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Social Determinants of Health: Impacts on Primary Care

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Abstract

Understanding the social determinants of health (SDH) is essential to justify the central role of primary health care (PHC) as a strategy that promotes equity. SDH—including socioeconomic factors such as income, education, housing conditions, and social support—directly shape disease risk and severity, often exerting greater influence than isolated biomedical interventions. PHC stands out as a privileged setting to address these factors due to its community embeddedness, longitudinal patient relationships, and comprehensive care approach. Nevertheless, despite international guidelines recommending practices that confront social vulnerability contexts, a persistent gap remains between theory and effective implementation in everyday service delivery. This essay discusses how PHC can systematically integrate SDH into clinical and management workflows to reduce inequalities and improve population outcomes. Drawing from international evidence and innovative initiatives, it highlights the use of social screening tools, community health workers, and financing models adjusted for vulnerability, while addressing both current limitations and opportunities. The theory of "fundamental causes" explains that individuals with higher socioeconomic status possess a repertoire of resources—such as education, social capital, prestige, and power—that provide continuous protection against new diseases, perpetuating health inequalities even in biomedical advancement contexts. Consequently, improving environmental conditions alone does not eliminate disparities: privileged groups quickly adopt new preventive measures, maintaining the social gradient in health. Despite recognizing SDH's importance, most PHC professionals lack training, preparation, and institutional resources to address them effectively. Initiatives in U.S. community health centers using tools like

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PRAPARE demonstrate that data collection alone is insufficient without strong links to social services. High rates of food insecurity, inadequate housing, and transportation issues among PHC users compromise treatment adherence and access, creating real barriers to humanized care. To overcome a strictly biomedical model, PHC must incorporate preventive and community-based strategies guided by theoretical frameworks for screening, resource allocation, and monitoring SDH-related outcomes. Examples include "social prescribing" in the UK and the integration of "link workers" to connect patients with social support services—both shown to reduce hospitalizations and improve community well-being. Financing models that consider social vulnerability, such as capitation adjustments and specific SDH coding (e.g., ICD-10 Z55–Z65), promote resource allocation aligned with need. Tools like the Area Deprivation Index (ADI) aid in mapping vulnerability and guiding resource planning. Sustainable action on SDH requires investments in professional training—both undergraduate and continuing education—to enable health workers to identify, refer, and monitor socially driven health needs. PHC's transformative potential depends on political commitment, reoriented care models, and public policies that ensure appropriate funding for vulnerable populations, making the promotion of health and social justice a feasible mission.

Keywords: *social determinants of health, primary health care, health equity, community health, social prescribing, healthcare access, public health policy*

Introduction

Understanding the social determinants of health (SDH) is essential to justify the central role of primary care as a strategy for promoting equity. SDH—including socioeconomic factors such as income, education, housing conditions, and social support—directly shape the risk and severity of disease, often surpassing the impact of isolated biomedical interventions (Link & Phelan, 1995; Marmot et al., 2008).

Primary health care (PHC) presents itself as a privileged setting to address these factors due to its reach, longitudinal bond with the community, and comprehensive care approach. However, despite international guidelines recommending practices that address social contexts of vulnerability, a persistent gap remains between theory and effective implementation in everyday services (World Health Organization, 2008; Gottlieb et al., 2018).

The relevance of this essay lies in discussing how PHC can systematically integrate SDH into clinical and management workflows to reduce inequalities and improve population outcomes. For this, we highlight international evidence and innovative initiatives that employ social screening, community health workers, and financing adjusted for vulnerability, while also addressing current limitations and opportunities.

Methodology

This qualitative essay was developed through a literature review of recognized academic and institutional databases, seeking relevant empirical and theoretical studies published over the past two decades on SDH and primary care. A dialogical approach was used to correlate concepts, intervention models, and available data for critical reflection.

Development

The theory of "fundamental causes" argues that individuals with higher socioeconomic status have access to a repertoire of resources—education, social capital, prestige, and power—that provide continuous protection against emerging diseases, thus perpetuating inequalities even amid biomedical advancements (Link & Phelan, 1995).

This explanatory perspective clarifies why simple improvements in environmental conditions, such as sanitation or vaccination, do not eliminate disparities: advantaged groups tend to rapidly adopt new preventive resources, maintaining the social health gradient (Phelan & Link, 2005).

In PHC, although most professionals recognize the importance of SDH, few are trained to act on them, revealing a lack of preparation, training, and institutional resources aimed at effectively addressing these issues in practice (Gottlieb et al., 2018).

Experiences in U.S. community health centers show that although screening tools like PRAPARE are used, mere data collection is insufficient without effective links to social services, limiting real impact on reducing social needs and improving perceived well-being (Bensabatian et al., 2018). Studies identify high rates of food insecurity, lack of transportation, and inadequate housing among PHC users—factors that compromise treatment adherence, appointment attendance, and medication use, representing real barriers to humane care (Jih et al., 2023).

Overcoming the strict biomedical model requires incorporating preventive and community-based strategies, using theoretical frameworks to guide screening, resource provision, and monitoring of SDH responses, thus shaping a collective health–oriented PHC (Artiga & Hinton, 2018).

In England, the practice of *social prescribing*—prescribing activities such as support groups, gardening, or art—has reduced symptoms of depression, anxiety, and loneliness, while easing clinical burdens and strengthening community bonds (Bickerdike et al., 2017). Another effective initiative involves “link workers” integrated into PHC teams, tasked with connecting patients to social services, housing, transportation, and legal support, resulting in fewer hospitalizations and unnecessary referrals (Polley et al., 2017).

Funding models that ignore population vulnerability worsen disparities. Countries that adjust capitation contracts based on social need ensure additional resources for the most vulnerable regions, strengthening equitable access (Asaria et al., 2016). The inclusion of specific SDH codes, such as Z55–Z65 from ICD-10, in electronic health records enables institutional and operational recognition of these factors. This practice supports concrete action, monitoring, and even value-based billing, encouraging PHC teams to address social contexts (Hatef et al., 2019).

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The Patient-Centered Medical Home (PCMH) model, when it strengthens teams with social workers and community specialists, shows better outcomes in child asthma control, immunization, and reduced hospitalizations, evidencing health management gains through SDH integration (Bitton et al., 2018).

The use of indicators like the Area Deprivation Index (ADI) helps map regions with greater vulnerability, prioritize planning of policies and resources, and evaluate PHC impact more sensitively to social inequalities (Kind & Buckingham, 2018). To ensure PHC expands its actions on SDH sustainably, investment in professional training—both at undergraduate and continuing education levels—is essential so health workers become competent in identifying, referring, and monitoring constantly evolving social determinants (Gottlieb & Adler, 2023).

Conclusion

PHC holds transformative potential to reduce health inequalities by incorporating practices that address social determinants, from systematic screenings and community actions to restructuring financing and integrating social contexts into health systems. Strategies such as social prescribing, the integration of community health agents, and the use of social assessment tools point toward a more inclusive and equitable model.

However, making these paths effective depends on political commitment, professional training, and reorientation of the care model, with public policies that ensure adequate funding for the most vulnerable populations. Only then can primary care fulfill its mission of promoting health and social justice.

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