

HealthAffairs

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# Health Policy Brief

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## Health Gaps. Among different populations across the United States, substantial disparities in health and health care persist.

### WHAT'S THE ISSUE?

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. 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.

### WHAT'S THE BACKGROUND?

**GEOGRAPHY:** Where we live, learn, and work defines—to a surprisingly high degree—our health. Research confirms that some regions of the country have healthier residents than others; the South has long been less healthy than northern and coastal regions. State rankings of overall “health” are regularly posted and discussed in the popular media. But most striking are the county-level analyses. Researchers Erika Cheng and David Kindig found that life expectancy varies from county to county by as much as ten years or more. Majid Ezzati and colleagues documented a widening inequality in mortality when comparing counties over a four-decade period ending in 1999, with mortality actually increasing in the worst-off counties, especially for women.

Christopher Murray and colleagues' 2013 research graphically demonstrates that life

expectancies in some counties in the United States are among the best in the world, although people in other US counties can expect to live no longer than people in developing countries.

**RACE AND GENDER:** Research also shows that health varies depending on individual characteristics, starting with race and gender. For example, the latest research by Kenneth Kochanek and colleagues 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.

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

Health disparities also can be linked to ethnicity, language, and sexual orientation. Moreover, they are closely correlated to education, income, and social class. In particu-

**“Differences in health are not simple consequences of one factor or another.”**

lar, as noted by Mariachiara Di Cesare and colleagues, in most countries, including the United States, people with low socioeconomic status have higher risks of dying from non-communicable diseases, such as cardiovascular disease, cancer, diabetes, and chronic respiratory disease, than those in more advantaged communities.

These correlations do not mean that geography or demographic characteristics are directly or solely causing disparities in health. 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.)

**LOOKING AHEAD:** When S. Jay Olshansky and colleagues looked at life expectancy trends over the 18 years ending in 2008 for US adults, they found that when race and education were considered, disparities not only were substantial (up to 14 years or more) but also increased over time (Exhibit 1).

In 2011 Eric Reither and colleagues applied a new method to forecast mortality that takes into account factors such as the rising obesity epidemic and its complications. The result is the declining health status of younger cohorts in the United States. What’s more, it may be de-

cadecades before we see the full negative impact of these trends on longevity in the United States. In other words, substantial numbers of American children may have shorter life expectancies than their parents because of unhealthy lifestyles developed during their lives.

**WHAT ARE THE POLICY IMPLICATIONS?**

Although some disparities may not be preventable, the majority can be prevented.

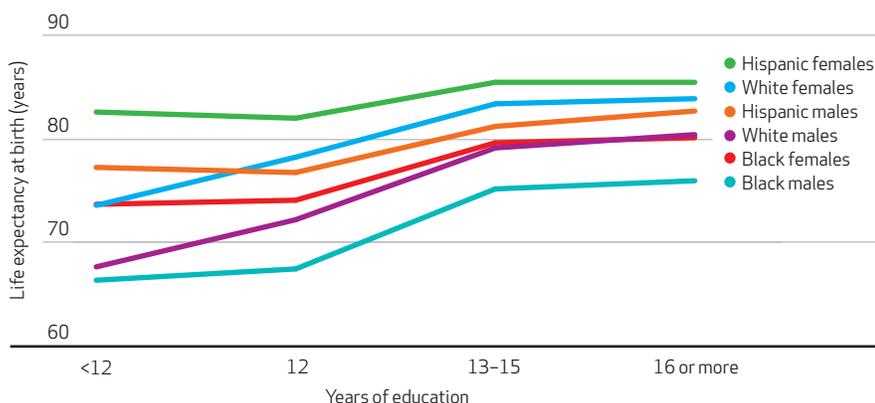
The causes of preventable disparities can be grouped into three main categories. The first of these factors includes modifiable behaviors, such as diet, exercise, smoking, and how people understand and cope with their own conditions, including asthma, diabetes, and high blood pressure. Research initially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

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). 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.

Recent studies confirm and underscore long-known actual differences in the care that different populations receive. In just one of many examples, Justin Dimick and colleagues found that nationally black patients tended to live closer to higher-quality hospitals than white patients did, but that black patients were

**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.

# 30

## Years gained

According to the Centers for Disease Control and Prevention, during the twentieth century Americans gained about 30 years in life expectancy at birth.

**“Evidence does show a strong connection between having health insurance; getting regular health care; and, ultimately, being healthier.”**

25–58 percent more likely than white patients to receive surgery at low-quality hospitals.

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.

Nevertheless, evidence does show a strong connection between having health insurance; getting regular health care; and, ultimately, being healthier. This idea is fundamental to the Affordable Care Act’s focus on expanding health care coverage to more Americans—as well as other strategies to expand access to primary care outlined below.

### WHAT’S NEXT?

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.

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. At least three separate teams—led by McGinnis, Mokdad, and Murray—have found that these behaviors have consistently ranked number one or two over several decades in actions leading to death in the United States. Others, including the Commission to Build a Healthier America, are focusing current efforts on improving health outcomes through interventions aimed at people’s social, cultur-

al, and physical environment, such as expanding early childhood educational opportunities and improving neighborhood design.

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.

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 *promotores*, into care teams where they have proven themselves time and again as key components of patient-centered care.

Another recent focus has been the impact of improved patient engagement and health literacy in helping to close health gaps: Research has suggested that patients who are actively engaged and involved in their care enjoy better clinical outcomes at lower costs (See the [Health Policy Brief](#) on Patient Engagement published February 14, 2013, for more information.) Some efforts, like the California Endowment’s Building Healthy Communities initiative, combine several strategies and integrate economic development with public health and medical care. The endowment’s program has invested hundreds of millions of dollars into 14 communities to improve health

# 3.8

## Years lower

In 2010 the life expectancy for the black population was 3.8 years lower than that of the white population.

generally and narrow specific health gaps. Its grants have ranged from efforts to enroll children and families in health care programs to support for parks and open spaces and from healthy eating programs for children to economic development, including support for youth interested in health careers. Among its measures for success are reductions in childhood obesity and youth violence and increases in school attendance and access to quality health care.

National efforts to reduce disparities, such as the Health Disparities Portal to Understanding, Learning, Sharing, and Educating

Resource Center at the Centers for Medicare and Medicaid Services, have been established to serve as a clearinghouse of information and to track progress. And the National Academy for State Health Policy has outlined opportunities for states to advance health equity through implementation of the Affordable Care Act. The results of these investments will be inherently hard to measure, and the path forward will likely involve multiple approaches. Few would argue, however, against the need to find ways to close the gaps and to advance health equity within the United States. ■

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