



ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

Beyond Health Care: The Intersection of Socioeconomic Factors and Health

Task Force on Prevention
North Carolina Institute of Medicine
Raleigh, NC
April 24, 2009



America's Health Crisis



- Some of us can expect to live an average of 20 years less than others, depending on our race, income and education, and where we live
- We spend more than \$2 trillion/year on health care, yet:
 - In life expectancy and infant mortality, the US ranks near the bottom in comparison with other industrialized nations
- Poor health limits the productivity of our citizens
- Many health gaps have not decreased in more than a generation
 - Some gaps have grown larger
- Within each racial and ethnic group, lower-income adults have higher rates of poor or fair health than their more affluent counterparts



Losing Ground in Health: Americans are less healthy than people in many other countries

INFANT MORTALITY

- We are losing ground among industrialized countries with respect to important health indicators
- Our ranking for infant mortality has slipped from 18th in 1980 to 25 in 2002

1980	Rank	2002
IMR = 6.9 Sweden	1	Iceland IMR = 2.3
Japan	2	Finland
Finland	3	Japan
Iceland	4	Sweden
Norway	5	Norway
Denmark	6	Austria
Netherlands	7	Czech Republic
Switzerland	8	France
France	9	Spain
Canada	10	Germany
Australia	11	Belgium
Ireland	12	Denmark
Luxembourg	13	Italy
Belgium	14	Australia
United Kingdom	15	Netherlands
Spain	16	Portugal
Germany	17	Switzerland
IMR = 12.6 United States	18	Greece
New Zealand	19	Ireland
Austria	20	Luxembourg
Italy	21	United Kingdom
Czech Republic	22	Korea
Korea	23	Canada
Greece	24	New Zealand
Slovak Republic	25	United States IMR = 7.0
Hungary	26	Hungary
Portugal	27	Poland
Poland	28	Slovak Republic
Mexico	29	Mexico
Turkey	30	Turkey



Losing Ground in Health: Americans are less healthy than people in many other countries

LIFE EXPECTANCY

- In 1980, the U.S. ranked 14th among industrialized countries in life expectancy at birth. By 2003, we had slipped to 23rd place.

1980	Rank	2003
LE = 76.7 Iceland	1	Japan LE = 81.8
Switzerland	2	Iceland
Japan	3	Spain
Netherlands	4	Switzerland
Norway	5	Australia
Sweden	6	Sweden
Spain	7	Italy
Canada	8	Canada
Australia	9	Norway
Greece	10	France
Denmark	11	New Zealand
France	12	Austria
Italy	13	Netherlands
LE = 73.7 United States	14	Finland
Belgium	15	United Kingdom
Finland	16	Germany
New Zealand	17	Luxembourg
United Kingdom	18	Belgium
Germany	19	Greece
Ireland	20	Ireland
Austria	21	Portugal
Luxembourg	22	Denmark
Portugal	23	United States LE = 77.2
Slovak Republic	24	Korea
Czech Republic	25	Czech Republic
Poland	26	Mexico
Hungary	27	Poland
Mexico	28	Slovak Republic
Korea	29	Hungary
Turkey	30	Turkey



Why a Commission?

Raise visibility for the issue

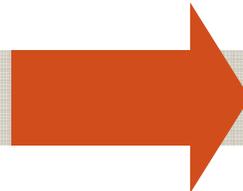
Expand the dialogue on health

- To non-medical factors
- To social factors



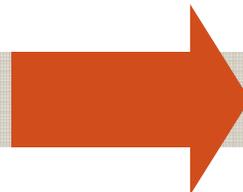
Increase understanding

Develop fresh ideas & solutions



Motivate action

Make recommendations



Move to solutions





Why Now?

Lack of awareness about the problems and lack of policy action

Little distinction between health & health care

Strong feeling that individuals are responsible for their own health

Need a bridge between ideological and political differences;
fresh approach may appeal to both parties



Commission Leadership



Mark McClellan

Physician and economist who helped develop and then effectively implemented Medicare prescription drug benefit. Former CMS Administrator (2004) and FDA Commissioner (2002). Director of the Engelberg Center for Health Care Reform, Senior Fellow in Economic Studies and Leonard D. Schaeffer Director's Chair in Health Policy Studies at the Brookings Institution.



Alice M. Rivlin

Former U.S. Cabinet official, and an expert on the budget. First woman to hold the position of Director of the Office of Management and Budget and was founding director of the Congressional Budget office. Currently, Director of Greater Washington Research Program at Brookings Institution.



Commissioners



Katherine Baicker
Professor of Health Economics, Department of Health Policy and Management,
Harvard University



Angela Glover Blackwell
Founder and Chief Executive Officer, PolicyLink



Sheila P. Burke
Faculty Research Fellow and Adjunct Lecturer in Public Policy, Kennedy School of
Government, Harvard University



Linda M. Dillman
Executive Vice President of Benefits and Risk Management, Wal-Mart Stores, Inc.



Sen. Bill Frist
Schultz Visiting Professor of International Economic Policy, Princeton University



Allan Golston
U.S. Program President, The Bill & Melinda Gates Foundation



Commissioners



Kati Haycock
President, The Education Trust



Hugh Panero
Co-Founder and Former President and Chief Executive Officer, XM Satellite Radio



Dennis Rivera
Chair, SEIU Healthcare



Carole Simpson
Leader-in-Residence, Emerson College School of Communication and Former Anchor,
ABC News



Jim Towey
President, Saint Vincent College



Gail L. Warden
Professor, University of Michigan School of Public Health and
President Emeritus, Henry Ford Health System



Commission Objectives

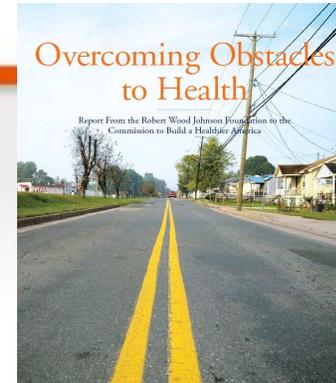
Raise awareness and identify areas for action by:

- Address work to decision-makers in public and private sector
 - Reach non-traditional allies and advocates for social and policy changes
 - Make academic research on social inequalities more accessible to policy makers
 - Conduct work in a nonpartisan fashion
 - Recommend solutions that are sustainable, flexible and relevant
-



Insights from Baseline Report:

February 2008



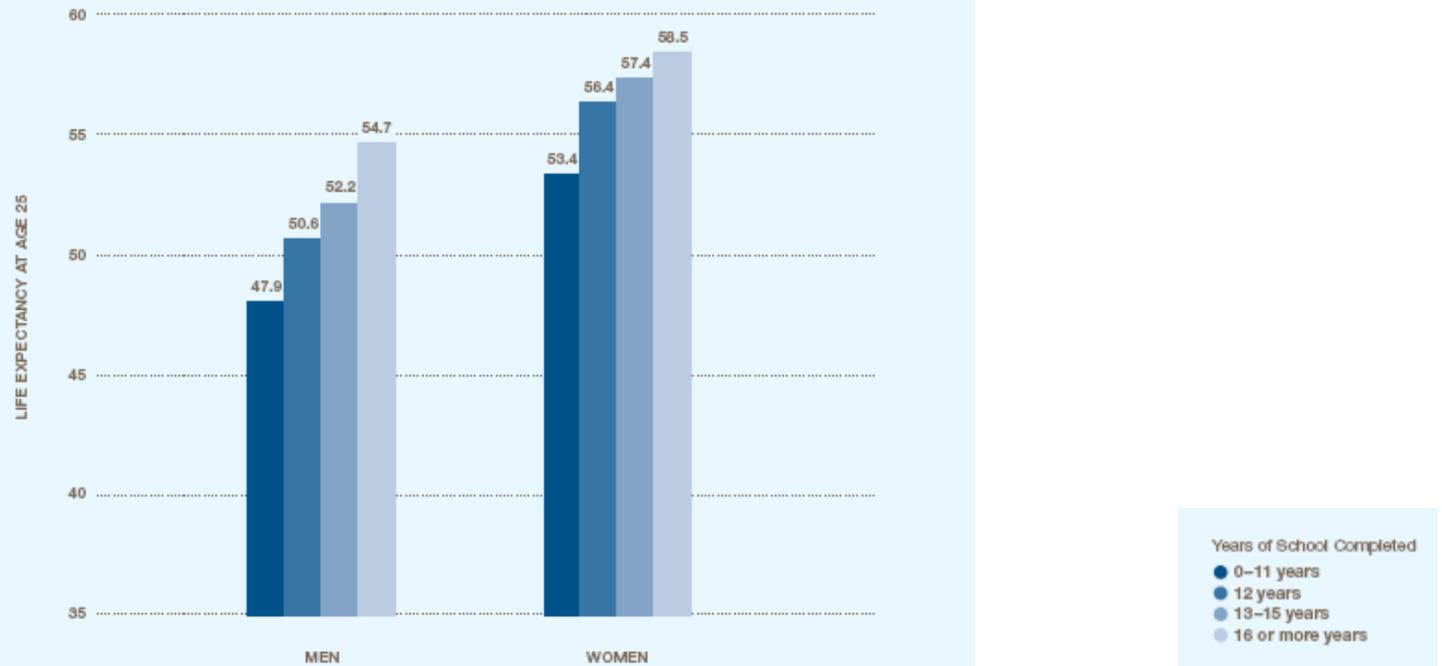
- The U.S. is not realizing its health potential. Everyone could be doing better.
 - We need to take a fresh look because what we have been doing is not working
 - We need to look beyond medical care
 - How to create opportunities for everyone to lead healthy lives; how to help people choose health
 - This is a timely moment to seek solutions.
-



Americans at every education level should be healthier

More Education, Longer Life

figure 2a For both men and women, more education often means longer life.*
College graduates can expect to live at least five years longer than individuals who have not finished high school.

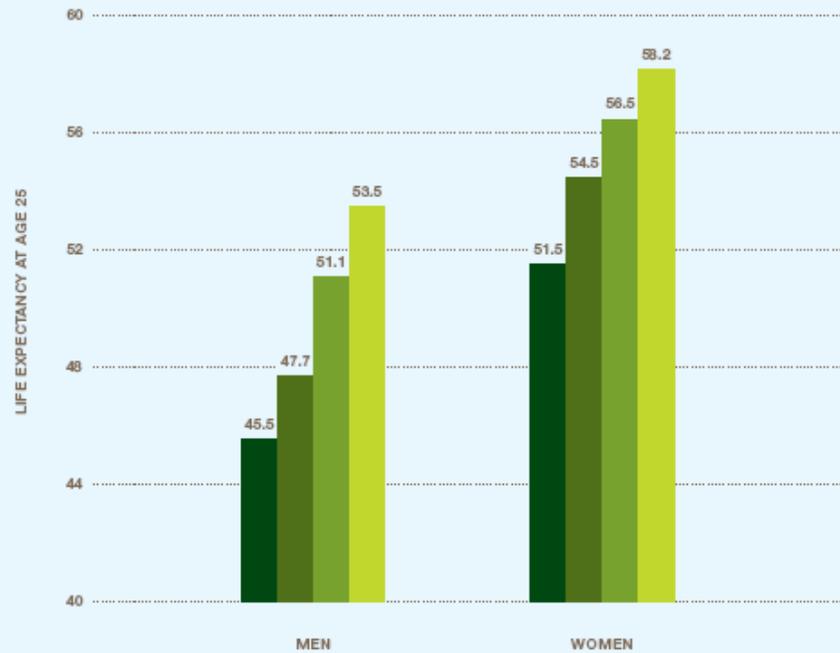




Americans at every income level should be healthier

Higher Income, Longer Life

figure 2b Adult life expectancy* increases with increasing income. Men and women in the highest-income group can expect to live at least six and a half years longer than poor men and women.



Family Income
(Percent of Federal Poverty Level)

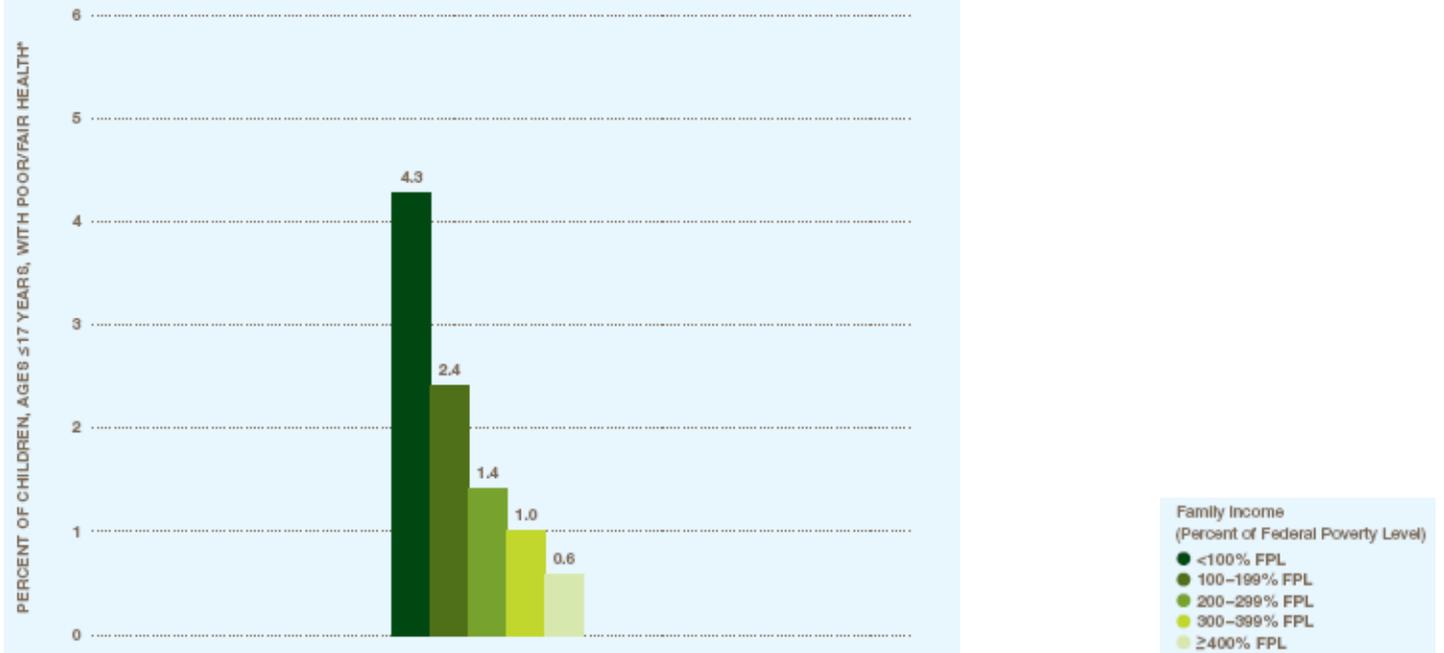
- ≤100% FPL
- 101-200% FPL
- 201-400% FPL
- >400% FPL



America's children at every income level should be healthier

Parents' Income, A Child's Chances for Health

figure 3c Children in poor families are about seven times as likely to be in poor or fair health as children in the highest-income families.

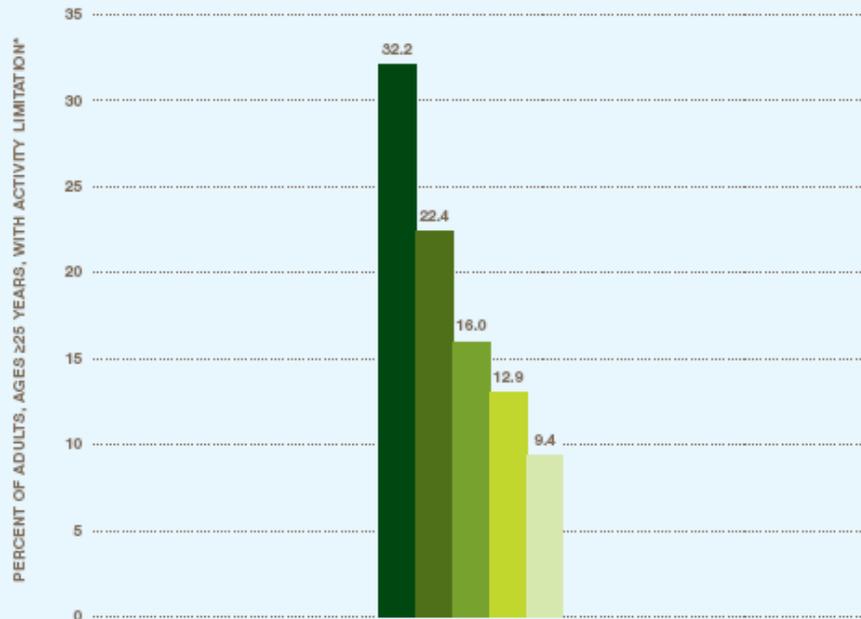




Individuals with lower family incomes are more likely to have chronic disease that limits their activity

Lower Income, More Chronic Illness

figure 4 Nearly one in every three poor adults has their activity limited by chronic illness, compared with fewer than one in 10 adults in the highest-income group.



Family Income
(Percent of Federal Poverty Level)

- <100% FPL
- 100-199% FPL
- 200-299% FPL
- 300-399% FPL
- ≥400% FPL

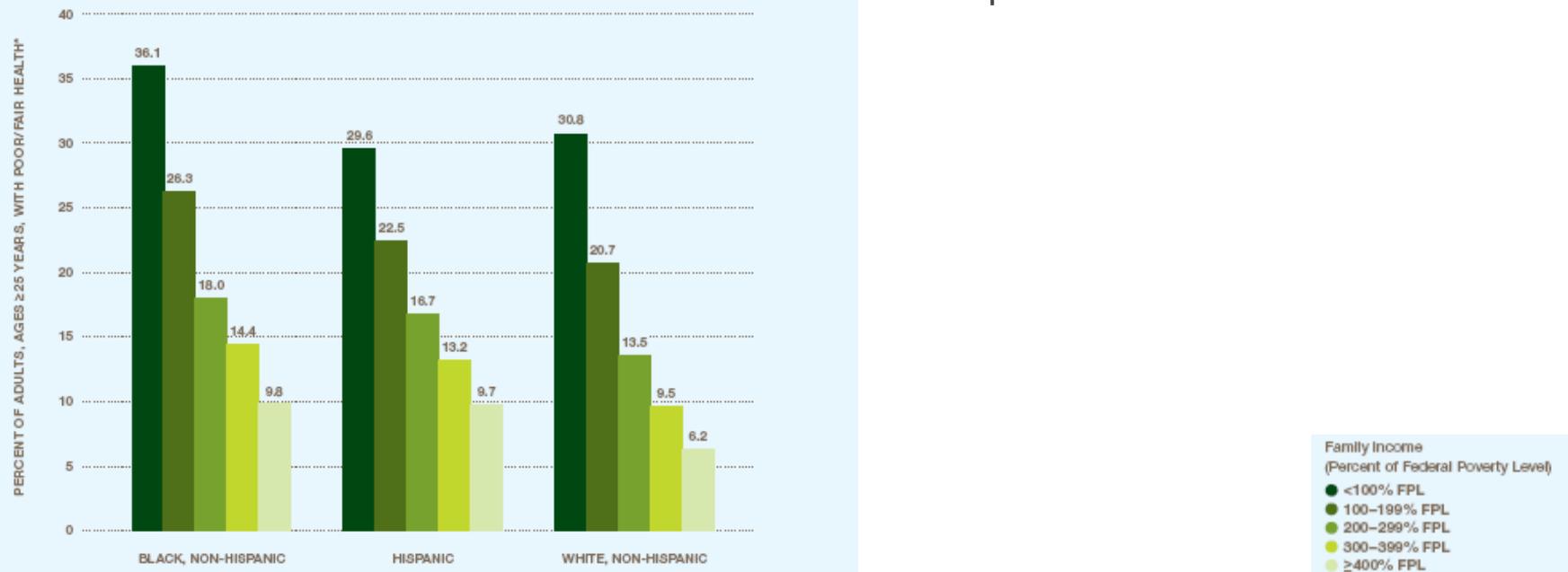
- While people in the most disadvantaged groups typically experience the poorest health, even middle-class Americans are less healthy than Americans with greater advantages



Socioeconomic and racial or ethnic differences are closely linked

Income Is Linked With Health Regardless of Racial or Ethnic Group

figure 7b Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.



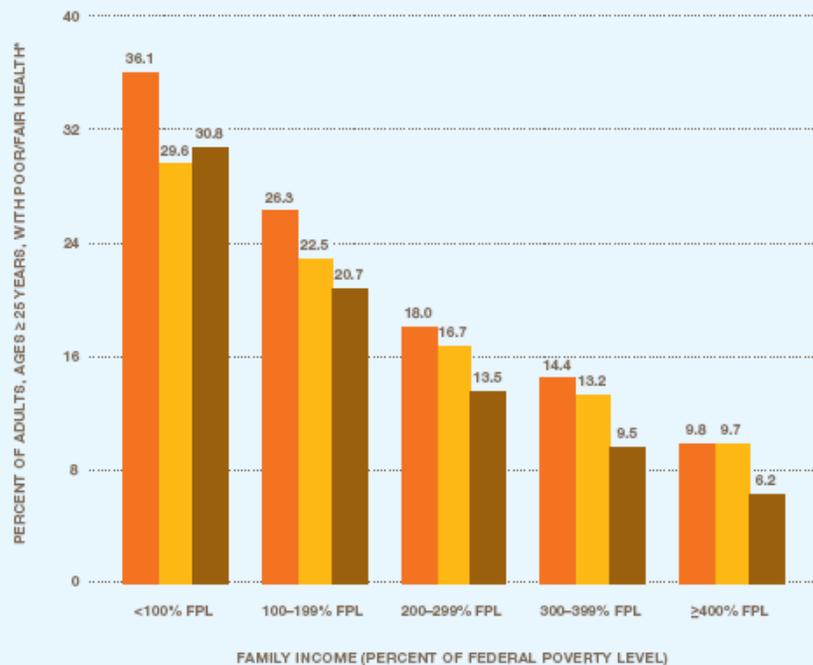
- These patterns – for health status but seen across a wide range of health conditions -- tell us that both income and race are important for health and health disparities.



Socioeconomic and racial or ethnic differences are closely linked

Racial or Ethnic Differences in Health Regardless of Income

figure 7c Racial or ethnic disparities do not simply reflect differences in income. Racial or ethnic disparities in the likelihood of poor or fair health are seen within each income group. Both income and racial or ethnic group matter.



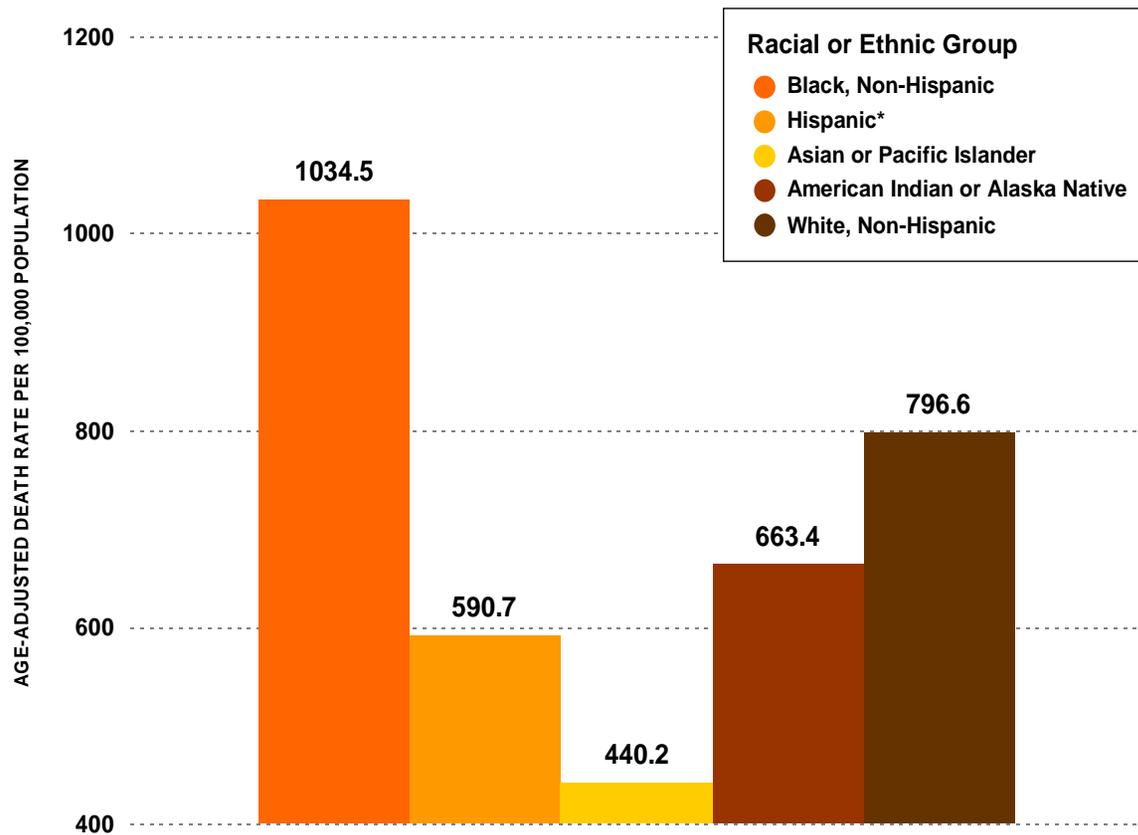
- These patterns tell us that both income and race are important for health and health disparities.

Racial or Ethnic Group
● Black, Non-Hispanic
● Hispanic
● White, Non-Hispanic



Overall, Blacks have the highest age-adjusted mortality rates

Figure 2. Overall, blacks have the highest age-adjusted mortality rates.



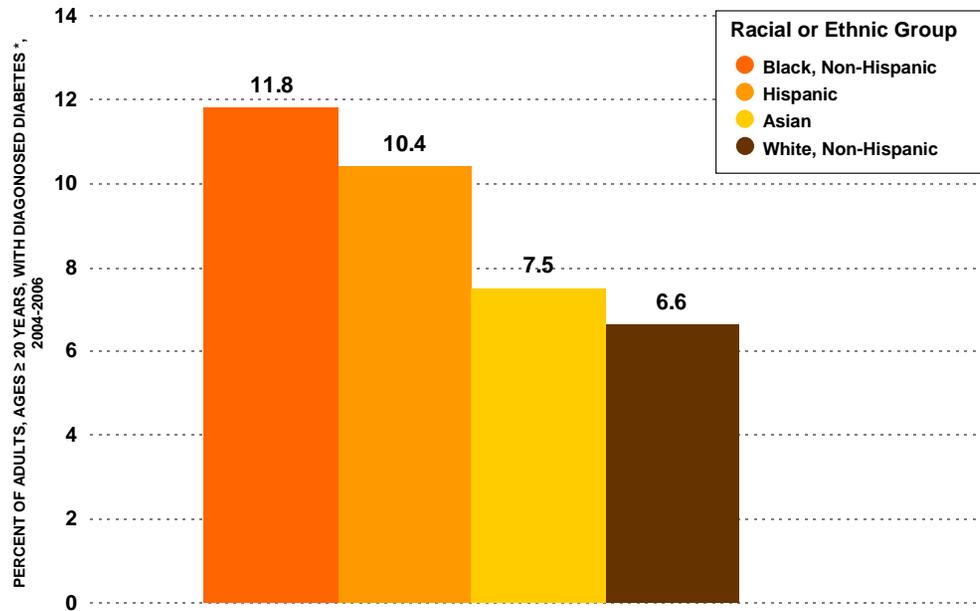
* Persons of Hispanic origin may be of any race.

Source: Kung HC, Hoyert DL, Xu J, et al. "Deaths: Final Data for 2005." *National Vital Statistics Report*, vol 56, no 10. Hyattsville, MD: National Center for Health Statistics, 2008.



Adult Blacks, Hispanics and Asians all have higher rates of diabetes than adult whites

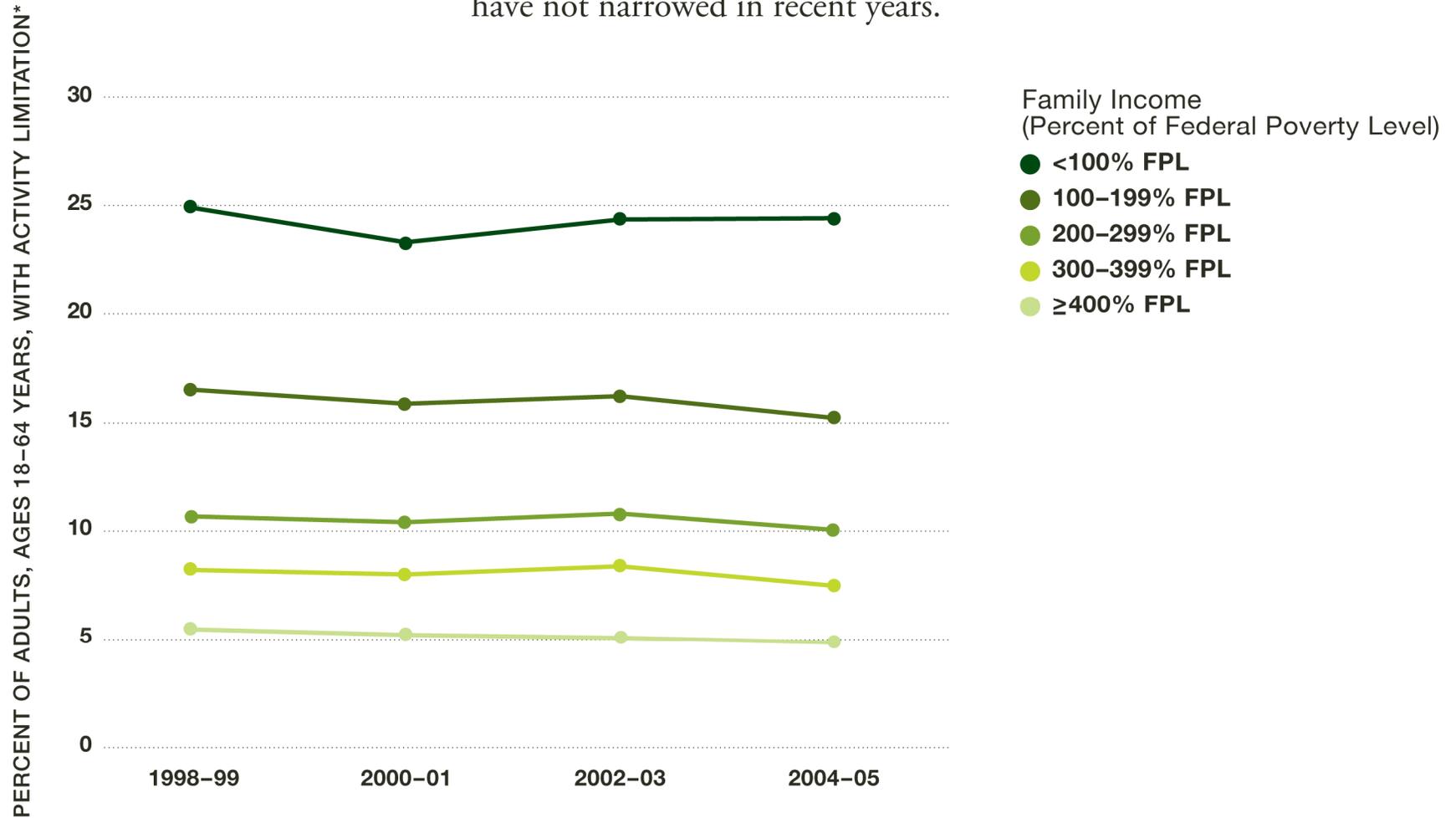
Figure 3. Adult blacks, Hispanics and Asians all have higher rates of diabetes than adult whites. Diabetes increases the risk of heart disease, stroke and premature death.



*Age-adjusted
Source: Centers for Disease Control and Prevention. *National Diabetes Fact Sheet, 2007.*

Persistent Gaps in Health by Income

Income disparities in the percent of adults with limited activity due to chronic illness have not narrowed in recent years.



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: National Health Interview Survey, 1998-2005.

*Age-adjusted

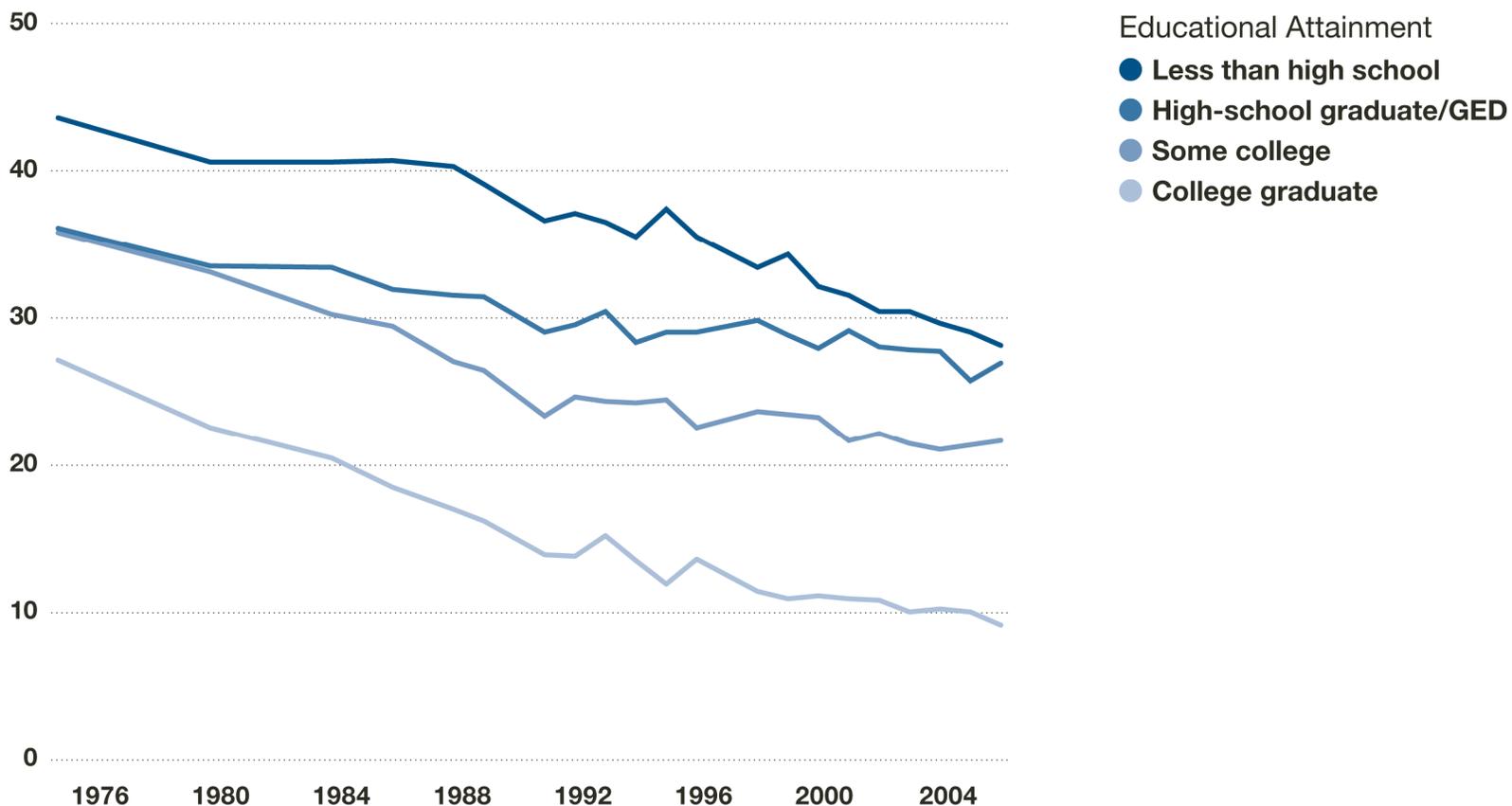
© 2008 Robert Wood Johnson Foundation

www.commissiononhealth.org

Persistent Gaps in Health Behaviors: Smoking

Education disparities in cigarette smoking have persisted over decades, and the gaps between college graduates and those with less education appear to have widened.

PERCENT OF ADULTS, AGES ≥25 YEARS, WHO ARE CURRENT SMOKERS*



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: National Center for Health Statistics. *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD.

*Age-adjusted

© 2008 Robert Wood Johnson Foundation

www.commissiononhealth.org



- Prevailing view has been that more medical care and better behaviors would make us healthy
 - And that health education would change behavior
- But international comparisons show we are not getting value for our investment in medical care
- And behaviors have not improved adequately
 - Obesity has worsened, physical activity has not improved, and smoking disparities have widened
- We need to ask:
 - *What influences behaviors?*
 - *How could those conditions be changed?*
 - *What else influences health, that we haven't focused on?*



Relative Risks for Poor Health:

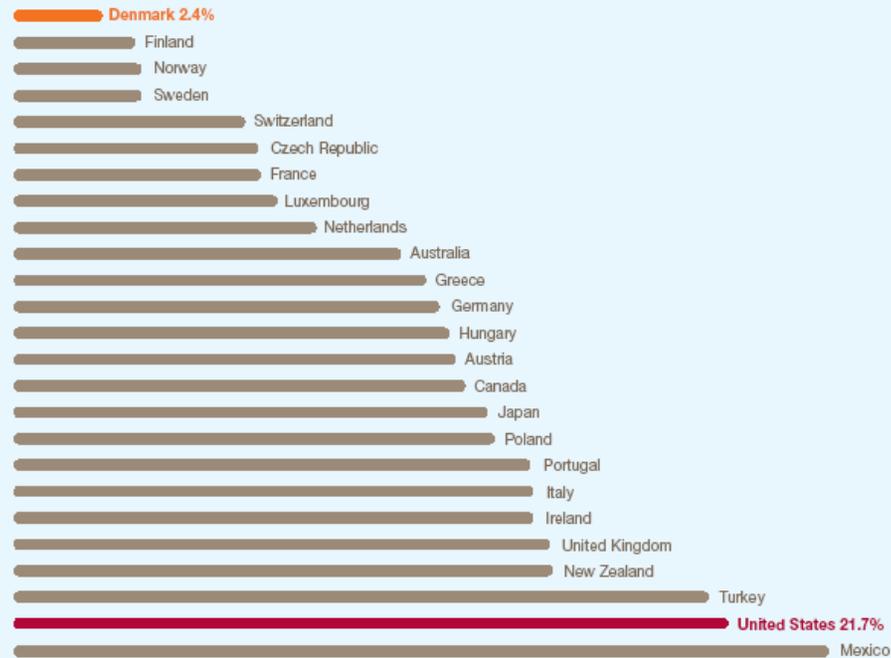
- College graduates can expect to live five years longer than Americans who have not completed high school.
 - On average, affluent Americans can expect to live over six years longer than poor Americans.
 - Babies born to women who did not finish high school are nearly twice as likely to die before their first birthdays as babies whose mothers completed college.
 - Geography and income matter. Whites in Louisiana, for instance, have an age-adjusted death rate that is 30 percent higher than that for whites in Minnesota, where the median household income was about \$19,000 higher than in Louisiana in 2005–2006.
 - In every racial or ethnic group, lower-income Americans have higher rates of poor or fair health than their more affluent counterparts.
-



The U.S. has a higher proportion of its population – and particularly of its children – living in poverty than most other affluent countries

More Child Poverty in America

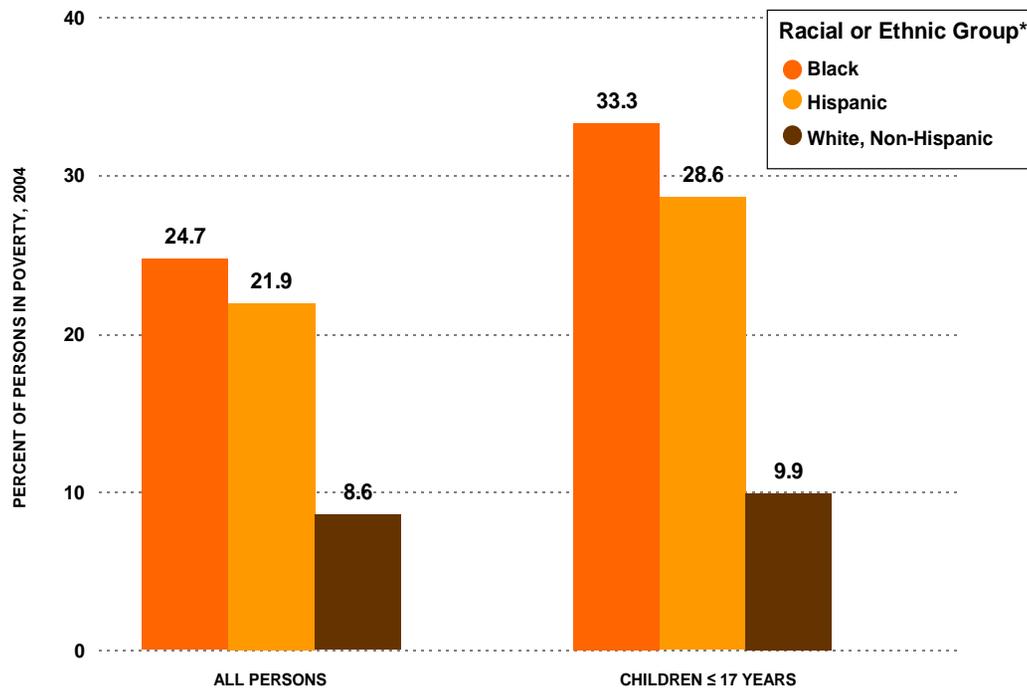
figure 11 The U.S. has higher rates of child poverty* than many other countries. In 2000, one-fifth of American children were poor—a proportion that was nine times higher than in Denmark.





Blacks and Hispanics are more likely than whites to experience poverty; disparities are largest in childhood

Figure 5. Blacks and Hispanics are more likely than whites to experience poverty; the disparities are largest in childhood.

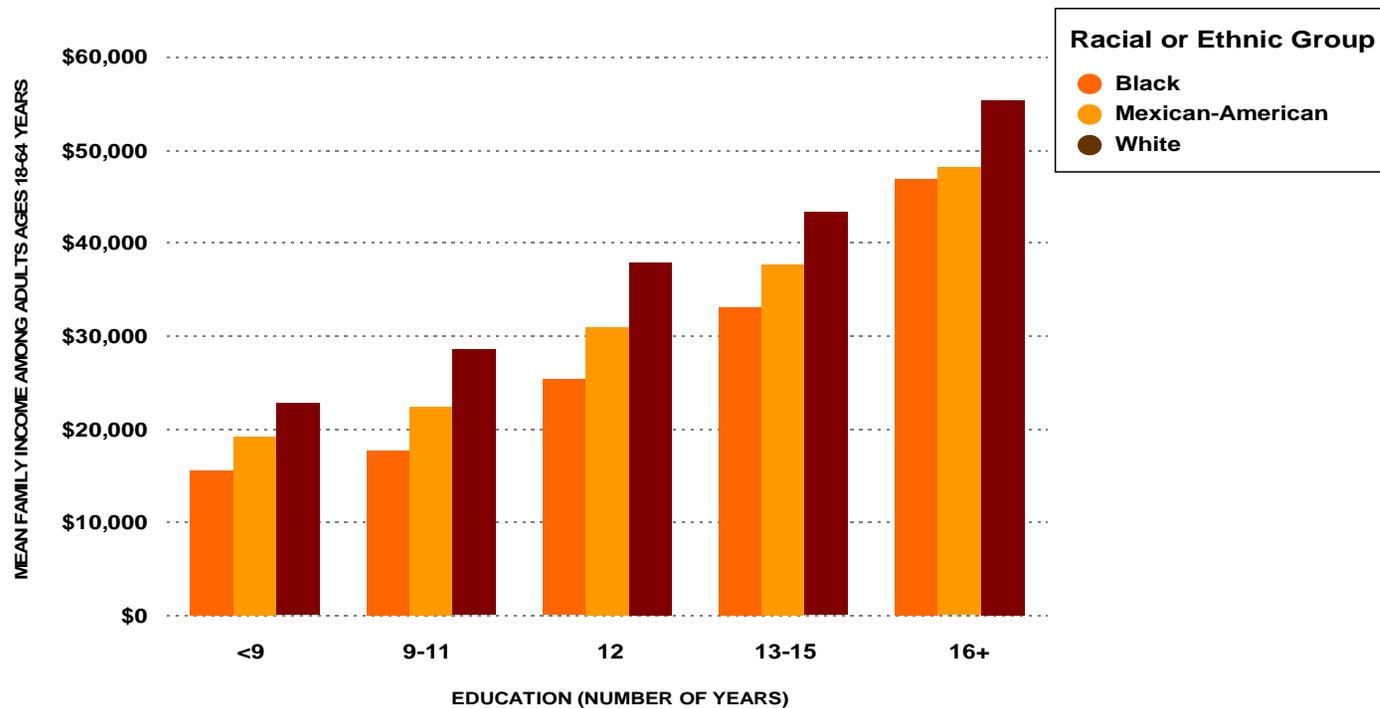


*Persons of Hispanic origin may be of any race. Blacks include persons of Hispanic and non-Hispanic origin.
Source: National Center for Health Statistics. *Health, United States, 2006 with Chartbook on Trends in the Health of Americans*. Hyattsville, MD.



At every educational level, Blacks and Mexican Americans have lower mean family incomes than whites

Figure 6. At every educational level, blacks and Mexican Americans have lower mean family incomes than whites.

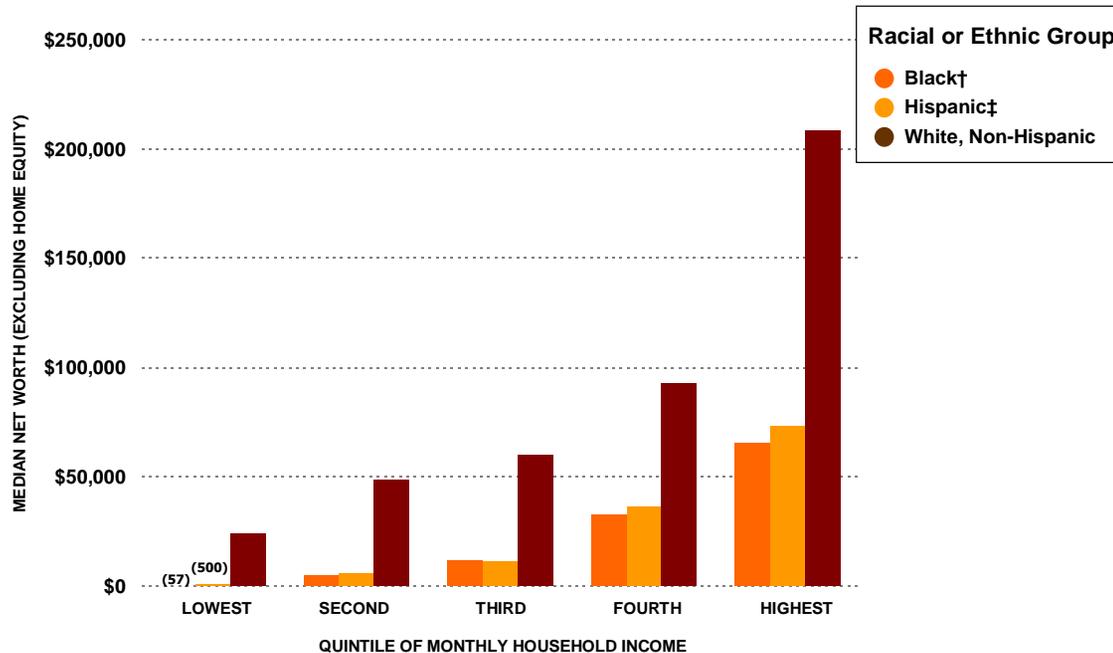


Source: Braveman PA et al. Socioeconomic status in health research: One size does not fit all. *JAMA*, 294(22), 2005. Based on National Health Interview Survey, 1989-1994.



At each level of income, Blacks and Hispanics have far less accumulated wealth than whites.

Figure 7. At every income level, blacks and Hispanics have less accumulated wealth than whites.



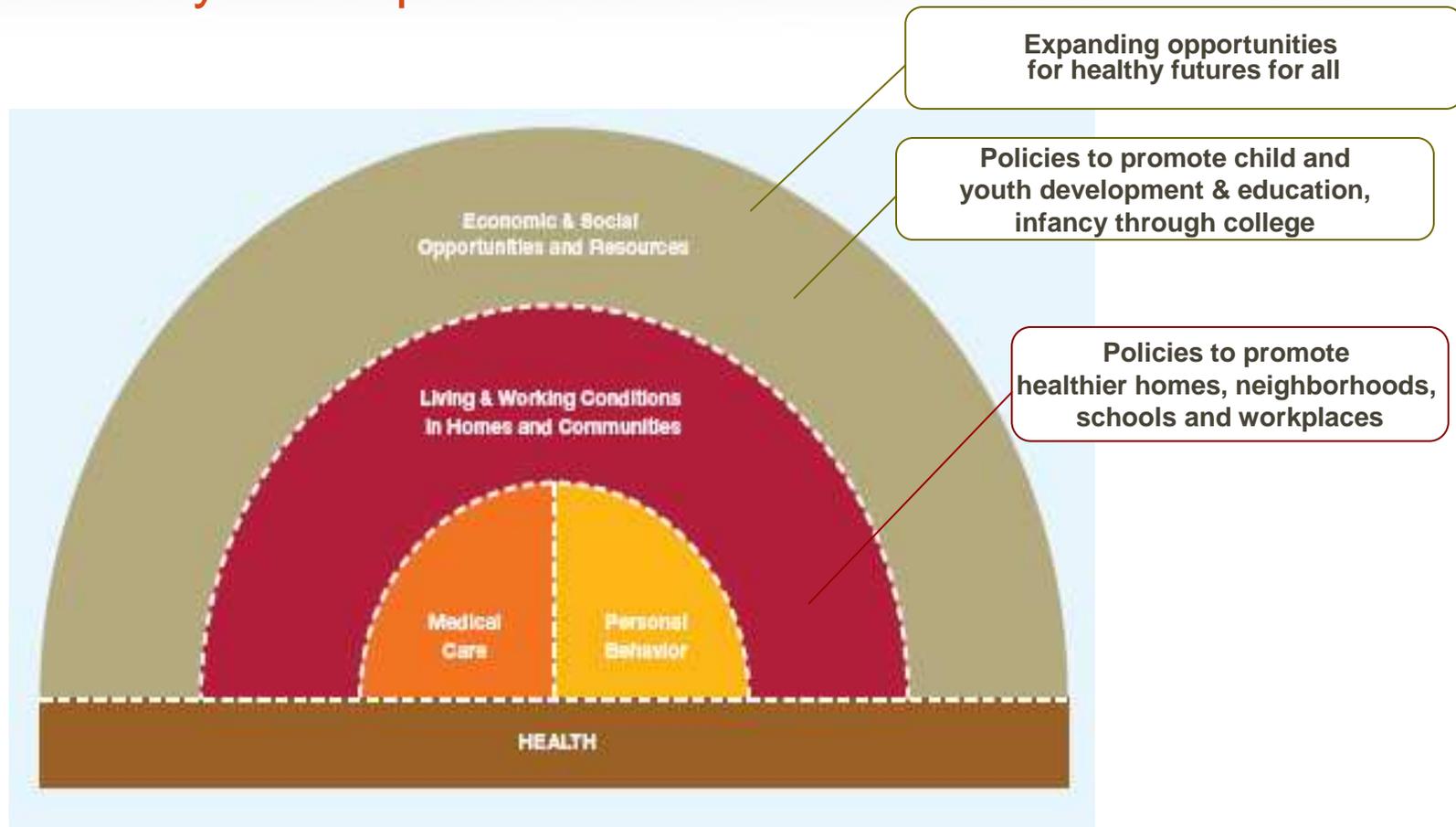
†Report does not indicate whether Blacks are non-Hispanic

‡Persons of Hispanic origin may be of any race

Source: Braveman PA et al. Socioeconomic status in health research: One size does not fit all. *JAMA*, 294(22), 2005. Based on US Census Bureau Survey of Income and Program Participation, 2000.



Commission Focused on Non-Medical Pathways to Improve Health





Knowledge has accumulated about what affects health across the life course:

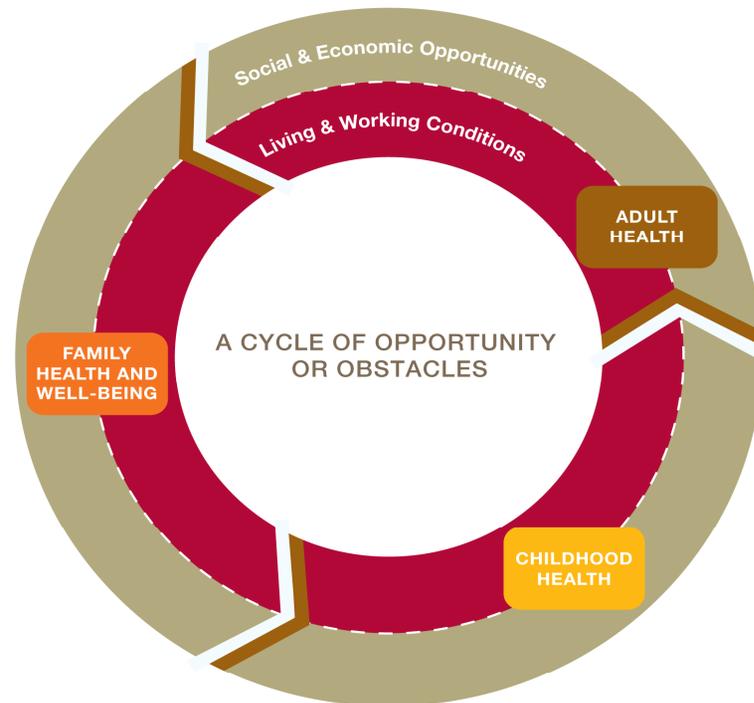
- The role of experiences early in life
- The role of child care and education
- The role of psychosocial factors including working conditions and social environments—specifically *stress*
- What affects health behaviors
- Interventions that do and do not work – at least at the local level



...And Across Generations

Social Advantage and Health Across Lifetimes and Generations

Social disadvantage and health disadvantage accumulate over time, creating ever more daunting obstacles to health.



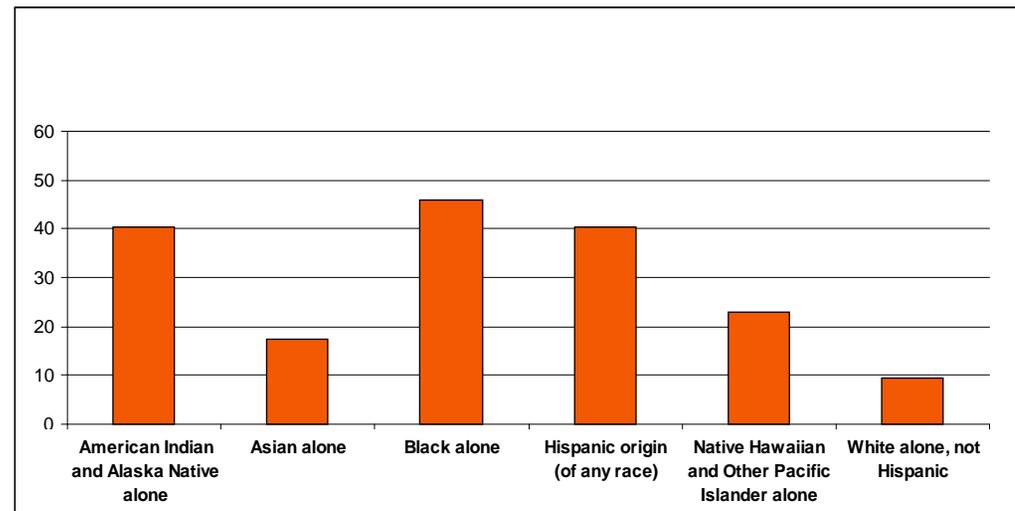
Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
© 2008 Robert Wood Johnson Foundation

www.commissiononhealth.org



Percent of people in different racial or ethnic groups living in poor* neighborhoods.

At any income level, Blacks and Hispanics are more likely to live in poor neighborhoods than whites of similar income.

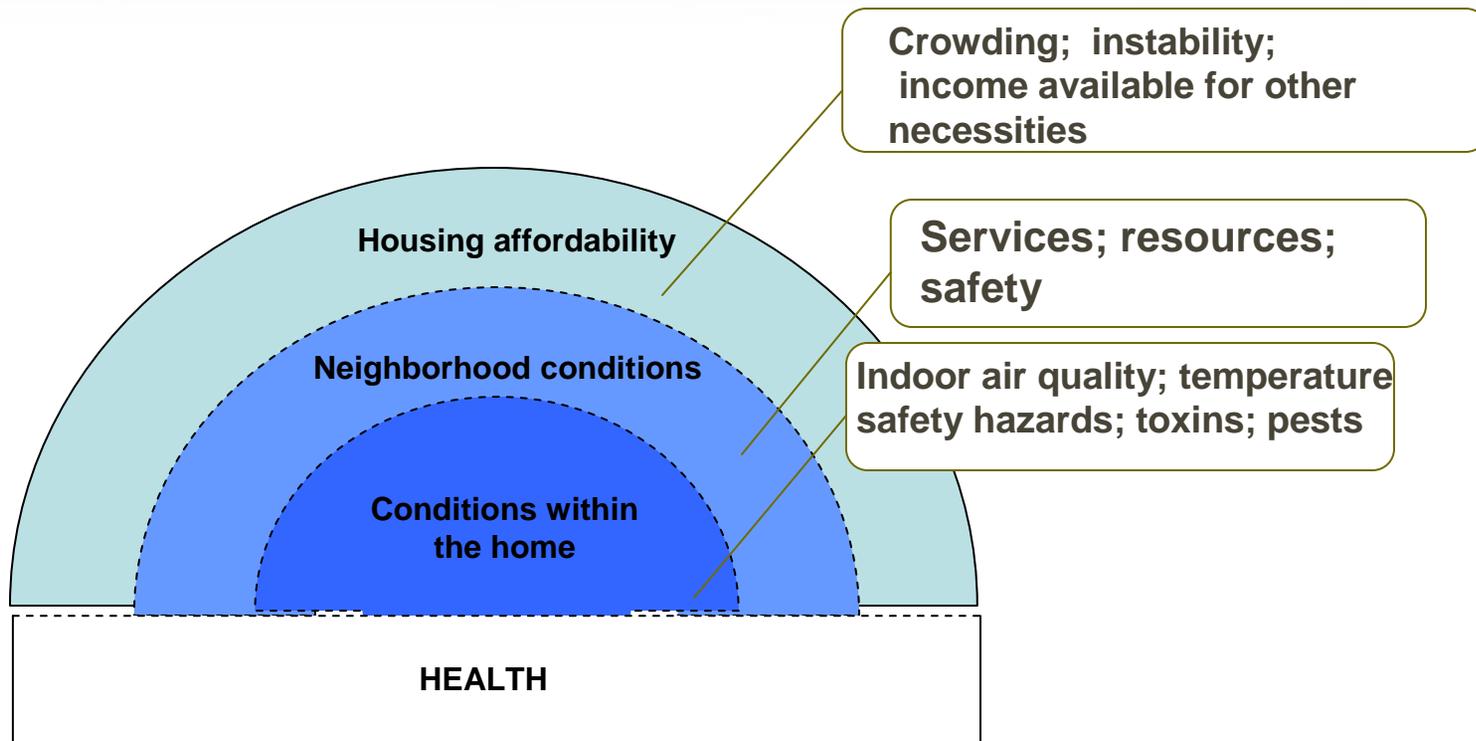


·A poor neighborhood is one in which at least 20% of residents have incomes at or below the federal poverty level.

Adapted from Bishaw A. *Areas with concentrated poverty: 1999*. Washington, D.C.: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau; 2005.



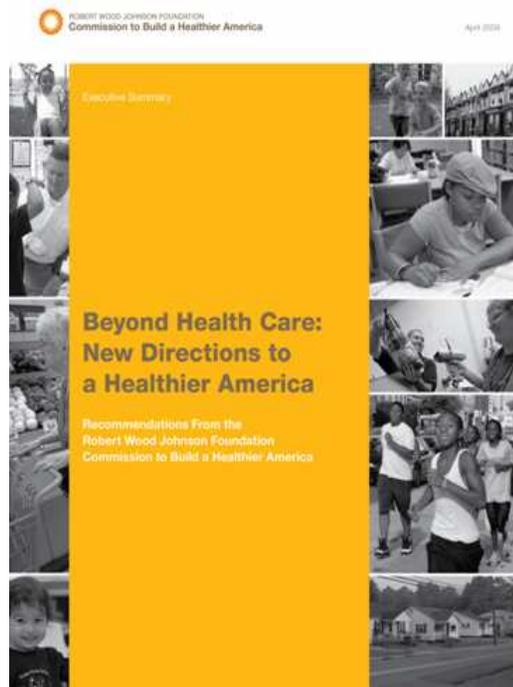
Housing Influences Health in Many Ways





The Commission's Recommendations

A twin philosophy: Good health requires personal responsibility and a societal commitment to remove the obstacles preventing too many Americans from making healthy decisions



The recommendations focus on people and the places where we spend the bulk of our time:

- Homes and Communities
- Schools
- Workplaces

April 2009

Building a healthier America is feasible in years, not decades, if we collaborate and act on what is making a difference



Starting Early

- ◆ Ensure that all children have high-quality early developmental support (child care, education and other services). This will require committing substantial additional resources to meet the early developmental needs particularly of children in low-income families.
 - ◆ Feed children only healthy foods in schools.
 - ◆ Require all schools (K-12) to include time for all children to be physically active every day.
-



Accessing Healthy Foods

→ Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families with nutritious food.

→ Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.*

*Larson et al, 2009, AJPM 36(1): Neighborhood Environments: Disparities in Access to Healthy Foods in the U.S.



Creating Healthy Communities

- ◆ Become a smoke-free nation. Eliminating smoking remains one of the most important contributions to longer, healthier lives.
 - ◆ Integrate safety and wellness into every aspect of community life.
 - ◆ Develop a “health impact” rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
 - ◆ Create “healthy community” demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.
-



Measuring Progress, Building In Accountability

Decision makers at national, state, and local levels need reliable data on health status, disparities, and the effects of social determinants of health.

- Better data must be developed for use at the local level, in particular.
- Fund research to understand the health effects of social factors and promote application of findings by decision makers.



Resources: www.commissiononhealth.org

- *Overcoming Obstacles to Health*
- Charts
- Leadership blog
- Multimedia personal stories
- Commission information and activities
- Commission news coverage
- Relevant news articles
- Interactive education and health tool
- State-level child health data
- Issue briefs
- *Beyond Health Care: New Directions to a Healthier America*
- State-level adult health data (May '09)





ROBERT WOOD JOHNSON FOUNDATION

Commission to Build a Healthier America