Transatlantic reflections: reaching out to tackle global health inequalities

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Differences in healthcare funding and attitudes between clinicians in the UK and colleagues in the USA are well-known. These issues often come to the fore in political campaigns, reflected most recently by Barack Obama's efforts to reform US healthcare. In the UK, changes are already afoot in the National Health Service (NHS) as the new Conservative–Liberal Democrat coalition government make their mark.¹

Health inequalities, whether by age, gender, ethnicity or other demographic, are an important area for population health across both sides of the Atlantic. There are clear ideological differences, such as views about the social determinants of health and ways to intervene to reduce any inequalities. For example, the National Institute for Health and Clinical Excellence (NICE), with its mandate for systematic assessment of the evidence base, is often lauded in the UK and now has a mandate for public health as well as clinical interventions; it is fair to say efforts to adapt such a body for the USA have been less well-received. Conversely, inequalities in ethnicity occur in both countries, but there are valuable lessons that can be learnt in the UK from North American colleagues attempting to apply practice in the real world. There is clearly much either side can learn from the other.

With this in mind, two articles in this issue of the *JRSM* allow us to reflect on some of the combined experiences. In the first of these, Professor Mike Kelly (Director of Public Health at NICE) gives a summary of the social factors that are involved in the health gradient.² This is a complex topic, made even more challenging as factors that are relevant for the individual are not necessarily so at the population level. He gives us much to think about, but an evidence-based approach is clearly a fundamental component in public health, just as it is in clinical practice. The synthesis of research evidence,

with a hierarchy based on cumulative findings, is important to ensure that recommendations and practice are as bias-free as possible. A multi-disciplinary approach, comprising clinicians, epidemiologists and those from other fields, is required to help tackle these inequalities – in fact a description of most NICE committees – but how would this work practically outside the UK? Finally, Professor Kelly reminds us that, just as with other factors, an objective understanding of the relative and absolute risks of the social and economic determinants can help tackle health problems. For example, smokers have a greater absolute risk of coronary heart disease (CHD), which may be even higher for 'poorer' smokers – but what are the actual risks of smoking versus being 'poor', and what can we do about the latter? We already know that most CHD is mediated by a number of risk factors (e.g. smoking, hypertension, abnormal lipids, obesity and diabetes in the INTERHEART study).³ Therefore, public health and clinical efforts surely need to tackle these factors as well as, rather than instead of, any longer-term social changes?

Much of the focus on health inequalities has been by ethnicity, and we move from principles to practice in Wayne Giles' piece on lessons learned from the Racial and Ethnic Approaches to Community Health (REACH) Program from the USA.⁴ Clearly the demographics are different – while a large proportion of ethnic minorities in the UK are of South Asian extraction, the burden of ethnicity-related inequality in the USA occurs in African-Americans. There is also a more subtle approach to tackle healthcare inequalities in the REACH programme, reflecting different cultural attitudes to health intervention. The key issue in the USA has been setting up the infrastructure for community healthcare issues, with Centres of Excellence acting

Figure 1
Healthcare spending as percentage of gross domestic product (GDP) in 2005 (adapted from *The Economist*)

as exemplars to surrounding regions. While such efforts are to be commended, it remains to be seen whether they can lead to real 'change', which alters clinical outcomes as well as subjective appearances. For example, Dr Giles highlights the example of serum cholesterol coming down in these programmes. Especially when no research studies have been set up to infer such changes, there can be difficulties in inferring causality and over-interpretation of such findings. Could it simply be that more cholesterol-lowering medications are now being given in the USA? Nevertheless, to its credit, REACH does show that innovative community-based solutions with culturally appropriate tailored approaches can be implemented. Action as well as rhetoric is important, and colleagues in the UK may be able to apply some aspects to their practice.

More broadly speaking, calls for clinicians to lead healthcare 'change' have resonated in both the UK and the USA.⁵ Every UK citizen, regardless of colour, creed or gender, is entitled to free care in the NHS whereas 15% of US citizens have no health

insurance.⁶ Nor does the USA have a national screening strategy *per se*, highlighting a lack of focus on preventative strategies, although the mentorship provided by REACH will potentially feed into the healthcare reform 'changes' currently taking place. Hence, the REACH programme, especially with an evidence-based programme, may be a key driver to tackle healthcare inequalities, particularly if a North American 'NICE'-style institution does ever emerge.

It is often remarked that 'health is global', and questions of healthcare and health inequality are dilemmas not just for the USA and the UK but the whole world. For example, there is the common misconception that the USA spends much less on public healthcare than the UK, which is not strictly true per capita. The differences in public versus private funding are even starker for much larger populations such as India and China (Figure 1).⁷ Healthcare is not as simple as gross domestic product or sheer monetary spending alone, and requires more rigorous analyses, but crude figures can nevertheless help to inform the debate. Regardless of which approaches to tackle healthcare inequalities clinicians and people involved in public health adopt, these ongoing national issues clearly have global implications.

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