Can Public Health Narrow the Health Gap Between the United States and Its Peer Nations? A Public Health of Consequence, January 2018

See also Kindig, et al., p. 87.

Health achievement in the United States lags substantially behind that of its peer nations.[1] Combined with the observation that the United States spends more on its health than any other peer nation, this has resulted in academic papers[2] that aim to explore this seeming paradox. The Institute of Medicine's report "For the Public's Health: Investing in a Healthier Future," published in 2012,[3] suggested, as one of its recommendations, that the United States should aspire to achieve health indicators comparable, on average, to those achieved by high-income peer nations by 2030.

In this issue of *AJPH*, an incisive analysis by Kindig et al. aims to assess whether it is indeed realistic that the United States could close the gap in health indicators compared with other high-income countries (p. 87). In short, Kindig et al. suggest that although closing this gap is not impossible or without precedent, best available data suggest that the United States is not on track to do so and that—barring a deviation from current approaches—the United States will at best not narrow the gap, and at worst widen it.

This analysis by Kindig et al. is sobering, if not surprising. Most importantly, the article well articulates the foundational reasons why this gap exists by outlining the complex and often intractable interplay between the multiple major causes of death—including accidents, injuries, homicide, heart disease, stroke, and HIV/AIDS—and their likely contributory factors—including caloric consumption patterns, gun violence, condomless sexual intercourse, environments that hinder physical activity, barriers to health care access, child poverty, and high and rising income inequality—the latter we have, of late, not had the national willpower to adequately address.

GRAPPLING WITH THE COMPLEXITY

Simply put, it is complicated. There are no more "silver bullets"; there is no single factor that can be identified as being responsible for the country's overall health disadvantage. Unstated, but implicit, in the article by Kindig et al. is the observation that while the United States spends an extraordinary amount of money on health care, it underspends on the other areas that can address some of these core issues that the article identifies. A growing body of work has shown that the United States spends less than other high-income countries on the social and economic conditions that can create a floor on which to build a health-producing environment.[4] This manifests in the particularities of US health indicators—the United States lags behind peer nations at all age groups with the exception of the oldest age groups when, of course, the country's massive investment in medicine has some payoff, prolonging life somewhat for those older than 80 years, even if it pays little heed to quality of those gained life months.[1]

Therefore, at core, we understand the problem. We overspend on medical care, but we underspend on all the other forces that create healthy social, physical, and economic environments: the core remit of public health.[5] Kindig et al. offer that reversing this state of affairs will require "political will and a strong national public and private commitment." We agree, but ask, what is required to nudge forward such political will, and to encourage such commitment? In the spirit of building on the work by Kindig et al., we suggest three courses of action that the public health community can—perhaps should—undertake to address this challenge.

SENSIBLE ACTIONS

First, in many respects, this challenge is *the* health concern in the United States and should stand as a core motivation for all we do, relentlessly so. We say that as a reminder for us to avoid distraction, helping to clarify our motivation to focus on scholarship and practice that can reduce this gap. Until public health scholarship focuses as much on the multiplicity of social, economic, and cultural causes that are identified by Kindig et al. as we currently do on the more proximal behavioral causes of health, we will fall short of delivering on our role of providing the evidence base that can help the United States tackle what should be our core concern. We recognize that the reasons why scholarship on these foundational factors lags behind other work are many and, to a substantial degree, rest on the availability of funding that is shaped by forces larger than the public health community itself. However, it falls to us to continue pushing this line of work and advocating avenues that can fund it if we are to find solutions that can chip away at this problem.

Second, even if we were able to generate scholarship that is up to the task, it will have little penetrance without our active engagement with communicating our findings more effectively than has been our modus operandi to date. In a cluttered message-scape, a solution that is, as we note here, complicated, has a high mountain to climb to penetrate the public

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consciousness. In addition, our current health indicators, as noted by Kindig et al., are the result of processes that have long been set in motion, on accumulated intergenerational and life-course factors whose manifestation lags these processes by decades. This challenges our communication further: and, once again, the answer is complicated, and it takes time. And yet, communicate it we must. The national health conversation is overwhelmingly dominated by a conversation about medicine and health care, interspersed with a mistaken emphasis on individual determination of health. That is a long way away from where the conversation needs to be to become receptive to the ideas in which Kindig et al. suggest solutions to this conundrum lie.

Third, a set of complicated solutions that depend on multiple factors must, by definition, engage complicated cross-sectoral solutions. This is easier said than done. Public health is, as much as any other field of inquiry and action, self-referential and much more comfortable talking within itself than it is across communities. Although interdisciplinarity may be fashionable, our structures and incentives are not aligned with our urgent need to engage fields as disparate as housing, sanitation, education, and finance in the aspirations of public health. A full embrace of these multiple sectors ultimately requires that we structure our thinking and doing—from our earliest days of training students, through our production of scholarship, and through our daily work in public health practice—toward cross-sectoral work. Whereas other fields may wish to do this to generate disruption and innovation, public health has no choice *but* to do this, given the challenge of the US health disadvantage described by Kindig et al.

MEETING THE CHALLENGE

In sum, the United States currently faces a fundamental unhealthy mismatch between our spending and our health outcomes. The core solution to this mismatch rests on an embrace of the complexity of the answer needed to address it. And rising to the task, moving toward this solution will require public health to think, and do, differently, with a focus on scholarship that is more consequential, a relentless embrace of our responsibility to communicate to shift the public conversation, and a generosity of engagement with colleagues from across sectors. Importantly, these approaches are not discretionary, but rather first steps on a long road toward addressing the US health disadvantage. AJPH

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