

from Johnston, D., Ed. (2014).  
Divided: the perils of our growing inequality.  
New York, New Press.

## INEQUALITY KILLS

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*For nearly two hundred years America was one of the healthiest countries, but no more. A public health expert explains what changed and how we can make Americans healthier.*

Around the time of the founding of the United States, it was one of the healthiest places in the world. Even though what we think of as quality health care or public health services were not around yet, the common cause of developing a nation provided a strong sense of community and that solidarity probably supported a relatively healthy population. Around 1900, the movement to get the fecal matter out of the water produced vast health improvements by reducing the risk of infectious disease. Rising living standards and public health improvements continued so that by 1950, shared economic growth had produced “the good life” in America. At that time we were one of the world’s longest-lived countries.

But something happened around 1970: the United States began focusing on the business of medical care, rather than on producing health. This happened at the same time that income inequality started rising, a rise that has continued. The ranking of U.S. health in relation to other countries began to fall, until today, over thirty

nations have better health by many measures than the United States. We've lost touch with the conditions that promote health and need to refocus on finding them.

What is health? For individuals the actual definition of health is difficult, although there are healthy ranges for measurements such as blood pressure, cholesterol, and body weight. However, for populations there are a number of well-accepted measures of health. Average length of life, or measures that include the quality of those years, as well as rates of death in infancy or childhood are commonly used and can be compared for different populations and countries. Mortality rates in general, describing the ages at which people are likely to die, are accepted designations of population health and correlate very highly with people's own descriptions of how healthy they are.

For a country like the United States, normal health status should be comparable to what the healthiest nations achieve. What is the relative health status of Americans? A good place to begin the discussion is a book issued in 2013, *U.S. Health in International Perspective: Shorter Lives, Poorer Health* by the U.S. Institute of Medicine (IOM). The institute was authorized in 1970 as a branch of the National Academy of Sciences to provide unbiased, science-based advice to decision makers and the public on matters of the nation's health. Today it has an annual budget of fifty million dollars and is headed by Harvey Fineberg, former provost of Harvard University and prior to that the dean of the Harvard School of Public Health. These facts suggest that the IOM is headed by a scholar who is recognized by academics of the highest order.

Fineberg summarized the basic message of the book in the foreword. "Americans die sooner and experience more illness than residents in many other countries," he wrote. "Americans with healthy behaviors or those who are white, insured, college-educated, or in upper-income groups appear to be in worse health than similar groups in comparison countries."

The comparison countries Finberg referred to were the other rich nations with comparable data. The IOM report and other data show that the United States has higher rates of deaths from heart attacks, motor-vehicle crashes, violence (especially firearm induced),

and AIDS than the thirty other most developed countries. We are at the bottom of most lists that rank mortality levels among the wealthy countries, and worse off than some middle-income nations as well. This well-documented fact is quite unknown to the great bulk of Americans, who will suffer the consequences nonetheless.

Infant death rates, those occurring in the first year of life, are a particularly sensitive measure of health in a population. According to a U.S. Centers for Disease Control and Prevention report released in 2013, our infant mortality rate is about 6.1 deaths for every thousand live births. Sweden has an infant mortality rate less than half of ours, 2.1 deaths per thousand births. If we had Sweden's rate of infant deaths, the United States would have around forty-seven fewer infants dying every day in the United States. That is what is achievable: every day forty-seven babies wouldn't die if we had Sweden's rate of infant deaths.

Why do we rank so badly in health? The IOM report spends about 150 pages explaining the U.S. health disadvantage. The U.S. health care system was not, in a surprise to many, a focus of this explanation. Many of the usual measures of the success of a health care system are favorable in the United States, such as the observation that we have lower levels of cholesterol and blood pressure than people in many longer-lived countries. The United States also has higher rates of cancer screening and lower stroke mortality than other healthier rich nations.

Yet those successes of the health care system do not make us healthy. The most generous estimate of the impact of health care on the health of societies is on the order of 10 percent, and may well be less than that. As the IOM report suggests, we need look elsewhere to understand why we die so young in this country.

The report points out ways that the political system is linked to our relatively high infant mortality, those forty-seven babies wasted every day. They relate those deaths to our corporatist political system and actually point the finger at our media and advertising as being at least partly responsible.

The report concludes that while the American health care system is far from perfect, and is the subject of about 42 percent of all world health spending, its failings explain only a small part of the

U.S. health disadvantage. The same is true for our public health system of clinics and services to prevent or address specific problems. Fixing the health care system won't do it.

The distinction between health and health care is a critical one, but something that seems not to be well understood by the lay public, health care professionals, or policy makers. Every time we hear the word *health*, we should ask ourselves whether that term refers to health itself, or to the much more limited concept of health care. Making that distinction will help us find the road to health.

If the culprit is not health care, are individual health-related behaviors, often blamed for the high death rates in some groups, causing our low ranking in health? Apparently not. Americans smoke less than both men and women in the healthier countries, so tobacco, though important, is not a significant cause for our higher mortality. Diet and other similar individual behaviors prevalent in the United States also don't account for our health disadvantage compared to other rich nations.

When asked to identify solutions to our poor health status as a nation, many respond that we need more education. Many see education as the solution to a wide range of problems. But on average the U.S. population has more years of schooling than in any other country in the world. And while we spend a great deal of money on education, we don't get much bang for those bucks. The IOM report points out that reading, science, and mathematics outcomes for U.S. fifteen-year-olds are poor compared to other countries. Just as with health care, we spend a great deal on education and have little to show for it.

The IOM report presents appalling information about violence and firearm deaths in the United States. But although we have very high rates of violent deaths for young people compared to other rich nations, that risk is a sideshow, too. The violent deaths of children are terrible events, but if we count up, for example, all the school shootings, they average out to about ten deaths a year. However tragic for the individual families, youth violence is an insignificant cause of our relatively limited life spans.

The report also includes a long section on the factors for our

high death rates. Among the main causes cited are poverty, income inequality, low social status, stress, epigenetics (factors on the genome telling your genes to switch on or off, speak loudly or whisper, that are influenced by a host of environmental factors broadly considered and are transmitted across generations), and early-life disadvantage. Although recent attention has been paid to the rising economic inequality in the United States, the links of that trend to our health have not been presented to the public. Those associations remain buried in academic research.

The life-course perspective in particular is out of the public eye. Looking more deeply into research on the effects of early life, it is possible to estimate that roughly half of our health as adults is programmed from the time of conception to around two years of age. The importance of these “first thousand days” is the subject of increased interest and study, and explains a lot about the difficulties of focusing on short-term interventions to improve health. Countries with healthier populations structure this formative period by making it easier for parents to parent. In practical terms, this means that in modern societies where most people work outside the home, providing paid parental leave is the single most effective social intervention that can be undertaken for improving health. It can be thought of in the same light as public sanitation systems that make water safe to drink. We all benefit, rich and poor alike, from clean water, from sewage treatment, from immunizations and other public health measures.

Everyone in a society gains when children grow up to be healthy adults. The rest of the world seems to understand this simple fact, and only three countries in the world don’t have a policy, at least on the books, for paid maternal leave—Liberia, Papua New Guinea, and the United States. What does that say about our understanding, or concern, about the health of our youth?

Differences in mortality rates are not just a statistical concern—they reflect suffering and pain for very real individuals and families. The higher mortality in the United States is an example of what Paul Farmer, the noted physician and anthropologist, calls structural violence. The forty-seven infant deaths occur every day because of the way society in the United States is structured, resulting

in our health status being that of a middle-income country, not a rich country.

There is growing evidence that the factor most responsible for the relatively poor health in the United States is the vast and rising inequality in wealth and income that we not only tolerate, but resist changing. Inequality is the central element, the upstream cause of the social disadvantage described in the IOM report. A political system that fosters inequality limits the attainment of health.

The claim that economic inequality is a major reason for our poor health requires that several standard criteria for claiming causality are satisfied: the results are confirmed by many different studies by different investigators over different time periods; there is a dose-response relationship, meaning more inequality leads to worse health; no other contending explanation is posited; and the relationship is biologically plausible, with likely mechanisms through which inequality works. The field of study called stress biology of social comparisons is one such way inequality acts. Those studies confirm that all the criteria for linking inequality to poorer health are met, concluding that the extent of inequality in society reflects the range of caring and sharing, with more unequal populations sharing less. Those who are poorer struggle to be accepted in society and the rich also suffer its effects.

A recent Harvard study estimated that about one death in three in this country results from our very high income inequality. Inequality kills through structural violence. There is no smoking gun with this form of violence, which simply produces a lethally large social and economic gap between rich and poor.

If we face the grim reality of our failure to support the health of the public in the United States, it's critical to identify approaches to change the system that isn't working. The last part of the IOM report lays out ideas for what to do, saying that we know enough to act without requiring more research. Their call to action is the need to alert the public to our alarmingly low relative health status and stimulate a national discussion about it.

But who should lead that discussion? The report suggests that it should come from independent, nonpartisan, objective organizations. Who are those groups in the United States? Scientists

clearly are not the best source of information, since a large proportion of the American public distrusts science, scientific bodies, and their knowledge. For example, despite clear scientific evidence, Americans are less likely than people in other rich countries to believe climate change is taking place. In one study, America had the smallest proportion of people believing in evolution among more than sixty countries reviewed.

Agnostologists—those who introduce ignorance into our scientific debates—have been hard at work creating a misinformed American public.

The corporate-dominated media seem oblivious to the impact of inequality and almost never point out our poor health status relative to other nations. A vast array of philanthropic and non-governmental organizations in the United States deals mostly with the symptoms of our sick society and not with the basic conditions causing the disease.

Creating awareness and understanding of the basic problems constraining our achievement of better health will be a major challenge. Americans as a people simply have not been good at evaluating information in a critical manner. A very successful ploy of advertisers is the endless repetition of simple statements that stick in people's minds. That process of "manufacturing consent" has been used widely in political spheres as well; a few years ago the widely repeated slogan "Iraq Has Weapons of Mass Destruction" had the public enraged, supporting the invasion of Iraq despite any evidence to support the accusation.

To save those forty-seven infant lives every day, we could take a similar action, and create a broken record to run throughout the entire range of public spheres, from local and county governments to the national administration, Congress, and the courts, with the message: "Americans Die Younger Than People in All the Other Rich Nations." If that statement were included in every speech made by governmental leaders and other public figures, repeated over and over, it might stimulate us to invade our own nation to improve its health status. Only widespread understanding of the problem we face will lead us to develop effective solutions.

The IOM report also discussed looking at healthier countries

to see if some of their policies impacting health could be applicable here. The U.S. public is generally ignorant of some very good examples of “what can be done” among European countries. For those who recoil at the idea that we could learn anything from other countries, a look at our own not so distant history points out what Americans thought, and did, before we became so lethally unequal. In 1969 a Republican president proposed a Family Assistance Plan that would have guaranteed a basic income for all American families. Editorial opinion then was 95 percent in favor of such support to families. Our values at that time were to decry the poverty in our midst to try to make it vanish from the country. President Nixon’s bill passed the House of Representatives, then languished in the Senate. When Nixon became embroiled in the Watergate scandal it died—along with a credible, feasible plan to strengthen the health of families in this country and prevent what was soon to become a relentless decline in our relative health.

We can return to those values and pledge to support healthy families. Let’s leave that club we are in with Liberia and Papua New Guinea, and join those nations that recognize the importance of early life. We could start by granting every family paid leave, beginning with pregnancy and continuing for the first two years after a child’s birth. The first thousand days are when parental well-being and care matter the most. Studies demonstrate that paid leave policies have important health benefits for infants, although we may have to wait a generation or two for the process to bring about major improvements in the population at large.

Tackling inequality directly would have a greater impact on health than any more direct “health” intervention, and the time may be ripe for those actions. We could follow the lead of other countries and consider having a maximum pay ratio within companies; Switzerland, for example, has proposed that the salary ratio of CEO to the lowest-paid worker should not be greater than 12:1. We could return the maximum tax rates to the levels they were when we were much healthier relative to other nations; many today are shocked to hear that in 1966 the highest marginal tax rate was 70 percent. Similarly, we could tax corporations at rates that more

realistically reflect their profit levels as we did in the past. These efforts will be resisted by the elite, although even the top 1 percent will be healthier when there is less inequality.

Another beneficial measure would foster more employee-owned enterprises. Already 130 million Americans participate in ownership of co-op businesses and credit unions. Public banks, as an alternative to corporate, profit-oriented ones, could stabilize the public economy. North Dakota has had a state bank for over ninety years, and that state suffered far less during the 2008–9 economic meltdown than the rest of the country.

The basic changes needed will only occur if we address current government policies that mostly serve the rich. While the United States is not alone in this regard, the excesses in our system, which some call a kleptocracy, limit what ordinary people can demand from their government. The rich do not face the same constraints, as was so clearly evident in the bailouts during the recent economic crisis. Changing this power imbalance is the real challenge we face.

Finally, let's monitor our efforts in getting back our health. We need to look at progress in reducing inequality and make sure that information is widely known. We need to track the U.S. standing in the Olympics of health—the ranking of countries by health outcomes. While the United States wins gold medals in the Billionaire, Incarceration, and Health Care Spending Olympics, we are not even in the start-up for the final day's race in the Health Olympics.

What gets measured gets done. Let's measure health outcomes and have every American know how much shorter their lives are than they need to be. That will have us watching for progress. The president should report on our health and inequality goals in the annual State of the Union speech.

Countries can set health goals, just as the United States set a goal to land a human on the moon in the 1960s. We monitored progress toward that goal and were eventually successful. The United Kingdom, for example, set a child poverty reduction goal a few years ago and monitors success toward that aim. Australia has set a goal of being the healthiest nation in the world by 2020.

It will not be easy, but they have outlined a plan and are monitoring progress.

The United States also regularly sets goals. The effort began with the Healthy People 2000 outcomes; but when we failed to reach those targets, we set more lofty ones for 2010—which again we didn’t achieve. For 2020 we need to set realistic goals, benchmarks, and strategies for getting there, and we need to achieve them. Those strategies need to include meaningful social and economic changes that will give everyone in the country a chance of growing up, and living a long and healthy life.

Every single day that we delay, another forty-seven American babies will die needlessly.