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Data, social determinants, and better decision-making for health: The report of the 3-D Commission

In April 2020, The Rockefeller Foundation and Boston University School of Public Health launched the Commission on Health Determinants, Data, and Decision-Making (3-D Commission) with the aim of creating a common language among health determinants, data science, and decision-making—both health and non-health related—toward the end of improving the health of populations. The report—an output of more than a year of discussion and research among a multisectoral group of distinguished experts representing academe, the private sector, civil society, and government—explores the key social and economic drivers that influence health outcomes and illustrates how data on social determinants of health (SDoH) can be integrated into decision-making processes. The report argues for a holistic definition of SDoH to drive cross-sectoral collaboration, address health inequities, and promote accountability and offers a set of principles and recommendations designed to support the development of a SDoH-based, data-driven approach to decision-making and foster demand for public and private investment in SDoH.

The recent proliferation of big data presents tremendous potential and opportunity both to understand SDoH better and to guide decision-making to improve the health of individuals and populations. However, a lack of leadership, priority setting, and investment has impeded progress in effective translation of such progress into data-driven action on SDoH. There are multiple challenges to achieving such goals—including data availability, data hierarchy, nonuniform definitions and measurements of SDoH, public mistrust in the use of big data, and lack of engagement of marginalized populations—that are experienced across high-income, middle-income, and low-income countries.
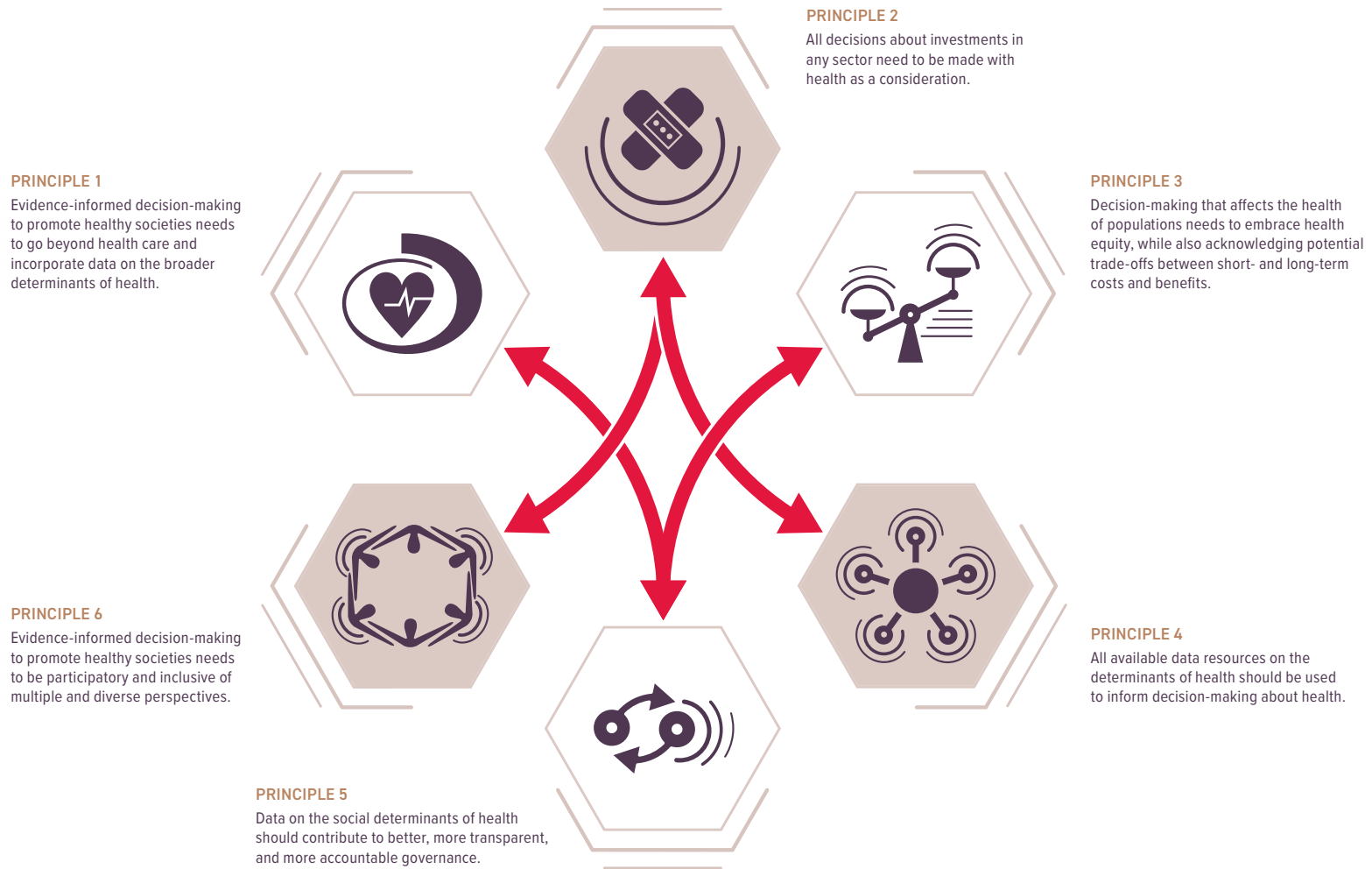
Despite increasing awareness of the need to incorporate SDoH into decision-making by academe and civil society, the uptake of evidence-informed policies and programs that tackle SDoH or build on the growing availability of data to improve health outcomes has been slow. Catalyzing action for health across different sectors requires a common language and an understanding that improved health should translate to returns on financial investment and gains in productivity as well as overall population well-being. Political will among decision-makers is also a critical challenge to enacting SDoH-focused policy. As the impact of policies addressing SDoH will likely be difficult to discern in the near term, promoting population health is a choice that the decision-maker must make consciously, sometimes irrespective of short-term political exigencies.

There are three interconnected, pragmatic areas needed for the vision of the 3-D Commission to translate into actionable policies and programs: political will, technical capacity, and community engagement. First, creating political will requires developing a common language with decision-makers in different sectors, highlighting the potential returns on investment for other sectors, and nuancing and broadening metrics of societal advancement beyond economic indicators. Second, technical capacity is needed to translate a new appreciation for data and SDoH into actionable directives that can be used to improve policy decisions and population health outcomes. Third, engaging communities in decision-making processes can then lead to better decisions being made. Inclusion in the decision-making process means that decision-makers listen to a wide range of stakeholders while formulating decisions: this diversity of thought and perspective helps to compensate for the lack of perfect data. The three areas also require a basic level of trust from the population, which, in turn, can lead to greater levels of trust that will inform, support, and reinforce better decision-making for health.

To improve the health of populations and address health disparities caused by social structural inequities—and exacerbated by COVID-19—a whole-of-society approach is needed. This will require a concerted effort to reframe key issues and adopt common understandings of cross-sector challenges that affect health. All relevant actors must understand the role that SDoH plays in shaping health outcomes; therefore, critical questions on data collection and use will need to be addressed. This report—and its principles and associated recommendations—offers a roadmap for making these goals a reality.

3-D Commission principles

PRINCIPLE 1
Evidence-informed decision-making to promote healthy societies needs to go beyond health care and incorporate data on the broader determinants of health.

PRINCIPLE 2
All decisions about investments in any sector need to be made with health as a consideration.

PRINCIPLE 3
Decision-making that affects the health of populations needs to embrace health equity, while also acknowledging potential trade-offs between short- and long-term costs and benefits.

PRINCIPLE 4
All available data resources on the determinants of health should be used to inform decision-making about health.

PRINCIPLE 5
Data on the social determinants of health should contribute to better, more transparent, and more accountable governance.

PRINCIPLE 6
Evidence-informed decision-making to promote healthy societies needs to be participatory and inclusive of multiple and diverse perspectives.

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3-D Commission recommendations

- Relevant international, regional, national, and local entities, including funders, should **systematically collect and make available, in real time, quality data characterizing the full range of determinants of health—including for example, education, housing, economics—to decision-makers and communities locally and nationally.**

- National governments should **develop transparent systems that collect data about the social determinants of health, and explicitly use these data in decision-making processes.**

- Relevant international, regional, national, and local entities, including funders, should **embed follow-through monitoring processes to ensure accountability for data-informed decision-making around health.**

- Relevant international, regional, national, and local entities, including funders, should **center community engagement in acquisition and interpretation of data and make such data widely available to relevant communities.**

Case study: The Urban Indian Health Institute's efforts to decolonize data

In the United States, American Indian and Alaska Natives suffer from health disparities at disproportionate rates as compared to other ethnic groups.[1] Chronic and infectious disease and unintended injury with extraordinarily high levels of co-morbidity and mortality are just some of the health areas where American Indians and Alaska Natives experience higher rates than others.[2] To improve the health outcomes of American Indians and Alaska Natives, decision-makers need to prioritize community engagement in the data collection and interpretation process and make the resulting data and analysis widely available to impacted communities.

Today, seven out of ten American Indian/Alaska Native people in the United States live in large, urban centers.[3] However, because the American Indian/Alaska Native population makes up a comparatively smaller percentage of the entire urban population, this group is often viewed as statistically insignificant in mainstream data on health outcomes.[4] Additionally, mainstream data collection methods often combine American Indian/Alaska Native respondents with respondents from other racial/ethnic groups or place American Indian/Alaska Native respondents into umbrella categories such as "Other", which essentially serves to render their differentiated experiences invisible.[5] Moreover, when researchers do collect data about American Indian/Alaska Native people, they often approach American Indian/Alaska Native communities with a deficits mindset, measuring only problems and gaps, not solutions, assets, or strengths. [6,7]

The Urban Indian Health Institute (UIHI) is an organization in the United States whose mission is to decolonize data practices. While definitions of decolonization vary,[8] most include two dimensions: first, acknowledging and eliminating—or, at the very least, mitigating—the historical and present-day legacy of the

violent imposition of colonization and imperialism,[9] and second, intentionally making space for, returning space to, and elevating the ways of knowing of communities who have resisted oppression by colonialist and imperialist powers to this day.[10,11]

One of UIHI's key projects that embodies the recommendations of the 3-D Commission pertaining to data collection and dissemination has been the creation of a first-of-its-kind, interactive, and publicly available health indicator data dashboard for urban American Indian/Alaska Native people in the United States. This dashboard provides health data for Indigenous communities in 30 urban Indian health areas, as well as national aggregates, putting the issues affecting urban American Indian/Alaska Native communities firmly on the map. UIHI also ensures that American Indian/Alaska Native people have power over how their data are shared and used. While UIHI does share collected data with external partners, it does so in a way that honors the self-determination and data sovereignty of Indigenous people (e.g., Community Health Profiles that provide a snapshot of urban Indian health for individual service areas throughout the country).[12]

1 Urban Indian Health Institute: A Division of the Seattle Indian Health Board. *Urban Indian Health*; 2021 https://www.uihi.org/urban-indian-health/
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4 Ibid.
5 Ibid.
6 Ibid.
7 It is Time to Decolonize Data. *Montana Budget & Policy Center*; 2019. https://montanabudget.org/post/time-to-decolonize-data
8 Khandwala, Anoushka. Decolonizing Means Many Things To Many People – Four Practitioners Discuss Decolonizing Design; 2020. https://eyeondesign.aiga.org/decolonizing-means-many-things-to-many-people-four-practitioners-discuss-decolonizing-design/
9 Nordling, L. How decolonization could reshape South African science. *Nature*. 2018 Feb 8;554(7691): 159-162. doi:10.1038/d41586-018-01696-w. PMID: 29420501.
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11 Ibid.
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