Woodrow Wilson International Center for Scholars

Health Status Disparities in the United States

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Edited Transcript-
Dr. Gregg Bloche- Opening Presentation

We have begun our longest, and surely our most expensive, Presidential campaign. Already, health has moved to the fore as a campaign issue and the candidates have had lots to say about expanding coverage and controlling costs.

I confess to a Groundhog Day feeling about the political discussion so far. To those of us with some gray hair, it is numbingly familiar, except that the numbers keep getting bigger and scarier. Forty-five million Americans are uninsured, and this number is rising by about a million a year. We Americans spend sixteen percent of GDP—or more than $2 trillion—on medical care every year. And we have newer sets of scarier numbers to add to the discussion. Patients only get about 55 percent of the care they need[i], and as many as 100,000 Americans a year die from medical injuries[ii].

So, Americans should be forgiven for thinking that our health problems are pretty much all the result of medical care that is too expensive, too riddled with errors, and not available to those unable to pay. But, as the distinguished speakers at this conference will tell you—in much richer detail than I could—medical care plays a surprisingly small role in determining our health. It has been estimated that medical advances account for only about a fifth of the increase in longevity in industrialized countries over the past 100 years. What explains the rest? Public sanitation and pest abatement account for a lot: clean water and sewage systems; the draining of swamps; and the killing of mosquitoes, rats, and other unpleasant creatures. On the other hand, the twentieth century brought its own set of new public health problems: sedentary lifestyles, chemical pollutants, smoking, overeating, and the like.

It is not clear how far the balance of public health solutions and problems has tipped in the past century, and it is not clear to what extent traditional public health policies account for our huge improvements in population-wide health. What is clear, though, and what is astonishingly absent from our discussions of health policy in our political campaigns and our public discourse, is that our health status has much more to do with how we live—with the social and economic conditions that shape our lives—than with the medical care that we receive or with what public health authorities do to control contagious disease. Even lifestyle factors like smoking and overeating pale by comparison to social and economic conditions when it comes to determining our health.

This remarkable fact, this "inconvenient truth," has potentially explosive political implications. That is because we Americans think about health in a very different way than we think about the material conditions of our lives, or even the social hierarchies within which we live. We argue a lot about the causes and remedies for social and economic inequalities, and the roles of race and ethnicity in this mix, but we are by and large accepting of enormous differences in wealth and status. Some of us are deeply concerned by abject poverty, but even the hard-core Democrats among us seem to accept that some families of four with young kids ride in beaten up old Chevys and barely survive on Wal-Mart wages, while others ride in Lexus SUVs with drop-down TVs to private-school soccer matches. We accept that some of us are CEOs while others of us serve them coffee or park their cars at charity auctions. And though we don't admire the boss who abuses his help—who yells at his secretary or won't let her take off a couple hours to meet with her kid's teacher at public school—we put up with it.

Yet we feel differently about health. Polls show that the vast majority of us think everyone should have access to fairly good medical care at public expense if he or she can't afford to pay for it. Additionally, the vast majority of us think that health is a matter of right, or at least a matter of social obligation. We think we owe each other, through our government, a serious effort to protect and to promote everyone's health with little regard for social and economic standing. But I haven't met anyone who thinks his government owes him or her a new Buick, or a Honda, let alone a BMW with the latest electronic gadgetry.

We tell ourselves various philosophic stories about our different view of health—for example, Rawlsian stories about the opportunities we'd want, from behind the veil, or communitarian, Walzerian stories about the common rights and goods that should be distributed to all in a society, equitably, as an expression of membership. In economics language, we think of health as a "merit good," or "merit want"—something that should be distributed equitably, not based on the existing distribution of wealth. We do not think of Buicks, BMWs, or even protection from nasty bosses in quite this way.

Enter, from the left—the far left, claim some of my friends at the American Enterprise Institute—the growing body of evidence that connects our health closely to our wealth, and to our sense of command and control over our lives, and to the insulation that this wealth and control gives us from life's daily, corrosive stresses.

Did you come to this conference on a crowded metro train, and were you jostled by harried passengers as you tried to get off? Or, did you drive, and worry, at most, about how to find the parking entrance, and then how to find your way through the bowels of the parking garage, up to this room? Or did your personal driver bring you, stress-free, to the closest entrance? And do you have to race to your kid's school, by 3 p.m., to pick her up, or will your nanny drive one of your other cars to get her, then be with her until you get home?

The evidence is overwhelming that wealth, and the social advantages that come with it, beget health, and that poverty begets illness. The evidence is overwhelming that health disparities between the most prosperous and the worst-off, in America and abroad, are mainly the product of social and economic disparities rather than disparities in medical care provision.

There is also a good deal of proof that there is a gradient relationship between wealth and health: the more prosperous we are, the healthier we are. Furthermore, there is a controversial claim, made by some, that societies with lower degrees of economic inequality are healthier societies overall. The social, psychological, and biological mechanisms behind these relationships, both the proven ones and the more controversial ones, are only dimly understood. Diet, exercise, and other lifestyle factors are thought to play a role, but the relationship between wealth, status, and health remains strong even after these influences are factored out.

Emerging biological theories of health disparity, supported by some evidence, point to relationships between:

- a sense of control, or lack thereof, and biological mediators of stress response, and physiological wear and tear, including serum cortisol levels and sympathetic nervous system activation;
- anxiety, its biological mediators, and risk of myocardial infarction;
- subjectively-experienced stress, immune suppression, and the our ability to fight off infections and suppress the many, microscopic occurrences of malignancy;
- passive coping styles (after all, the secretary gets in trouble for snapping out at his boss), increased arterial resistance, and development of high blood pressure; and
- social isolation, which is more common among poor people and members of disadvantaged minority groups, and more intense subjective (and biological) responses to stress.

This is morally and politically explosive material. That's because it pushes us to recast material inequalities, which we tend to accept, as health matters—indeed as health matters that are much more important than medical care! This transforms tolerable inequality into a serious moral problem—because we think about health so differently.

For political leaders concerned about inequality in America, this presents an extraordinary leadership opportunity— an opportunity that our Presidential candidates should seize. The mounting social and biological evidence of a tight relationship between wealth, status, and health is an unfolding biological Katrina scenario, a stunning story of the economy's impact on human well-being.

Some conservatives who worry about challenges to the prevailing distribution of privilege have indeed been stunned. Newt Gingrich and others warn of looming Leninism if wealth-driven disparities in health become grounds for public intervention to achieve greater equity. I doubt Leninism is a threat; indeed I'm disinclined to allow health to trump Americans' traditional commitments to liberty and opportunity. However, I do hope that bold leaders will step forward and use what we know about the relationship between privilege and well-being to push us further than we might otherwise travel along the arc of justice. The prominent role of health in the looming Presidential campaign presents an extraordinary opportunity for our leaders to do so.

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Some of the most important contributors to our understanding of the social determinants of health are here with us today, and can help define the moral framework for action. Thank you.

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i McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The Quality of Health Care Delivered to Adults in the United States, New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645.

ii Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000, To Err Is Human: Building a Safer Health System, National Academies Press.