

Living Sicker and Dying Younger:

United States Lags in Global Health Gains

Shorter lives and poorer health: this was the striking conclusion of leading public health experts convened by the National Research Council (NRC) and the Institute of Medicine (IOM) when examining the research evidence on how health and life expectancy in the United States compares to that of other high-income democracies around the world.¹ They also found that this U.S. “health disadvantage” has been growing over the past several decades and that unless we change course, the United States will continue to miss out on the superior health and life expectancy enjoyed in Western Europe, Japan, Australia, and Canada.

LEAST HEALTHY AND SHORTEST-LIVED

On a range of diverse measures, Americans rank poorly compared to people living in other high-income countries. For example:

- The infant mortality rate has stagnated in the United States over the past decade but continued to improve elsewhere. Over the period 2005-2009, the U.S. rate was more than twice as high as countries like Sweden, Japan, Finland, and Norway, and exceeded other wealthy countries by a sizeable margin (OECD 2012).
- A boy born in the United States in 2007 could expect to live 75.6 years, a full 3.7 years less than a boy born at the same time in Switzerland and less than a male child born in any of 16 peer countries (Ho and Preston 2011).
- U.S. children and adults experience significantly higher rates of premature death compared to people in other high-income countries. In 1990, Americans lost approximately 35 percent more years of life before age 50 than did their peers; by 2009 this discrepancy had grown to close to 75 percent (Palloni and Yonker 2012).
- Americans reach middle age in relatively poor health: U.S. adults between the ages of 50-54 have a higher prevalence of heart disease, stroke, diabetes, hypertension, and obesity than their counterparts in 10 European countries (NRC and IOM 2013). U.S. mortality rates for men and women between 50-74 are among the very highest of peer nations.

This pattern of relatively poor performance in health and survival extends to the incidence of low birthweight, injuries and homicides, adolescent pregnancy and sexually transmitted

infections, HIV and AIDS, drug-related deaths, obesity and diabetes, chronic lung disease, and disability. For a number of key indicators that have been tracked over time, the gap between the United States and other high-income countries has been growing, particularly among women.

The size of the gap between the United States and its peers, the widening of this gap over time, and the consistency of this gap across indicators are all causes for concern. Nevertheless, there are a few areas in which the United States demonstrates an advantage over its peers, notably in lower cancer death rates and better control over blood pressure and cholesterol levels. Interestingly, once Americans reach age 75, they can expect to live *longer* than their counterparts in 16 peer countries. Research to uncover why this is so may help us learn more about the most effective ways of improving the relative health of people in the under-75 age groups.

WHAT EXPLAINS THE U.S. HEALTH SHORTFALL?

There is no evidence to suggest that U.S. health fares poorly as a result of inadequate spending. At present, the United States devotes almost one-fifth of its national income to health-related goods and services, with expenditures amounting to \$7,960 per person in 2009, a level that is more than double the \$3,223 median per capita spending among member countries of the Organization for Economic Cooperation and Development (OECD 2011).

Certainly, the large number of Americans without health insurance and the barriers in access to services faced by some segments of the population help explain why the United States has a health disadvantage relative to countries with universal

Factors explaining U.S. health shortfalls, relative to other wealthy countries, include:

- health care that is inaccessible or unaffordable for the uninsured and underinsured,
- unhealthy behaviors,
- social and economic conditions, and
- community and environmental factors.

¹ The summary research findings and conclusions presented in this Issue Focus are drawn from *U.S. Health in International Perspective: Shorter Lives, Poorer Health* (NRC and IOM 2013). The implications of these findings and conclusions for health grantmakers were developed by the author of this Issue Focus in consultation with the report's editors.

health coverage or national health care service delivery systems. The NRC/IOM report, however, makes clear that this is not the whole story. In fact, findings from several studies indicate that the gap between the United States and peer countries cannot be fully explained by the relatively poor health status of people who are impoverished or uninsured. Even Americans from advantaged groups—those who are insured, well-educated, upper-income, and not a racial minority—are in worse health, on average, than people in similar circumstances who live in other countries. Such findings indicate that expanding coverage will not, in and of itself, suffice to address the U.S. health disadvantage.

The report points to a number of other factors that are likely contributors to the U.S. health disadvantage, although their specific roles and relative importance require further investigation. Certain health-related behaviors are known to affect health outcomes: while Americans are less likely to smoke cigarettes and may consume less alcohol than people in other countries, Americans also take in more calories per person, have higher rates of drug abuse, are less likely to use seat belts, are involved in more alcohol-related traffic accidents, and are more likely to use firearms in acts of violence. Certain characteristics of American communities and physical environments, such as land-use decisions predicated on automobile transportation, likely contribute to health indirectly, through influence on behavior, as well as directly. In addition, the United States has relatively higher levels of poverty, including child poverty, greater income inequality, and lower rates of social mobility. At the same time, safety net programs that serve to cushion the negative health effects of poverty and socioeconomic disadvantage are less robust in the United States in comparison with other wealthy nations.

IMPLICATIONS FOR HEALTH GRANTMAKERS

The NRC/IOM report documented trends that have long been appreciated by population health experts, but that have not yet infiltrated the knowledge base of many policymakers or the general public. In fact, findings of deficiencies in relative health status run contrary to pervasive beliefs among Americans generally about the relative performance of the U.S. health care system and the quality of its services. Therefore, spreading the word about the pervasive U.S. health disadvantage is a key recommendation of the report. This is an activity for which health grantmakers are well suited and arguably best situated to take the lead.

Conducting an information campaign would be a public service, in that such knowledge could help drive demand for remedial actions and stimulate debate regarding priorities and acceptable trade-offs. Nevertheless, some stakeholders in the health care industry have incentives to downplay information that might be viewed as evidence of ineffective or inefficient use of resources. Such political realities call into question

how likely it is that government actors will take the lead in disseminating information about U.S. health performance, leaving the door open for grantmakers to take on this public service.

Examples of a public information campaign on which others could build include the work of The California Endowment, which has led efforts to inform Californians that their “zip code is more important than their genetic code” as a determinant of their health, emphasizing that health care is determined by the conditions in which people live, learn, work and play, and not just the medical care they receive (Flores 2013). In light of the low level of public awareness and potential resistance to findings that run counter to existing beliefs, it will be important for such campaigns to be designed carefully, choosing appropriate messages and taking into account what is known about how such information is best delivered, absorbed, and spread.

Grantmakers can also help raise awareness by including information about relative U.S. health status in outreach and public engagement efforts, in the context of ongoing disease- or population-focused work. Similarly, when selecting new priorities for programming, foundations may want to prioritize efforts to address health problems in which the U.S. health disadvantage, relative to what has been achieved elsewhere, appears greatest.

Additionally, grantmakers can help address the U.S. health disadvantage through actions that go beyond public information and prioritization of programs to address health disadvantages. The results of international comparisons suggest the need to evaluate the potential for rechanneling the flow of health resources to activities that will promote population health, as determined by evaluations of domestic programs and studies of how other countries are achieving better health outcomes. Such efforts could conceivably include prioritizing policies and practices that improve health through socioeconomic, environmental, or other indirect channels, as well as directly through the provision of preventative or curative health services. Grantmakers stand to play a role in advocating for and sponsoring investigations of this kind, and in promoting change based on the results of such work, as evidenced by examples such as the Robert Wood Johnson Foundation’s Commission to Build a Healthier America, which recently reconvened to develop guidance on promoting health in early childhood and through community-level improvements (RWJF 2013).

In light of the compelling evidence of the need for change that has now been documented by the nation’s most prestigious scientific academies, health grantmakers working in all areas of the field will want to consider whether and how they can serve as advocates and agents for change. Successful outreach, investigation, and advocacy could drive the improvements in population health that are needed for the United States to achieve the better health outcomes other countries are enjoying now.

SOURCES

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