Chronic Diseases: Are you Addressing the Social Determinants of Health?

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Chronic Disease

- “Illnesses that are prolonged, do not resolve spontaneously and are rarely cured completely.”
- Communicable and non-communicable
  - HIV/AIDS, Hepatitis C

• One-third of Canadians have at least one chronic health condition

• These figures will likely increase, given that the number of Canadians over the age of 65 is expected to rise from 4.2 million in 2005 to 9.8 million by 2036

(Turcotte & Schellenberg, Health Council of Canada, 2007)
Economic Burden In Canada

- 58% of all annual health-care spending = $68 billion a year

- Indirect costs = $122 billion in loss of income and productivity
Management of Chronic Illnesses

- Cancer
- Diabetes
- Cardiovascular and cerebrovascular disease
- Respiratory disease
- Obesity
Where diabetes hits hardest

The Northwest and East of Toronto are hardest hit by diabetes.

Source: ICES Atlas

Toronto Star Interactive Graphic
Age-standardized percentage of women aged 25 and older who reported having selected chronic diseases, by annual household income, in Ontario, 2005

**DATA SOURCES:** Canadian Community Health Survey (CCHS), 2005 (Cycle 3.1); †Canadian Community Health Survey (CCHS), 2005 (Cycle 3.1) and 2007

^ Obstructive lung disease includes asthma, chronic bronchitis, emphysema or chronic obstructive pulmonary disease

“Social justice — or the lack thereof — has a greater impact on the health of the world’s population than medical treatment.”
Health Equity

When everyone can attain their full health potential and are not disadvantaged due to their social position or other socially determined circumstances.

(Brennan, Baker & Metzler, 2008)

Health inequities are the unfair and avoidable differences in health status.
Social Determinants of Health

• The conditions in which people are born, grow, live, work and age.
• These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.
How does poverty affect health?

- Stress due to inadequate resources to face daily challenges and lack of personal control
- Limited access to healthy food
- Limited access to physical activity options
- Limited access to health care, medications, supplies
- Substandard housing, homelessness, frequent moves
- Physical safety concerns
- Insufficient social support networks
- Insecure working conditions
- Transportation, childcare issues
Social Determinants of Health

Fig. 2. The health gradient

Individually oriented preventive action

Health hazards

- Environmental health hazards
- Lack of education
- Inadequate food and nutrition
- Unemployment
- Poor housing
- Poverty

Source: adapted from Making partners: intersectoral action for health (13)
What is needed?

Responsive supports at multiple levels:

- point of care
- health-care system
- policy levels
Chronic Disease Management in Primary Care

Impacts and Opportunities
Case Study
The Challenge

• Growing number of patients with chronic disease
• Multiple co-morbidities
• Complex care needs
• Issues with access to health care
• Lifestyle concerns (smoking, obesity, inactivity, stress, etc.)
• Primary prevention
Case Study

Anna S.
Anna S.

- 53-year old patient who lives with husband
- Combined income $22,000/year (Anna is on disability and husband is self-employed)
Anna S.

• Diabetic on insulin with history of CVA, poorly controlled hypertension, COPD as well as chronic renal failure and diabetic retinopathy
• No medical insurance and cannot afford pharmacare co-pay for medications
• Has been relying on compassionate medication programs through team at primary care clinic.
Anna S.

- Limited income
- Literacy level
- Limited social support
- No access to public transportation
Anna S.

• Discharged from hospital on Friday after an admission for exacerbation of COPD; stops at primary care clinic en route home to fill new Rx for HTN and a new inhaler.
• Provided with a 15-page booklet on how to manage her COPD as well as a referral to pulmonary rehab.
• Insulin adjusted and advised to test blood glucose 3-4 times each day
• Unable to fill her Rx, as she does not get her disability cheque until next week and compassionate program unavailable for the new medications.
Solutions

Structure  Processes  Resources
How are we addressing SDH at the primary care level?

- Building strong collaborative teams
- Integrating the assessment of the impact of poverty, housing, literacy, etc., on health
- Building networks to address gaps and enhance communication
How will we know if we have made a difference?

- Know your patient population
- Plan systematic strategies to address needs
- Measure outcomes
- Provide feedback to the team and revise plan
Measurable Outcomes

• Access to care
• Ability to acquire required medications
• Target values are met
• Ability to demonstrate appropriate techniques (insulin admin and use of a puffer)
• SDH documented in patient health record
How can the social determinants be addressed in the management of chronic diseases in primary care?

- Fostering intersectoral relationships
- Building interprofessional collaboration
- Assessing the impact of the SDH, such as income, housing, literacy, etc., on health and self-management.
Social determinants of health impact health and strongly influence health outcomes in all areas of care, including chronic disease management.
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