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Action on Health Disparities in the United States

Commission on Social Determinants of Health

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HERE ARE 2 TRUISMS. RICH COUNTRIES HAVE BETTER health than poor countries, and medical care improves health. Consider, then, the case of the United States, which is among the richest countries in the world and spends more than any other country on medical care, US \$6350 per person in 2005.¹ Does the United States then have the best health? Not quite. Life expectancy from birth to age 65 years is one useful measure of premature mortality: the United States ranks 36th in the world for men and 42nd for women.² If not by greater national income or more spending on medical care, how should the task of improving health in the United States be approached? Pay attention to the social determinants of health.

Commission on Social Determinants of Health

Because of concern with global health inequity the director-general of the World Health Organization established the Commission on Social Determinants of Health (CSDH) in 2005. The CSDH produced recommendations, based on evidence, about what could be done to further the cause of health equity.³ The CSDH highlighted inequities between countries—life expectancy at birth in Zambia (41.2 years) is half that of Japan (82.4 years)⁴—but also health inequities within

countries (such as the United States) that can be dramatic. Within the Scottish city of Glasgow, there is a 28-year gap in life expectancy between the richest and poorest areas; among the poorest, male life expectancy is 8 years less than the average life expectancy in India.³ The gap in life expectancy between men in Washington, DC, and in suburban Maryland is 17 years.³ Rich countries have no cause for complacency. The CSDH was oriented to countries at low, medium, and high income.⁵

The gap between top and bottom highlights the magnitude of the difference in health outcomes but the CSDH emphasized the graded relation between socioeconomic position and health, the social gradient that exists within countries.⁶ A previous comparison of men and women aged 55 to 64 years demonstrated the social gradient in health and showed higher illness rates in the United States than in England,⁷ consistent with shorter life expectancy to age 65 years in the United States. At every point along the scale of income or education, the health of Americans was worse than that of the English.

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The CSDH call for action on social determinants of health also applies to differences between ethnic groups. It has been estimated that in the United States 886 202 deaths could have been averted between 1991 and 2000 if mortality rates between white and black individuals had been equalized.⁸

Health inequities between the worst off and the best off in rich countries and the social gradient in health imply that the focus should not only be on absolute material deprivation. The poor of Glasgow or Washington, DC, are not poor by global standards. In Glasgow and in Washington, DC, tap water is fit to drink, food is rarely contaminated and is plentiful, and although there are a few exceptions, no one lives in squatter settlements. In India 76% of the population live on \$2 a day or less⁴; yet men in India, on average, have longer life expectancy than the poorest men of Glasgow and about the same as men in Washington, DC.

This comparison with India shows how powerful the action of social determinants can be—rivaling the effects of material deprivation—a lesson also conveyed by the gradient in health observed in both rich and poor economies. A further and crucial implication of the gradient is that inequities in health apply to everyone below the top socioeconomic position. Therefore, social action should deal with the entire gradient, and all of society, not only with those at the bottom.

Evidence shows that the slope of a health gradient is not fixed; it is responsive to political, social, and economic changes. The gradient in adult mortality by educational level worsened in Russia after 1992 following the political, social, and economic upheaval caused by the breakup of the Soviet Union.⁹ In the United States, the gradient in life expectancy by socioeconomic deprivation has worsened for both men and women since 1980.¹⁰

Health and Health Inequities in the United States

The Commission's recommendations for action to promote health equity are based on 3 principles of action: improve the circumstances in which people are born, grow, live, work, and age; tackle the inequitable distribution of power, money, and resources—the structural drivers of conditions of daily life—globally, nationally, and locally; and measure the problem, evaluate action, and expand the knowledge base.³

Several themes from the CSDH report that are, among others, highly relevant to inequities within the United States are as follows.

Health Care. Globally, every year at least 100 million individuals are forced into poverty because of out-of-pocket health expenditures.³ In the United States, the maldistribution of availability of health care rightly claims much attention. But this should not distract from attention to other social determinants of health. The United States spends about 2.5 times more per person on medical care than the

English. In the comparison of English and US adults, referred to above, more than 90% of participants had health insurance.⁷ Nevertheless, the Americans had worse health than did the English.

Equity From the Start. The CSDH placed great emphasis on early childhood development and education. The relation between education and health in adult life is clear. To the extent that this relation is causal, it is important to improve the education of children, particularly those born to parents who themselves have low educational attainment. A recent Organisation for Economic Co-operation and Development (OECD) report¹¹ gives scant encouragement to the United States. It evaluated math scores of 15-year-olds in relation to their parents' education. Those whose parents had low educational achievement performed worse than those whose parents were highly educated—but the deficit in the United States was greater than the average for all OECD countries. In Sweden, for example, parents' educational status made less difference to the math scores of 15-year-olds.

Fair Financing. Within countries, observational data show that income is correlated with mortality and life expectancy; however, between rich countries, there is little relation between a country's national income and life expectancy. An interpretation, then, of the correlation of income to mortality within a rich country such as the United States is that income is a marker of relative position within society; relative position, in turn, is related to social conditions that are important for health including good early childhood development, access to good-quality education, rewarding work with some degree of autonomy, decent housing, and a clean and safe living environment.

Increasing levels of income inequality in a society are likely to lead to a worsening of the relative position of those with lower standing in the socioeconomic hierarchy. This is not to enter the debate as to whether income inequality, per se, is related to a country's overall level of life expectancy. It is to say, however, that if relative position worsens, conditions for those at the bottom will be relatively worse than for those at the top.

Real earnings of US working men whose starting full-time salaries were below the median declined between 1980 and 2005, while real earnings increased for men earning higher incomes.¹¹ By contrast, real earnings increased between 1980 and 2003 across all income deciles in the United Kingdom, although the income of higher earners increased more than that of lower earners.¹¹ The United States has the third highest poverty rate (50% median income) in OECD countries, below Turkey and Mexico and well above average for OECD countries. Furthermore, the United States ranks fourth in the OECD for disposable income inequality.¹¹ Market income and disposable income inequalities and poverty rates are susceptible to government economic and social policy choices.

The Individual and Society

The way society is organized through political choices influences health outcomes, but the individual is not lost in the CSDH's approach,¹² which emphasizes collective and individual empowerment, including material, psychosocial, and political empowerment. Individuals need basic material conditions for health, control over their lives, and active participation in decisions that affect their lives. The aim of public policy should be to create the social conditions to meet these needs.³

Putting Social Determinants of Health Into Practice to Improve Population Health

Positioning health equity as a key performance indicator in all social and economic policy making has the potential to drive significant reductions in health inequities.³ How would this work in practice? Early childhood development—including the physical, social-emotional, and language-cognitive domains—is among the key areas for action described by the CSDH.³ President Obama's commitment to prioritize early childhood education is therefore promising.

The current global economic crisis brings work and employment conditions into sharp focus. Since December 2007, the start of the recession, 3.6 million jobs have been lost in the United States.¹³ Job insecurity, unemployment, and deterioration of working conditions are all potentially harmful to population health and require urgent attention.

Former CSDH commissioners Wilensky and Satcher¹⁴ hold the view that action across the social determinants may gain bipartisan support in the United States. The Robert Wood Johnson Foundation has set up the Commission to Build a Healthier America with a strong focus on what can be done across the social determinants of health.¹⁵

The CSDH's findings and recommendations are necessarily general because of their global application. The recommendations require "translation" into specific policies for particular country contexts. Several countries are in the process of doing this: Chile, Brazil, Argentina, Sri Lanka, Thailand, and a number of European countries. In England, Prime Minister Gordon Brown¹⁶ said: "[T]he health inequalities we are talking about are not only unjust, . . . they also limit the development and the prosperity of communities, whole nations, and even continents." He announced an independent review of health inequalities in England (chaired by M.G.M.) that is taking the CSDH's recommendations and developing evidence-based strategy across social and economic policy areas to improve health equity. Other countries around the world are taking action.³ What is needed? Put simply: leadership from the top of government, action across social and economic policy areas, and participation from communities across society. Action needs to take place at local, regional, national, and global levels.

The international response to the current global financial crisis provides the opportunity for the international community to recommit to a more representative multilateral system with fairer participation by all countries and the opportunity to place health equity at the heart of multilateral policy development in areas including trade, finance, responses to climate change, and international security. The United States has a leading role internationally. A world of hope and expectation rests on the new US president. How will President Obama respond to the commission's call to action?

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