Opinion

The Complicity of the Population Health Scientist

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ONE OF THE LEADING ONLINE DICTIONARIES SELECTED *complicit* as the word of the year for 2017. Dictionary.com defined it as “choosing to be involved in an illegal or questionable act, especially with others.” The editors chose *complicit*, they said, because of its visibility in American politics and culture. They highlighted complicity by commission, especially by the many participants in dubious political schemes throughout the year, but also complicity by omission, for instance, in the long-standing cases of sexual assault and harassment that became public in 2017 because perpetrators had been abetted by those around them turning a blind eye to abusive conduct.

The selection of the word made me wonder about the responsibilities of population health scientists, especially the extent to which we may be complicit in “questionable acts” and what we may do to prevent being so.

Are we, for example, complicit in accepting the baffling state of American health? The United States lags in health indicators behind our peer high-income countries. We have lower life expectancy and higher mortality than a broad range of countries, from Sweden to the United Kingdom to Spain. It was not always like this. As recently as the mid-1980s we were around median health compared to many other countries. But as high-income countries’ health has improved, the United States has been surpassed by nearly all of them. A recent analysis suggested that we are unlikely to close the gap anytime soon.¹ In order to catch up to projected estimates for Western Europe by 2030, the United States would need to have life expectancy grow by more than 0.32% a year between now and 2030; very few US states are growing at that pace, suggesting that we will not catch up and likely will fall further behind.

I find this lag astonishing, and I am puzzled why it does not dominate conversations about health services and policy, and particularly why it

does not dominate the academic health science agenda. That it does not seems to be a result of our tacit agreement that this turn of events reflects a particularly American pathology that should be accepted. While population health scientists have documented these findings, most of our colleagues in the biomedical research enterprise have focused more energy on precision medicine and its offshoots than on understanding why our national health continues to lag behind that of our peer countries and what to do to remedy the situation. Is ignoring the causes and potential solutions to America's abysmal health indicators tacit complicity with a status quo that should be far from acceptable?

We are also complicit in accepting persistent and enormous health gaps within the United States as well as among industrialized countries. Within the United States, life expectancy gaps of 15–20 years between counties across state lines have long been established. Recent analyses show comparable health gaps between neighborhoods within counties, even in counties that are overall doing relatively well on their health indicators.² That we would tolerate an 18-year life expectancy gap between areas that are a few miles apart is in and of itself remarkable. While there has been substantial, and appropriate, interest in racial health disparities in the country over the past 20 years, there has been much less attention paid to gaps in health between socioeconomic groups, to the “health have-nots,” who constitute nearly half of the American population.

Another recent analysis showed that the slope of the curve of the relationship between income and health is steepening and has done so even over the past decade.³ Income now matters more for health than it ever has before. By way of illustration, for 50-year-old men born in 1930, there was a 5-year gap in estimated life expectancy between men in the richest compared to the poorest income quintiles. By contrast, for 50-year-old men born in 1960, this same gap was more than 12 years.⁴ In a country where effective income for half the population has not changed for the past 40 years, a widening of health gaps along income axes portends the creation of a generation of health have-nots and the deepening and widening of disparities for decades to come.

Clearly the issue of poor overall health indicators is not unrelated to the concern with health gaps. Yet, each commands attention on its own merit. Acceptance of the growing role of socioeconomic factors in shaping health and health gaps that is not linked to remedial action

is complicit acquiescence to a status quo that should be anything but acceptable. Population health workers should be focusing all their energy on understanding the broader societal forces—especially political and economic forces—that are driving these widening inequities. Perhaps we could do this by freeing up intellectual space, made possible if we accord lower priority to studying such downstream factors as behavioral modifications that we know are likely to make only slight differences in health status, and then for only a short period of time.

A widely accepted definition of population health science is “the study of the conditions that shape distributions of health within and across populations.”⁵ And yet, evidence that overall health status and health gaps between groups within the United States are worsening suggests a challenge to the very mission of population health science. It is hard to avoid noting that we are paying less attention to foundational threats to population health than we should perhaps do.

There are, of course, many reasons for our inattention, but then again there are always rationalizations for misdeeds of omission. Perhaps we can learn from the word of the times and recognize our complicity in accepting a status quo that is currently acceptable, but should be unacceptable. And perhaps that can lead us toward a population health science that insistently aims to guide how we may improve the health of populations, for the betterment of all.

References

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