Social Determinants of Health: A Framework for Studying Cancer Health Disparities and Minority Participation in Research

Matthew Asare, PhD, Marie Flannery, PhD, RN, AOCN®, and Charles Kamen, PhD, MPH

The theory of social determinants of health (SDH) posits that the health of people and communities is affected by social and economic factors (i.e., economic stability, education, neighborhood and built environment, health and health care, and social and community context). These interrelated constructs may negatively affect minority patients’ ability to participate in cancer research. Understanding SDH can help nurse researchers assess and address barriers to research participation, as well as design trials to improve minority patients’ cancer-related health.

Background

Oncology nurses confront health disparity issues in numerous settings and across many roles in their work lives. These health disparity issues are often complex, challenging, and recurrent. Cancer health disparities are defined by the National Cancer Institute (2008) as “adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States” (para. 1). Groups affected by health disparities may differ in race, ethnicity, age, sexual orientation, disability, education, income, or geographic location, and they may experience disparities not only in cancer-related health factors but also in representation in cancer-related research.

Social Determinants of Health Framework

The SDH framework posits that the health of people and communities is affected by social and economic conditions. These same conditions can negatively influence an
individual’s ability and willingness to participate in research, including cancer research. This framework identifies five primary social and economic constructs that can influence cancer outcomes and research participation: (a) economic stability, (b) education, (c) neighborhood and built environment, (d) health and health care, and (e) social and community context.

**Economic stability:** Factors of this construct include income, employment, expenses, and debt, all of which can have a negative impact on an individual’s health and his or her ability to participate in research. For instance, individuals with low socioeconomic status may have poor living conditions that increase their cancer risk and affect their ability to afford quality cancer care (Barrett, 2002; Foley & Moertel, 1991; Holcombe, Jacobson, Li, & Moinpour, 1999; Klabunde, Springer, Butler, White, & Atkins, 1999; Swanson & Ward, 1995). Because some patients of racial and ethnic minorities experience a higher burden of economic instability, their participation in research studies tends to be low. Although explicit costs for participating in research or clinical trials are rare, the implicit costs (e.g., transportation, child care, parking, loss of income from missing work) can be overwhelming to patients who lack economic resources (Sharrocks, Spicer, Camidge, & Papa, 2014).

**Education:** This construct consists of literacy, linguistic fluency, vocational training, and higher education. Low levels of education can lead to low health literacy. As a result, individuals’ ability to access, understand, and act on complex health information, as well as communicate with health team members, fully engage in healthcare decision making, and select healthy behavior choices, can become more difficult. Low education levels can also directly contribute to low research participation; many studies have determined that individuals with low levels of education find information about research trials and informed consent to be complex and difficult to comprehend (Adams-Campbell et al., 2004; Crosson, Eissner, Brown, & Ter Maat, 2001). Individuals who do not have experience with research may not understand research principles or the importance of research participation; consequently, those with more education are overrepresented in research studies (Herndon, Kornblith, Holland, & Paskett, 2013).

**Neighborhood and built environment:** This construct describes the availability of transportation, safe and modern housing, safe walking paths and sidewalks, and neighborhood infrastructure. Lack of accessible transportation to doctors’ appointments can restrict access to health care and can compromise an individual’s ability to travel to take part in a research study; similarly, neighborhood factors (e.g., lack of accessibility of academic medical centers, affordable childcare, community outreach from researchers) can contribute to disparities in research participation (Barrett, 2002; Crosson et al., 2001; Foley & Moertel, 1991; Klabunde et al., 1999; Swanson & Ward, 1995).

**Health and health care:** This construct details the availability of health coverage and specialist healthcare providers, as well as the quality of care and the cultural competency of healthcare providers. These vary across healthcare settings and can either improve or compromise an individual’s health. Klabunde et al. (1999) observed that lack of access to care, poor quality of care, and low insurance coverage have been given as reasons for some patients’ refusal to participate in research studies. In addition, research studies are not always equally promoted or discussed across healthcare settings, and employees of clinics in lower-income neighborhoods may not know about or have access to clinical trials. Promoting the stereotype that minority patients are difficult to reach and noncompliant could prevent some physicians from referring minority patients to clinical trials (Taylor & Leitman, 2001).

**Social and community context:** This construct refers to the psychosocial aspects of a community (social integration, community engagement, trust, and social support) that can improve health and reduce health disparities. Certain minority communities may lack social integration and/or may be exposed to discrimination by the majority-dominated society. Exposure to discrimination may lead to difficulty engaging with the broader society, mistrust of elements of this society, and suspicion of healthcare systems that have historically exploited minority communities (Mays, Cochran, & Barnes, 2007). Trust has been a concern among minority populations regarding their participation in research studies—and in clinical trials in particular. Some of this mistrust is based on historical precedents of discrimination, as well as unethical research experiments, such as the Tuskegee Syphilis Study (Corbie-Smith, 1999; Green et al., 2000; Shavers, Lynch, & Burmeister, 2002). Taking mistrust into account when designing and promoting research studies in minority communities is essential.

The SDH framework posits that all of these social and economic constructs are interrelated. All are embedded within a broader sociocultural environment and can interact with an individual’s biologic factors (e.g., age, gender, genetics). For example, SDH factors negatively affecting patients in racial and ethnic minorities are the result of a longstanding history of discrimination, prejudice, and institutional discrimination in the United States.
Implications for Nursing

Although many oncology nurse researchers have led efforts to enhance participation of minority and underserved patients in research, many challenges and barriers remain. SDH constructs can inform nursing research in three separate ways: (a) measuring components of SDH in cancer research, (b) accounting for barriers related to SDH in recruitment, and (c) addressing SDH-related disparities through intervention design. In measuring components of SDH, oncology nurse researchers could include questions about social and economic factors in their questionnaires, asking not only about income and education but also about insurance status, living situation, and health literacy. When accounting for barriers related to SDH, researchers can acknowledge that transportation, child care, and reading level may prevent individuals from accessing and understanding research studies. The assumption that all patients read consent forms and understand what they are signing may not be true, and comprehension should be ensured. Taking the time to explain study protocol and informed consent to patients is imperative. Some minority patients are not aware of available studies or clinical trials because they have not been presented with clinical trial options or availability.

Conclusion

One of the major challenges to providing culturally sensitive and appropriate cancer care is the lack of generalizable findings from cancer research; low participation rates of minority patients in research studies contribute to this lack of generalizability. Although many nurses and nurse scientists have made inroads into understanding and studying disparities, much work remains. Cancer research studies reflecting population-based statistics should include at least 23% non-Caucasian participants. The SDH framework offers a way to examine disparities in cancer care outcomes and minority participation in cancer research. Consistent with many socioeconomic frameworks, the theory of SDH emphasizes examination of environmental and social factors that influence health. The current authors propose that the SDH framework continue to be applied by nurse researchers to the issue of recruitment to research studies. Given the complexity of the issues, using an orienting framework, like SDH, can be one strategy for progress.

References


Authorship Opportunity

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