American Health Improvement Depends upon Addressing Class Disparities

Steven A. Schroeder

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Steven A Schroeder

schroeder@medicine.ucsf.edu

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In my 2007 Shattuck Lecture I asserted that the United States performs poorly in standard international measures of health, and that the potential for improved national health status could only be achieved by focusing on social and behavioral factors associated with premature death and mortality, rather than pouring ever more resources into clinical services (Schroeder, 2007). In this review I will update those comparative international health rankings and then revisit the various components of the United States' poor performance. That analysis will draw upon the 2013 report of the Institute of Medicine, National Academy of Sciences Report: *Shorter Lives, Poorer Health: U.S. Health in International Perspective* (IOM, 2013). The essential point is that there is a widening health gap in this country between those who are well off and those who are vulnerable, and that a major reason for the U.S. relatively poor health performance is the poor health status of its lower socioeconomic classes.

Table 1 contrasts U.S. performance on health status measures--as summarized in my 2007 Shattuck Lecture, which compared the health status of 30 OECD countries, using data mainly from the 2002-2004 period--with updated comparisons from 34 OECD countries using statistics from 2012. The table highlights two major trends during the intervening period. First, virtually all health measures improved, both for America and the other countries, with the puzzling exception of maternal mortality in the U.S. Second, not only did the U.S. continue to rank poorly in comparison with these relatively prosperous countries, its relative performance declined. Since one explanation for the relatively poor U.S. international rankings is that we have a more heterogeneous population, I have also included data for whites only, which matches the populations of the mainly European nations of the OECD though not--of course--wealthy OECD Asian countries. Thus, although life expectancy at birth for American white women rose from 80.5 years to 81.4 years, the U.S. relative ranking fell from 19 out of 30 to 26 out of 33, with one missing OECD country for that category. Figure 1, from the IOM study, shows this trend for life expectancy for women between the years 1980 and 2006 for 22 high-income nations, including the U.S. Although the overall trend is clearly upward, the U. S. slid from the middle of the pack in 1980 to the bottom by 2006.

In my Shattuck Lecture I reviewed the well-known work of McGinnis and Foege (McGinnis, 1993), updated in 2002 (McGinnis, 2002), demonstrating the proportions of premature mortality contributed by different determinants of health. In brief, personal behavior patterns accounted for 40% of premature deaths, genetic composition 30%, social circumstances 15%, environmental exposures 5%,