



DO NOT DO...
Recommendations
in health inequities



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Coordination and editorial management:

Congresos y Ediciones semFYC

Carrer del Pi, 11, 2.^a planta, of. 13
08002 Barcelona
ediciones@semfy.com

Design: Falcó

ISBN: 978-84-124769-0-3
Legal Deposit: B-2006-2022

Printed in Spain

DO NOT DO...

Recommendations in health inequities



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Introduction

Community-centered care and person-centered care are two of the fundamental characteristics of Primary Care. A true biopsychosocial approach must incorporate the social determinants of health into clinical practice, thus combining these two essential dimensions.

This document lists some common Primary Care clinical practice procedures that should be avoided in order to improve the integration of social determinants into the consultation and help clinical practice avoid being a space that amplifies social inequalities, but rather to be a place where, within the possibilities, there is an attempt to reduce them or at least to cushion them.

1

Do not disregard problems patients may have in obtaining a health card

We must get involved in problems linked to health cards or access to the system; avoid referring patients to other services outside of the consultation without collaborating with them or without ensuring the level of resolution.

Health coverage is a key element in ensuring access to health care for the entire population. This health coverage is not simply an issue that is solved by the recognition of a right in an Official State Gazette; it also involves a process with many intermediate steps until access to the health care system materializes.

Possession of a health card provides access to the health care system for the entire population, theoretically on equal terms. Therefore, obtaining a card is an issue that demands the attention and involvement of all professionals who interact with the patient when exercising their functions.

Accessibility is a collective responsibility, not exclusively that of the administration and/or social work service. If an administrative problem cannot be solved, the patient must be granted access to the consultation in the event of a health problem, while being offered advice and assistance to facilitate their obtaining of more standardized and accessible procedures for assistance.

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2

Do not record value judgments about patient attitudes in their medical history

Recording value judgments in a patient’s medical record may represent a stigma that conditions health care (and access to other socio-economic resources such as assistance in cases of unemployment, disability, invalidity, homelessness or violence, etc.) that this person may later receive from different professionals.

In many cases, comments or annotations such as “40 minutes late” or “smells a lot of alcohol” transcend the limits of objective data and clinical follow-up and become a stigma that is often shared with we-don’t-really-know which professionals or for how long. They can become labels that reproduce the exclusion.

Taking the social context (the social determinants of health) into account can help us rethink these labels, as well as working together with the patient and assessing which aspects of the consultation’s or institution’s operations can be adapted to certain conditions and which are indispensable. Normative aspects of operation (such as appointment schedules) are useful and necessary, especially when applied flexibly, adapting them to specific situations and contexts.

A medical history that helps to improve the longitudinal continuity and coordination in patient accompaniment and care cannot and should not become a place for professional venting or pointing out actions or attitudes that may be considered inappropriate. If such comments are recorded there they are devoid of their moment and context and, therefore, are open to any interpretation (not shared with the patient) of what may have caused them.

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3

Don't be blinded by biomedical vision

The reasons for consultation should not be addressed from a purely biomedical point of view, whether in cause analysis or in the approach to solutions.

There is always a social context that needs to be taken into account and must be incorporated into comprehensive patient assessment. The main root causes of most health problems are social.

It may be of interest to analyze whether someone is being affected by any of the axes of social inequality: age, gender, social class, ethnicity, territory, functional diversity, etc.

Hope and quality of life, diabetes, cancer, cardiovascular and mental health problems and so many other diseases are more common in the most disadvantaged social classes, and their prognosis in these persons is also worse. This must therefore be taken into account when making an assessment and determining a treatment plan.

The answer should not always come exclusively from the patient's family physician. On many occasions, it can (and should) be addressed through collaborative work with institutions and/or groups that deal with issues involving housing, employment, education, social services, etc. Patients may benefit from social support, community resources or mutual assistance groups when faced with common difficulties.

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4

Do not reproduce the inverse care law

No less time and attention should be devoted to patients of lower socioeconomic classes or with different cultural standards than one's own.

The unequal social distribution of diseases should lead family physicians to devote more resources to the lower social classes. However, not only is this not the case, but the contrary is true: the greater the patient's social, economic and cultural gap with their physician, the less care and time is dedicated to them. This is what Tudor Hart, in 1971, formulated as the inverse care law: "The availability of good medical care tends to vary inversely with the need for it in the population served."

At the same time, it is important to remember that this inverse care law is not only limited to treatment in consultation, but also affects other dimensions. On the one hand, the greater the poverty and exclusion, the greater the barriers people face in accessing the health care system (healthcare exclusion, resource deficits in the places of greatest exclusion, previous history of negative relations with institutions), so there are some that do not even come to the consultation despite having significant health problems. On the other hand, this inverse care law is also replicated in other key health-related resources: education, work, housing, sports, food, etc. Additionally, it should be remembered that it affects not only the inequality axis of social class, but also all the other axes of inequality that influence people: gender, ethnicity, territory, age, functional diversity, etc.

This law can be reversed by working at three levels. One, in the consultation: carefully managing our time and involvement; facilitating home visits, ambulances, moving appointments up or helping those who need it most with processes; understanding this need from a biopsychosocial point of view. Two: collaborating with local organizations and institutions working to reduce social inequalities in health. Three: engaging in health advocacy for appropriate distribution of resources that is adapted to the needs of different social strata.

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5

Do not medicalize what is social or socialize what is medical

Do not medicalize or psychologize social problems, but do not ignore the physical and psychological malaise they produce.

The medicalization of what is social, that is, seeking to resolve certain social situations through medicine, has a multifactor origin (society, media, pharmaceutical industry, politicians, managers, health professionals, patients...) in which the health care sector plays a fundamental role.

Social problems can lead to malaise in people who suffer from them, but this does not mean a disease must be diagnosed. When patients who come to the clinic are medicalized (or psychologized) this produces iatrogenesis, overtreatment and all that this entails, such as unnecessary expenses and suffering. Focus on the root cause of the problem is lost, which can make it difficult to find the most effective solutions that target (often collectively) the real causes. The cause of the disease is attributed to the person, ignoring structural factors that generate systemic violence and discrimination and that also influence the loss of health and the ability to recover.

At the same time, especially in patients in situations of social vulnerability or exclusion, it is quite common to attribute the need for social responses to conditions requiring medical attention, similar to what happens in many situations with patients who have psychiatric diagnoses. Enthusiasm for demedicalization must not lead to falling into this error.

It is important not to lay blame or focus on individual solutions, but rather to take contexts and living conditions into account, incorporating a biopsychosocial and salutogenic perspective, but without failing to relieve suffering. The problems are complex and require a global approach.

Although intervention may not always cover everything, a broad perspective helps assess different approaches, and the one that best suits each situation can be chosen.

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6

Do not focus on deficiencies

The important thing is not only to have resources, but also to know how to use them.

Deficiencies are part of general practitioners' everyday reality, but there are always elements to promote patient autonomy in health care. Therefore, we recommend tackling the issue from a health and personal development perspective that makes it possible to strengthen the resources and skills of each person (and their community) to cope with life and manage health.

Even in situations of great difficulty, there are always individual and collective capacities put into play that should be identified for greater promotion of health.

One efficient intervention for health promotion is to empower people to manage a range of resources that can help meet life's challenges (influenced by social health determinants). These resources include experience, self-esteem, healthy habits, intelligence, commitment, social support, etc. Having resources is not the only question; first of all, someone must know that they exist; second, they need the self-confidence to 'demand' help; and third, they must use them.

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7

Do not assume that “where there’s a will, there’s a way” or disparage the person’s own self-care strategies

It is not a question of prescribing behaviors, but rather of promoting them.

The biopsychosocial model focuses on end users and their contextualization, both of which are essential in daily Family and Community Medicine practice. This is the way to individualize each diagnostic process and create therapeutic contexts for each patient. Failure to contextualize can lead to errors in decision-making by not taking sufficient information about the patient into account.

The professional-patient/citizen relationship must be based on a democratic, deliberative and participatory model. A good motivational interview must respect end users’ autonomous decisions, as they play the lead role in their own health and their own lives. The “prescription” of social behavior from a paternalistic perspective must be avoided.

As health care professionals, it is necessary to encourage the empowering of each person who is served, so they gain greater control over the decisions and actions that affect their health, and to enable them to make the right choices in their lifestyle. At the same time, it is essential to take care not to impose values, preferences, capacities..., but to help the patient find solutions based on their own abilities and specific situation.

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8

Do not reinforce the imbalance of power with those who come to the consultation in a situation of precariousness, poverty or exclusion

Do not forget the collective assumption of social responsibility, avoiding blame at the individual level.

Exercising the imbalance of power in the consultation promotes value judgments and stigmatizing labels in situations of difficulty or scarcity, thus generating a relationship of humiliation, condescension, shame and/or mistrust.

During professional activity it is necessary to have a broad, unbiased vision that creates positive, inclusive connections. Accomplishing this means acquiring an extensive understanding of the individual situation, the environment and the population, orienting assistance toward the collective and promoting social justice.

In order to be effective, we must avoid blame. We must provide the necessary information on associated behaviors and living conditions, because an intervention that is contingent on lifestyle modification in a decontextualized way can provoke a culpability effect and cause rejection, in addition to being ineffective.

The consultation must become a place for meeting, collaboration, caring, commitment, respect and trust; where the opinions, feelings and perceptions of the person in a situation of vulnerability are legitimized, without saddling them with responsibility that belongs to everyone.

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9

Do not favor verticality in the consultation

Family and Community Medicine contributes valuable technical knowledge: the patient is an expert on their own life. Offering and explaining options in order to reach a consensual plan, rather than proposing a unidirectional plan, is the best way to address the reason for the consultation.

It is essential to explain the reasons for the decisions that are expressed, putting the continuous process of information and informed consent into practice, with particular emphasis on explaining and clarifying the possible benefits and risks. This way, family and community physicians are the person's agents and it is the person who ultimately makes the decisions (although the objective is for decisions to be as consensual as possible).

Bioethics in consultation helps us understand the health care relationship as a deliberative relationship of trust between the practitioner and the user, which is established with the commitment to improve the user's quality of life (and not just their objective health indicators). The user becomes part of a unit of coexistence that decisively influences their health.

The consultation of each health professional and of Primary Care as a whole offered in a health care center represents a privileged space to generate helpful conversations with the community overall, taking into account its gender, generational, functional and cultural diversity, and its diverse relationships. Knowing the life expectations, values and culture of patients, families and communities is essential.

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10

Do not label patients according to rigid preconceptions or fall into cultural determinism when assessing their health status

It is important to build a clinical practice with a broad enough theoretical framework and knowledge to be able to explore reality and context beyond stereotypes.

Oftentimes, family physicians are obliged to use interpretative frameworks in the consultation that may be constructed based on stereotypes. These stereotypes may reflect reality more or less accurately, and have greater or lesser ability to speed up the establishment of diagnostic or therapeutic processes. Many of these interpretative frameworks can signify that decisions are made based on elements that are nothing more than stereotypes or clichés.

In the words of Iona Heath with regard to working with people of other cultures (and in general with any patient): “The objective must be to become better professionals, appreciating the privilege of alleviating the suffering, pain and disease of a population that is constantly evolving, culturally heterogeneous and ethnically diverse. It is essential to maintain our curiosity about how our patients understand and experience their own world and health. The classic questions of a good clinical interview: ‘Why do you think this is happening to you?’ or ‘How does what is happening to you affect your life?’ are essential.”

It is important not to make assumptions regarding purchasing power, language comprehension, certain cultural triggers, sexual orientation or practices, gender roles, religious ideology, consumption patterns... instead, it is appropriate to explore the context and adapt the service to the need.

There are validated tools that can be useful, in specific contexts, for a more or less systematic screening of situations that, otherwise, could go unnoticed or might be assumed based on socially constructed stereotypes. This is the case with both gender-based violence and poverty.

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11

Do not overlook care work, whether in the case history or in the preparation of therapeutic proposals and investigation into adherence to them

When considering patients' context and biography, especially for women patients, it is important to ask about the care tasks performed, either formally or informally, as they can be an important determinant of health as well as having an impact on the patient's ability to follow certain treatment regimens or recommendations.

For a long time, care tasks have represented work that is taken for granted in family and community structures; this care, overwhelmingly, has fallen on women, either in the form of professional work or as a mandate of family structures.

The burden of care appears as one of the possible factors to explain why women's perceived health is worse relative to men and, in addition, it can have a major impact on the development of disorders, whether in physical health or in psychic suffering and the interaction between the two.

In the book *Salubrismo o barbarie*, López Roman and López Ruiz state the following: "Thus, we find worse health among caregivers in all types of pathologies, from a higher prevalence of cardiovascular disease to headache, dorsalgia, joint pain, etc., but also a situation of economic dependence and social isolation that will have an impact on their health."

Addressing, on the one hand, the burden on caregivers and, on the other, including formal and informal care tasks as a health determinant, with a clear gender perspective, should help address a very present and invisible type of imbalance within Primary Care consultations.

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