Editorial

iMedPub Journals
www.imedpub.com

Journal of Nursing and Health Studies
ISSN 2574-2825

2016
Vol.1 No.1:2

DOI: 10.21767/2574-2825.100002

Health is More than Healthcare: It's Time for a Social Ecological Approach

Jody Early*

Associate Professor, School of Nursing and Health Studies, University of Washington Bothell, USA

***Corresponding author:** Early J, School of Nursing and Health Studies, University of Washington Bothell, USA, Tel: (425) 325-5323; E-mail: jearly3@uw.edu

Rec date: Oct 26, 2016; **Acc date:** Oct 28, 2016; **Pub date:** Oct 31, 2016

Citation: Early J. Health is More than Healthcare: It's time for a Social Ecological Approach. J Nurs Health Stud. 2016, 1:1.

Editorial

The inaugural edition of the *Journal of Nursing and Health Studies* comes at an important time- not only for healthcare in the United States but globally as well. In the U.S., the emergence of accountable care organizations [1] has led to a greater focus on prevention-moving beyond just treatment and tertiary care. Traditionally, American health systems have excelled at providing acute care. Biotechnology labs support this, spending billions searching for miracle drugs. World Bank data indicates the U.S. spends approximately 17% of GDP on healthcare, which may be contrast to neighboring countries, Mexico at 6% and Canada at 10% [2].

Altogether, these efforts can overlook populations who have limited access to healthcare (or when quality health services are available, they remain unaffordable). Consequently, groups who experience disparate percentages of chronic illness often go underserved by traditional health systems. This impacts not only patient wellness, but healthcare costs for everyone. While strategies exist for addressing these issues (e.g. home health services, disease management programs, and community outreach initiatives), these efforts are often not well coordinated with institutional healthcare.

Recently, I attended an inspiring presentation delivered by Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson foundation. Her presentation was entitled, "Joining Forces to Build a Culture of Health." The room was filled with health practitioners, academics and students. At the end of the presentation, during the Q&A, an individual (who happened to be a nurse), stood up and relayed a story about an individual she and her colleagues kept seeing recurrently in the emergency room where she worked.

"Mary," (as we will call her), was being evicted from her housing complex because the rent had gotten too high. She also struggled with alcoholism which was why, in addition to her uncontrolled diabetes, Mary had become a recurrent visitor to the ER. After providing this context, the person posed the question, "What can be done to help patients, like Mary, see their risk behaviors are causing them more acute health issues?"

I was actually perplexed by this question, not because I questioned its validity, but because we had just spent the last hour discussing the bigger picture. Dr. Lavizzo-Mourey eloquently provided a response that referenced back to her earlier points in her presentation about the need to look beyond the behavior itself and to consider the multitude of factors involved. To truly keep Mary from returning to the ER would take a committed team of community partners and sectors coming together to figure out ways to address such things as: unaffordable housing, community (dis) connectedness, lack of mental health services, and employment opportunities. Mary was rotating in and out of transitional housing. It was very unlikely that she would be worried about things like glycemic monitoring or cirrhosis of the liver until her ongoing, primary stress of finding consistent employment and shelter were resolved.

Decades of research have shown us that the health challenges people face are largely influenced by a wide range of factors which are social, cultural, environmental, economic and political [2]. Issues such as affordable housing, access to nutritious food, education, public safety, discrimination (of all forms), and the built environment are collectively known as social determinants. These intersecting and overlapping forces influence the communities where people are born, grow, work, live, and age. Where these determinants are unsatisfactory in communities, they contribute to chronic stress and create a situation where a person's zip code is a better predictor of health and life expectancy than one's genotype [3].

In short, it's time to use a broader (theoretical) approach to health and healthcare. Urie Bronfenbrenner's ecological framework for human development was introduced decades ago and has formed the basis of what is now the *Social Ecological Model of Health*. The model recognizes the broader interplay of influencing factors beyond the personal and demonstrates the interaction between, and interdependence among, the individual, interpersonal, organizational, community, and societal/policy factors (**Figure 1**).

The emphasis on addressing social determinants is also supported by the World Health Organization (WHO), which has identified the inequitable distribution of power, money, opportunity and resources as key drivers of unequal and poor health outcomes. Likewise, reports by the Robert Wood Johnson Foundation provide evidence of how unhealthy community conditions lead to harmful behaviors such as homicide, poor diet, risky sexual behavior, motor vehicles injuries, and limited activity patterns [4]. These behaviors are further linked to specific medical diagnoses, for example: heart disease, diabetes, asthma, liver disease, suicide, HIV, and

mental health conditions. In a vicious cycle, these medical problems create more risks within communities, leading to further health challenges, and so forth.

Figure 1 The social ecological model of health.

If we accept the powerful influence of these determinants, what can be done about them? How can we manage these factors to lessen their negative influence? It's more complex than simply improving access and quality of care or giving patients, like Mary, a brochure about reducing her sugary beverage intake. Improving access to care, the quality of that care, and individuals' attitudes and behaviors are certainly desirable goals. In fact, these are part of the United States' *Healthy People* objectives. However, without more comprehensive, cross-sector approaches, and without acknowledging and addressing the hegemonic thinking that exists within the health sector, we will continue to generate the same insufficient results [2,6].

Clearly, it's time to try things another way. We need more collective, creative, and broader efforts to help people before they present themselves for treatment in our hospitals, exam rooms, and ERs. This might also call for strategies that require expertise outside of traditional healthcare. Countries such as Taiwan, Norway, and Cuba meet this challenge not only by utilizing the skills of health practitioners, but also by leveraging support from social services, public health, education and urban affairs. Countries, such as Brazil, also engage and empower community members as lay health promoters to work as part of healthcare teams. Community health workers (CHWs), in particular, play a vital role in actualizing more comprehensive and coordinated care models that improve health for all. As community advocates, navigators, and cultural mediators, CHWs often form relationships of trust which connect individuals (especially from marginalized groups and low resource areas) to systems and resources in ways that others cannot [5].

Adopting more holistic, social ecological approach will also require more inter-professional and cross-sector team collaboration. One might argue that the creation of the accountable care organization (ACO) is a good start. ACOs bring together healthcare providers across geographic areas and require them to operate as partners rather than competitors. They focus on prevention and population health and engage a broad set of partners in this effort [2,3]. However, the ACO model still lacks clarity as to how the clinical delivery system intersects with the public health system. In particular, the ACO's relationships with the local public health authority as well as the community as a whole are paramount. As Hacker and Walker argues, the larger the overlap among the appointed ACO panel, the community population, and the public health system, the more the overall health of the community will contribute to the ACOs' ability to keep their patients healthy [6]. As countries, such as the U.S., move forward with implementing a more prevention-focused approach to health and healthcare, we must figure out the best ways to coordinate this broader effort [7,8].

As we begin to shift the healthcare paradigm toward prevention and equity, we must also figure out how to move beyond the silos of traditional services. How can we work with engage, and learn from communities in order to improve outcomes? The *Journal of Nursing and Health Studies* is an ideal platform for addressing these questions and sharing evidence of innovative solutions. As we consider these questions and others, we must also determine what is feasible, measurable, and cost-effective. While some changes may be novel and cost-saving, what can be done to preserve equity and fairness? In the years to come, health care systems, public health systems, and the higher education systems that prepare individuals to work in these sectors must continue to evolve in order to support more effective preventative and population-based approaches. It is only then that we can truly create and support a "culture of health."

References

1. Centers for medicare and medicaid services [CMMS] (2016) Medicare Shared Savings Program. Shared Savings Program. [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/]. Accessed on November 01, 2016.
2. Centers for medicare and medicaid services [CMMS] (2016) Advance Payment ACO Model. [https://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/]. Accessed on November 01, 2016.
3. Centers for medicare and medicaid services [CMMS] (2016) Pioneer ACO Model [https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/]. Accessed on November 01, 2016.
4. Schroeder S (2007) The Case for More Active Policy Attention to Health Promotion. N Engl J Med 357: 1221-1228.
5. The World Bank Group. Health expenditure, total (% of GDP) (2016) [http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS]. Accessed on November, 01, 2016.
6. Davis R (2015) Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health. Prevention Institute, USA.
7. Hacker K, Walker DK (2013) Achieving Population Health in Accountable Care Organizations. Am J Public Health 103: 1163-1167.
8. Early J, Burke-Winkelman S, Joshi A (2016) On the front lines of prevention: Promotores de Salud and their role in improving primary care for Latina women, families, and communities. Global J Health Edu Promo 17: 59-86.