say, heavy topic, to call the field's attention to? Why was this important to you at this time?

DR. KAPLAN:
Well, I've been involved in a lot of conversations with my colleagues through my opportunity to participate in The National Association of Chronic Disease Directors over the years and I know many of us have been struggling with the challenge of how do we promote better health and how do we promote healthier behaviors for people? And many people have understood that our ability to do this runs into barriers and limitations, that we can only do so much with our more traditional strategies. And so having information that we provide to people about the risks of smoking certainly had an impact on the decision people made in the 1960s, and 70s, and early 80s to quit smoking. But we know that policy initiatives that were then subsequently taken and that raised the tobacco tax, that made it harder for youth to access tobacco at an earlier age and become hooked for a lifelong nicotine addiction. Those policy choices made a profound impact on the choices of many people. And we saw, as well, that the price sensitivity of certain populations was such that raises in the tobacco tax actually could redress some of the health inequities that we saw when we simply relied on trying to win the hearts and minds of people who smoked by sharing information with them that smoking could kill them.

For many people who were experiencing the grip of tobacco addiction and nicotine addiction, which is an incredibly powerful addiction, their response to our information was, "Yeah. That's true. Nicotine can kill me. But it can kill me in 20 or 30 years. And my life is such that I have to make choices that really lead me to wonder about that long-term horizon and really lead me to wonder about what kinds of opportunities and choices are going to be available to me in that future." And so they have a different perspective on time given the kinds of stress and the kinds of limitations that are imposed on them by society in terms of the kinds of life choices they can make. And so a lot of our colleagues have been talking about health equity. We've been talking about the social determinants of health. We've been struggling to move into this field. And I think, what I observed in the last 10 years was a growing willingness, on the part of my colleagues across the country, to tackle these problems and to tackle these challenges, to engage in this work, an increasing conviction that this stuff matters. That this is really—at the heart of achieving health equity is our ability to understand the factors that shape people's lives

and the choices that they get presented. Because not everybody has the same kinds of choices presented to them. Their choices are constrained in deep and profound ways.

And so what has struck me as valuable through this challenge, was the opportunity to showcase what public health professionals across the country are doing about these challenges. And share information, not just about the fact that these things matter and are important, because I think, by and large, all of my colleagues get that now. And so what do we do about it and how do we make a difference? And how do we apply the energy, the resources and the commitment we have to these problems to really make a difference and improve the lives of all people? But particularly, those who are most vulnerable and who most historically have been disadvantaged in our society.

PAIGE ROHE:
What's been some of the feedback as you've been taking your president's jaunt on the road? You presented at The National Association of Chronic Disease Directors' annual Chronic Disease Academy to about 300 state and territorial health department staff. You presented at the National Network of Public Health Institute's annual conference. You've penned this article in Insights magazine. What's been the feedback from your peers about your thoughts on this important issue and this call to action?

DR. KAPLAN:
I think there's a lot of excitement and enthusiasm to hear more about how to tackle these problems and to learn from those around the country who have begun engaging with these challenges and these questions in different ways and to share that information and to hear about those examples in greater detail. So I've been met with a lot of curiosity and a lot of enthusiasm. I think people, as I expected, really do share a commitment to doing something about these problems. But they either lack the resources financially, in which they can sort of apply funds to make a difference to many of these different areas. Or they want some ideas about how to do this effectively at the local level. And getting those ideas out and sharing them more broadly is really what people are looking for. And that's what we've been able to share with them through the podcasts and through the academy and inviting our colleagues across the country to step forward. What we've learned is that there is already a tremendous amount of work going on, which showcases ways that public health can be involved in this arena. One resource, which we know about is the practical playbook and provides a great deal of resources and information about the kinds of strategies different agencies can undertake, the kinds of partnerships and collaborations they can pursue to really make a difference in all of these areas, whether it's the social determinants of health, adverse childhood experiences, or upstream factors.

PAIGE ROHE:
So let's say that we have a member who wants to participate in this and they've reviewed the resources, but is there a question that they could regularly ask in their program planning and in their program implementation that could at least help them consider how to address the social determinants of health in the work that they're currently doing? Is there a if you can just ask this one question in your program planning you will have started to consider or account for the social determinants of health in your work?

DR. KAPLAN:
I think if I were would characterize this question in a particular way would be to use the phrase "what else," sort of "what else am I missing?" For me, when I came into public health, my background wasn't in public health, it was in public policy. I joined public health in mid-career. And the story of Jon Snow and the cholera epidemic in London really was instrumental for me in terms of understanding what public health's role is, and how important it is in terms of looking at data, looking at populations, looking at behaviors, and drawing inferences from those sources of information to detect certain things that are going on that are shaping health that lie outside of the clinical relationship between a provider and a patient. So health historically has consisted of that clinical dyadic component of the doctor usually talking to a patient or treating a patient or dealing with a patient. But public health reminds us that those patients come into those arenas in a variety of different contexts and with a variety from circumstances behind them. And Dr. Snow's great insight was to realize that by turning off a pump in a particular area of London, he could shut down the source of an epidemic that was coming through the contaminated water being drunk and pulled from that pump. And so he was able to more effectively treat this outbreak of disease that was causing all kinds of morbidity and mortality within that community by simply taking an action at a population level, than all the nurses and all the providers in London combined.

And I think if we think about the social determinants of health in a similar way, and we ask ourselves, what are the reasons that are making people sick today? What kinds of sources of energy into their life, whether it's nutrition or our resources or opportunity that go into a person's life, that feed into the kinds of choices that they make and feed into the kind of health experiences that they have? And so if we think through that lens of asking ourselves constantly, what else is it that makes people sick and having appreciation and understanding that it's not just biological, that there are the social and economic and psychosocial forces and factors that exist out there, and that will continue to shape people and keep them beyond the reach of a clinical professional, then I think we'll have a better appreciation of the kinds of strategies that we need to pursue in order to address those factors. But we'll only uncover those factors if we keep asking ourselves, what else?

PAIGE ROHE:
Well, with that, we just have time for one more question and I think you've partially answered it. But what do you say to those stakeholders, maybe in different levels of government or maybe just in private partnerships who say you should stay in your lane, let housing deal with housing, let education deal with education? Why should public health get involved?

DR. KAPLAN:
Well, I think a lot of this very much is our lane. I think that thinking about the ways that educational experiences and interfaces with law enforcement and public safety, that those things shape the kinds of choices and health outcomes that people experience across their life—those seem to really matter. And I think people have an appreciation and understanding, and so part of it is to talk about and share that information and point out those relationships to other people. I do think one of the things that your question reminds us though, is we need to do that with great humility. We are latecomers to many of these tables, whether these are tables that are addressing economic deprivation in communities, that grow out of all kinds of historical legacy discrimination, or at challenges in educating people through a public education system, or challenges in both public safety and in criminal justice and social justice. All of these

conversations have existed for a long time. And public health has not been seen as a regular partner. And so when it shows up at those tables, it needs to approach those tables with some humility.

It has a story to tell, and it has an important narrative to share. And I think it can shed great light and insight in those partners' eyes on what matters and why this matters for health. Because very often when someone is working in a Department of Transportation, for instance, they're thinking about my central challenges, how do I move person A from point one to point two? And that is my central challenge is to do that as efficiently as possible. Public health reminds them that they have to do it safely too. And they have to think about all the factors that influence safety such as pollution, not just road safety, and speed and such. And so these are all tables where the health lens is not necessarily the primary lens, but it's a really important lens for shaping people's overall happiness, satisfaction, and enjoyment of life. And so speaking about that with humility, but with true conviction and power and eloquence is very important for public health.

PAIGE ROHE:
Well said. And with that, we are going to conclude our time today. Thank you so much, Dr. Kaplan, for joining us today to talk about defining socially determined.

We hope that you'll visit chronicdisease.org to review the rest of the podcasts in this series covering the social determinants of health.

ANNOUNCER:
Thank you for listening to Socially Determined, a podcast brought to you by the National Association of Chronic Disease Directors.

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