Get to Root of Disparities, CDC Official Says

BY JOYCE FRIEDEN

WASHINGTON — The definition of "health disparities" should be broadened to include the conditions that caused the affected groups to have poor health in the first place, according to Dr. Camara Jones of the Centers for Disease Control and Prevention.

The usual definition of health disparities refers to differences in the quality of care patients receive within the health care system, as well as differences in access to care, including preventive and curative services, Dr. Jones said at a meeting of the federal Advisory Committee on Minority Health.

However, "differences in life opportunities, exposures, and stresses that result in differences in underlying health status" also must be taken into account. So although health is partly determined by medical care and public health conditions, "it clearly extends beyond these [factors]," she said.

Dr. Jones said the social determinants of health include individual behaviors, such as what people choose to eat; individual resources, such as education, occupation, income, and wealth; neighborhood resources, such as housing, available grocery and dining choices, public safety, transportation, parks and recreation, and political clout; hazards and toxic exposures; and opportunity structures.

Therefore, reducing health disparities requires intervention in societal structures and attention to systems of power, said Dr. Jones, who is the CDC's research director on social determinants of health and equity. "We must address the social determinants of health, including poverty but also social determinants of equity, [such as] racism, in order to achieve social justice and eliminate health disparities," she said.

Progress in eliminating health disparities has been slow because the country has been "pruning [the problem] instead of getting to the root," she said. For example, it could be hypothesized that racism is a fundamental cause of disparities in health. (See box.)

Dr. Jones cited a U.N. treaty—the International Convention on the Elimination of All Forms of Racial Discrimination—that the United States signed in 1966 and ratified in 1994.

The U.N. has recommended that the United States establish a mechanism to ensure compliance with the treaty against racism at the federal, state, and local levels.

Responding to this directive might focus more attention on the ramifications of racism, Dr. Jones said. ■

Impact of Race, Ethnicity on Health

When people think about how racism affects health, the stress of being discriminated against often comes to mind, but there's another dimension as well, according to Dr. Jones.

A 2004 survey by the federal government found that the way people are perceived racially by others affects their perceived health status. Researchers asked more than 30,000 people to list both their actual race and the race others perceived them to be. They were also asked for perceptions of their own health status.

The results showed that, for example, Hispanics who were perceived by others as Hispanic responded less often that their health was "excellent" or "very good" (40%), compared with Hispanics who were perceived as white (54%). And the latter group had a lower percentage of "excellent" or "very good" responses, compared with whites who were perceived as white (59%).

The differences were similar among American Indians/Alaska Natives (AIANs), who comprised a small subgroup of respondents (321 people). Among those who both perceived themselves to be AIANs and were perceived that way by others, 32% reported themselves in "excellent" or "very good" health, compared with 53% of AIANs who were perceived to be white.

People who are usually classified by others as being white are significantly more likely to report that they are in excellent or very good health. "We live in a society that structures opportunities and assigns value based on how you look," she said.

WHO: Income, Social Status of Women Contributing to Ill Health

BY JONATHAN GARDNER

Improvements in women's health worldwide are being held back by inequalities in income and social status, discriminatory delivery systems, and a failure of leaders to tailor health care for women, a World Health Organization report shows.

The report, published in early November, said reproduction and sexuality remain distinctive features of women's health. Complications during pregnancy and birth were considered the leading cause of death among females aged 15-19 in developing countries and HIV/AIDS was named the world's leading cause of death of all women of reproductive age (15-44).

According to the report, women of all ages are harmed by preventable causes of death, such as communicable disease in developing countries, chronic diseases in both developing and developed nations, and disparities in treatment of men and women in health delivery systems. "As the report reveals, the obstacles to good health for women are not principally technical in nature. They are social and political," Dr. Margaret Chan, director general of WHO, said in a press briefing. "While it is tempting to think that poverty is the single most important determinant, this report shows otherwise."

According to the report:

► Lower respiratory infections are the leading killers of girls from birth to age 9 years in the world (17.6% of deaths) and in low-income countries (18.8%), but prematurity and low birthweight are the most common killers in middle-income countries (14.6%) and congenital anomalies in high-income countries (21.7%).

► Lower respiratory infections also take the most lives of girls aged 10-19 worldwide (8.9%) and in low-income countries (10.6%), but road traffic accidents are the biggest killers in middle-income (9.9%) and high-income (28.9%) countries.

► HIV/AIDS is the biggest killer worldwide of women of child-bearing age (19.2%), and also in low- and middle-income countries (22.3% and 15.4%), while road traffic accidents take the most lives in that age group in high-income countries (10.2%).

► Among women aged 20-59, HIV/AIDS still is the leading cause of deaths worldwide (13.3%) and in low- (18.2%) and middle-income (8.9%) countries, but in high-income countries breast cancer (11.5%) is the leading cause.

► Among women 60 and older, ischemic heart disease is the leading cause of death worldwide (19.2%) and in both low- (19.9%) and high-income countries (17.1%), although stroke is the leading cause in middle-income countries (21.7%).

Women often have longer life expectancies than men because of biological and behavioral differences and the reduction of maternal-related deaths in many parts of the world. However, gender-based discrimination overrides the biological advantages of women in other countries. A failure to have tailored treatments for women for conditions that affect both sexes is also a factor in female death rates.

The deficiencies in women's health also have a detrimental effect on health care systems, where women predominantly care for the sick, and on their children, who are harmed if their mothers suffer from such conditions as malnutrition and infectious disease, the report states. ■

Disparities Cited as Argument for Reform

BY ALICIA AULT

A continued wide disparity in access to and quality of care across the United States argues strongly for a national health reform plan, according to executives at the Commonwealth Fund, who released a state-by-state survey of 38 health indicators.

According to the survey, there is a fivefold difference in performance on the indicators between the highest-ranked states and the lowest.

"The differences we see among the states translate to real lives and real dollars," Karen Davis, president of the Commonwealth Fund, said at a press conference. "In the richest country in the world, there is no justification for any state to be far below the best state for quality and access to health care."

Health reform legislation under consideration in Congress would go a long way toward improving access and coverage, and that would increase quality overall, Ms. Davis said.

Since 2007, the number of uninsured adults has risen—and this survey was done on the eve of the recession, so the "worst is yet to come," according to Cathy Schoen, senior vice president of the Commonwealth Fund.

The top quartile comprises Connecticut, Hawaii, Iowa, Maine, Massachusetts, Minnesota, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, and Wisconsin.

Ten of the 13 states in the lowest quartile—Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Nevada, Oklahoma, Tennessee, and Texas—also ranked at the bottom on the previous 2007 report. Illinois, New Mexico, and North Carolina dropped into the lowest quartile since the last survey, while California, Georgia, and West Virginia moved up out of the last quartile in this most recent report. The lower-performing states had rates of uninsured adults and children that were double those in the top quartile.

The report also reflected some bright spots: The quality of hospital care for heart attack, heart failure, pneumonia, and the prevention of surgical complications improved dramatically for all states, as did the quality of nursing home care. ■