HEALTH GAPS

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Health Gaps

- Among different populations across the United States, substantial disparities in health and health care persist.
- At a time when health care providers and policy makers are exploring new models to promote better health and improve health care, different populations experience persistent and increasing disparities in health status.

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- In the United States, life expectancy and other health status measures vary dramatically depending on factors, such as race, gender, educational attainment, and ZIP code, that should not make a difference.

- This brief reviews recent research on health disparities.

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- The latest research found that in 2010 the life expectancy for the black population was 3.8 years lower than that of the white population. Gender differences are also very real.
- Historically, US females enjoyed longer life expectancies than males, but recent research found that the gender gap in longevity has narrowed--unfortunately because female mortality rose in 42 percent of US counties between 1992 and 2006.

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- When demographic factors such as race and gender combine, inequities are larger.
- In a groundbreaking study on "Eight Americas," the country was divided into race-county units, and the researchers found that the life expectancy of one subgroup of black males, identified as high-risk urban black males, was more than 20 years shorter than Asian females' life expectancy.

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- Health disparities also can be linked to ethnicity, language, and sexual orientation.
- Moreover, they are closely correlated to education, income, and social class.
- In most countries, including the United States, people with low socioeconomic status have higher risks of dying from noncommunicable diseases, such as cardiovascular disease, cancer, diabetes, and chronic respiratory disease, than those in more advantaged communities.

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- Differences in health are not simple consequences of one factor or another.
- Rather, multiple factors, including unique population and behavioral risk factors, contribute to these findings.
- The challenge now is to understand how the factors interact with each other and how to arrest or slow trends that seem to be getting worse.

(An October 6, 2011, Health Policy Brief on *Achieving Equity in Health* looked at how different organizations are working to address these factors and begin closing health gaps.)

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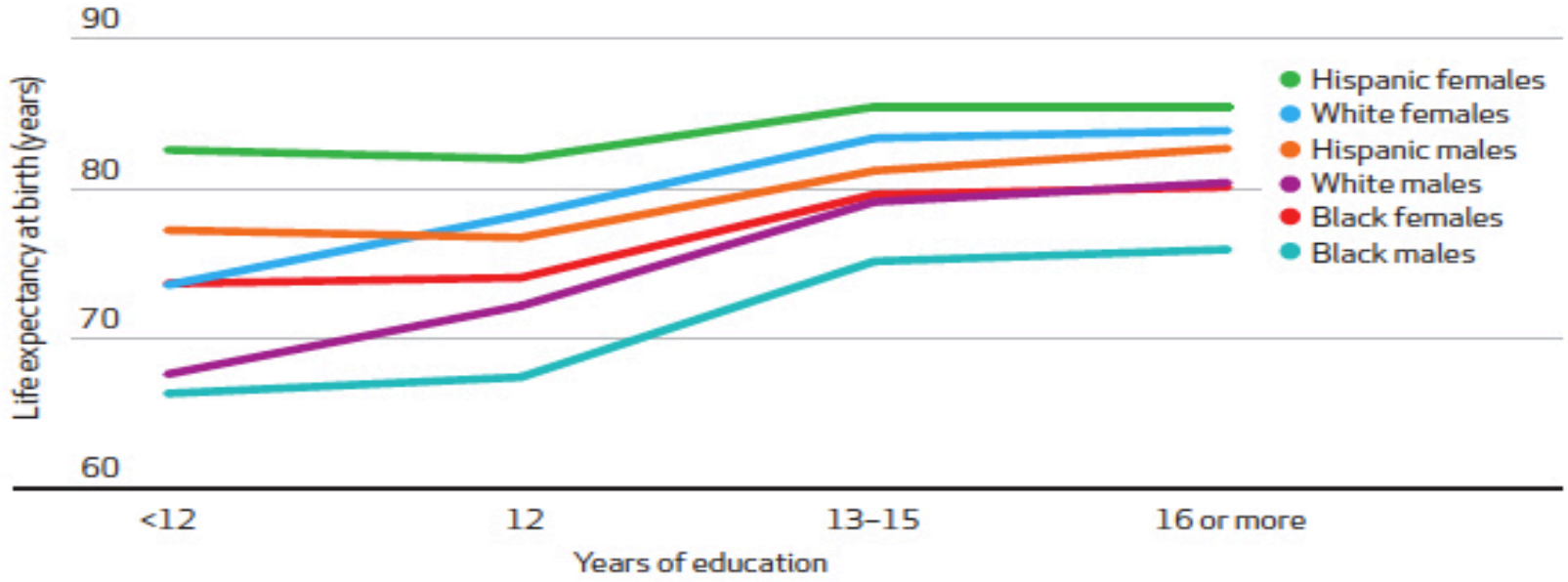
EXHIBIT 1

Life Expectancy at Birth, by Years of Education at Age 25, by Race and Gender, 2008



SOURCE Olshansky SJ, Antonucci T, Berkman L, Binstock RH, Boersch-Supan A, Cacioppo JT, et al., "Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up," *Health Affairs* 31, no. 8 (2012): 1803–13.

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- The causes of preventable disparities can be grouped into three main categories. The first of these factors includes modifiable behaviors, such as diet, exercise, smoking, and how people understand and cope with their own conditions, including asthma, diabetes, and high blood pressure.

- Research initially done in the early 1990s by J. Michael McGinnis and William Foege and updated in 2004 by Ali Mokdad and colleagues found that modifiable risk factors are the leading actual causes of death in the United States.

- In other words, although the top three causes of death in the United States are heart disease, cancer, and stroke, the top three external (non genetic) modifiable factors--or actual causes of death--are tobacco use, poor diet and physical inactivity, and alcohol consumption.

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- The second group of factors is the social, cultural, and physical environments in which people live and work.

- Having low education rates, being poor, and living in neighborhoods with few grocery stores or in cities designed for cars instead of for walking can all negatively affect residents' health.

- These categories can be shaped by the actions of both policy makers (for example, regulating or taxing tobacco and alcohol and improving schools) and individuals (for example, making better lifestyle choices and managing health conditions).

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- **The third major category is health care.**

- There is ongoing interest in the relationship between the quality of health care people receive and their actual health. How systems are organized and how health care providers act--or don't act--can create, exacerbate, or reduce health disparities.

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- Researchers see opportunities to reduce health disparities in emphasizing the important role of primary care. People who get high-quality and timely primary care have been shown to stay healthier and live longer. Many policy makers point to a shortage of doctors and other health care providers in vulnerable communities as a barrier to care for many populations.

- Yet investments to increase the number of doctors may not shrink health gaps on their own. The Dartmouth Atlas Project has consistently shown that the supply of doctors in any given region, which was hypothesized to have a positive impact on health, does not have a strong correlation with better care or better patient outcomes.

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- As research into the sources of America's health gaps continues, many policy makers have sought to translate the latest findings into effective policy solutions. According to the Centers for Disease Control and Prevention, during the twentieth century Americans gained about 30 years in life expectancy at birth, 25 of which were the result of public health efforts, such as vaccination, safer workplaces, control of communicable diseases (through clean water, sanitation, and antibiotics), and healthier mothers and babies.

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- Building on these successes and being cognizant of the large role behavior plays in preventable disparities, some advocates are using public health and policy tactics to address modifiable behaviors, such as tobacco use, sedentary lifestyles, and unhealthy eating habits that lead to adult and childhood onset obesity

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- Still other researchers and policy makers continue to look at how our health is shaped by the kind and quality of health care we receive. Ashish Jha recently described how the two primary theories used to explain disparities and propose solutions--cultural competence and the site where care is provided--intersect when looking at patterns of where providers recommend their patients have surgery. Some, such as the Robert Wood Johnson Foundation's Aligning Forces for Quality effort, the Commonwealth Fund, the Agency for Healthcare Research and Quality, and the Office of Minority Health at the Department of Health and Human Services, **have focused on the critical role of primary care in reducing inequalities in health by preventing disease**, especially noncommunicable diseases, through regular support, screenings, and vaccinations and, more broadly, on lifting the overall quality of health care in targeted communities.

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- In this context of health care, others have examined health care providers' role in counseling patients on topics such as where to live and how to exercise or quit smoking; cultural competence and cultural sensitivity among health care professionals; recruitment of would-be health professions students who are bilingual and better use of interpreters to help reduce communication barriers between providers and patients; addition of traditionally underrepresented minorities in the health professions, so they better reflect the general population and understand cultural norms; and the integration of lay workers, such as community health workers and promoters, into care teams where they have proven themselves time and again as key components of patient-centered care.