Op-Ed

An Unhealthy Mismatch

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AT THE HEART OF EFFORTS TO PROMOTE POPULATION HEALTH lies a mismatch between the collective interest in improving health and our understanding of what is required to do so. This mismatch shapes the health challenges we face as a nation and is a disparity that should inform both population health scholarship and how scholars must engage with the broader health conversation.

In order to explicate this mismatch, we need to understand the forces that produce healthier societies. By way of example, the past century has seen a remarkable improvement in the health of populations. While life expectancy in western countries was between 40 and 45 years until around 1900, these same countries gained more than 30 years in life expectancy in the ensuing 100 years. Much of this gain occurred during the first half of the 20th century thanks to a series of social and structural reforms. Most germane were the introduction of broad hygienic regulations to ensure safe food and water chains, and improvements in workplace, housing, and other fundamental living conditions, which contributed to more than two-thirds of these gains in health and life spans.

During the past 4 decades, however, health gains in western nations have slowed considerably. In particular, the United States has lagged behind its peers in health indicators during the past 35 years.¹ For example, in 1980 life expectancy in Chile was 68 years, and by 2014 it was 81 years. By comparison, US life expectancy in 1980 was 74 years and by 2014 it had fallen behind Chile at 79 years. The United States has also fallen behind compared to some middle-income countries. Cuba, for example, had a life expectancy of 74 years in 1980 and a life expectancy of 79 years in 2005, higher than the life expectancy of 77 years in the United States. Today, children born in America can expect to have shorter lives than children born in a range of other countries, including Singapore (life expectancy of 83 years), Greece (life expectancy of 81 years), and Cyprus (life expectancy of 80 years).

Much of this slowdown rests squarely on our collective disinvestment in the nonmedical conditions that produce health. The experience of the past century teaches us that health is not produced by medical advances alone, but also by the conditions that promote physical exercise, such as walkable cities, by environments free of pollution, by access to affordable and safe housing, and by the widespread availability of nutrient-rich foods, but not too much as to produce obesity and diabetes. It is precisely these conditions that create the American lags in health compared to its peers. The United States spends far less than other high-income countries on nonmedical factors that promote health, including education, housing, and formal health supports for low-income families.² These conditions rarely fall within the purview of the public or private actors (eg, hospitals, medical centers, departments of health) whose core mission is the generation of health. Rather, these conditions depend on a range of sectors (eg, housing, finance, social services) that do not have health as part of their core mission.

Investing in these foundational conditions is, quite simply, mandatory. Absent this effort the United States will continue to fall short on health indicators and will not achieve the national returns on our investment in health that we might wish, or expect. At core, we have little choice but to engage with, and encourage, the nonhealth sectors to contribute to the generation of health.³

What, then, are the key levers with which public health can influence the nonhealth sectors that are responsible for producing health? Investments made by these sectors are political and rest on the complex, frequently idiosyncratic processes that inform and influence resource allocations. In turn, the broader public conversation is an inescapable element of political decision making. A public conversation that values health and supports the actions that need to be taken to generate health is a necessary condition for prohealth action by nonhealth sectors.

The good news is that half of this challenge is clearly in hand. Health is very much a part of the current public discussion. For example, in the past decade alone we have seen an extraordinary increase in the public discussion around genetics.⁴ Opinion polls regularly show that health is one of the central concerns of the general public, and, of course, America spends far more on health care than any other high-income country.⁵

However, the second half of this challenge is wanting. Interest in health and health care has not translated into an interest in investments in the structures that create lasting and sustainable health. It

has resulted rather in an increase in medical care, and an ever-greater focus on high-end, end-of-life care that has made the United States the healthiest country for people over age 80, and one of the unhealthiest high-income countries for all other ages.¹ The notion that we cannot buy better health through more investment in curative care is poorly understood. For the vast majority of the American public, better health equals more medicine. While we are spending ever more money on health, that expenditure is nearly exclusively on curative care and various medical treatments that may or may not be necessary, with less than 5% of national health spending on preventive care. The real variance is that we spend far less than our peers on the sectors that are necessary to the production of health.

This mismatch between our avowed interest in health and our limited investment in areas that generate population health is one of the most important challenges we face in the first quarter of the 21st century. Working to recalibrate this mismatch must be at the heart of population health scholarship and action.

How do we do this? It seems to me that two factors are necessary, with the caveat that individually they are not sufficient to tackle this problem: (1) the generation of useful data and research about the foundational drivers of health that can inform decision making, and (2) our collective scholarly contribution to a public conversation that informs prohealth values, making investments in the forces that produce health appealing for those in other sectors. Those of us in academe bear a responsibility to tackle both of these areas, consistently, and with a clear focus on action that ultimately improves the health of populations.

References

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