Social Determinants of Health in People with Kidney Disease
An Introduction

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The papers that follow derive from talks delivered at the 2020 Alison Norris Symposium at the New York Academy of Medicine (NYAM). The program title was Social Determinants of Kidney Health, the fifth in a biennial series established to memorialize the life and work of Dr. Norris. Dr. Norris was a nephrologist with a practice in Bethesda, Maryland. She maintained a lifelong interest in issues related to patient advocacy. This interest had been articulated most clearly in 2008 in a preface, coauthored with Laurie Norris and Clarence Pearson, to an edited volume of Patient Advocacy for Health Care Quality: Strategies for Achieving Social Determinants of Health in People with Kidney Disease. Norris and her coauthors identified a “public health and medical continuum,” in essence, a spectrum extending from a broad view of disease prevention and provision of resources to the specific prescription and delivery of care on the basis of the values and expectations of an individual patient. Whether the frame of reference was societal or personal, the physician was expected to assume the role of a patient advocate. After Dr. Norris died an untimely death in 2009, these symposia at NYAM were established in her honor. The audience for each symposium was composed of nephrologists and trainees, nephrology nurses and social workers, and patients with kidney disease.

Consistent with the breadth of the mission, themes of the symposia have varied from the intensely personal to the societal. The inaugural event in 2011 was dedicated to examining psychosocial issues attendant to the dialysis experience: embarking on dialysis, dealing with the emotional stresses of dialysis, and withdrawing from dialysis. In the second symposium in 2013, the subject was kidney transplantation, and the focus was on allograft shortage and practical barriers to transplantation within the ESKD population. In 2015, the program organizers acknowledged the growing importance of palliative care principles for patients with CKD and patients with ESKD. This movement appeared to capture the spirit of the Norris charge in sensitating practitioners to the patient voice in configuring care plans, designing the treatment environment, and weighing patient-identified priorities in allocation of research resources. The fourth symposium in 2017 turned to societal issues, examining the effect of health care policy on the patient experience. Policy preferences could be manifest as direct economic incentives (what aspects of care were reimbursable) or, more subtly, as quality of care metrics. The symposium reviewed opportunities for advocacy groups to influence these policies.

The most recent symposium, Social Determinants of Kidney Health, was anchored in the public health arena but with speakers who had the depth of focus to show how systemic barriers have personal consequences.

It has slowly become increasingly apparent that psychosocial issues play a role in the survival and, more recently understood, the well-being of patients with ESKD and CKD, as a result of research performed over the last 40 years. In 1981, uncontrolled studies demonstrated that depression was associated with mortality in patients treated with home hemodialysis in the United Kingdom (2). The scope of research on psychosocial issues grew to include various factors linked to socioeconomic status (such as income, occupation, and education).

Race, however, became a key factor in evaluating outcomes from the very earliest investigations into ESKD treatment. Port (3) showed, startlingly, that Black patients with ESKD had improved survival on hemodialysis compared with White patients, an extraordinary finding that is not present in any other major chronic illness. This finding has also held up for more than 3 decades, although it has not been completely explained. Observational data from studies in the ESKD population and the Medicare population suggest that the role of poverty is also independently linked to mortality in these instances (2).

Port’s team, in 1987, reported differential survival by race in US patients with transplants as well (4), a finding corroborated recently in several more contemporary populations by Reeves-Daniel et al. (5) and others. These old findings illustrate several key points. Race, although a social construct, matters. An important biologic factor, a gene variant found almost exclusively in people of recent African descent, conveys great susceptibility to the development of several types of kidney disease and to more rapid progression of established disease (2,6). These gene variants have been linked to poorer survival of kidney transplants harvested from...
The quality of the examination room communication can be pivotal, for better or worse, in its influence on such decisions, an issue that was considered by Dr. Ebony Boulware of Duke University. Finally, a 180-degree assessment was provided in a forum led by Dr. Daniel Cukor of the Rogosin Institute, in which patients with CKD and patients with ESKD issued a report from the front on their views as recipients of kidney care.

Given the events of these last few months, during which the world has tried to cope with a pandemic and in which New York City fought for its life, a report of this symposium from January 2020 appears now as a warm remembrance of a gentler time. Beyond that, the crosscurrent of racial injustice with respect to basic personal and economic survival may seem to render discussion of CKD treatment disparities as a communication from an ivory tower. That being said, our personal path forward as nephrologists can only begin from where we live within the kidney community.

Now, the novel coronavirus pandemic—afflicting people of color preferentially for a variety of reasons (with psychosocial factors perhaps most prominently involved)—has exposed the important roles that race differences can play in acute health outcomes, as well as the role of structural racism, in direct and indirect ways. This symposium sought to bring together prominent experts in the field and focuses on the social determinants of health in patients with CKD and ESKD, which are as important to patients and outcomes as fluid and electrolyte balance, loss of nephron mass, anemia, and inflammation. Our patients cannot survive and thrive in environments characterized by poverty, racism, violence, and lack of access to proper food and shelter. To benefit the health of the nation, racism must be ended and poverty exterminated if the health of all, including patients with CKD and ESKD, is to improve.

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