

Exploring Perspectives on US Health: Insights from Future Professionals

Youssef Hassani Azami

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Committee:

Stephen Bezruchka

Marieka Klawitter

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Youssef Azami

University of Washington

Abstract

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Youssef Hassani Azami

Chair of the Supervisory Committee:

Stephen Bezruchka

Department of Health Systems and Population Health

Introduction

This work explored perceptions of US health status and the fact that Americans live shorter lives and have poorer health compared to other developed nations. Semi-structured interviews were conducted with graduate students in public health and public policy, categorizing questions into three main areas: defining health, identifying factors that produce health, and discussing policy prescriptions.

Methods

I developed a semi-structured interview guide and conducted a pilot test with Master of Public Health (MPH) and Master of Public Administration (MPA) students at the University of Washington. In order to select participants for the study, I used convenience sampling, based on considerations such as cost-effectiveness and logistical feasibility. Content analysis was done. Human subjects approval was obtained.

Findings

The interviews highlighted a predominant belief among participants that access to healthcare services is the primary factor determining health outcomes. Participants also acknowledged the influence of

individual circumstances and personal behaviors on health. Additionally, preventing poverty emerged as a secondary emphasis in discussions, but only as it relates to the individuals' ability to access healthcare services or food. Lastly, a smaller portion of the discussions revolved around psychosocial factors, albeit with less significance.

Conclusion

As health status among Americans continues to decline, efforts to improve population health have long included strategies aimed at enhancing access to healthcare and promoting healthy behaviors. These findings underscore the need for a comprehensive approach that considers educating professions on the broader conditions that produce health differences along social and economic gradients.

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INTRODUCTION

The US Health Disadvantage

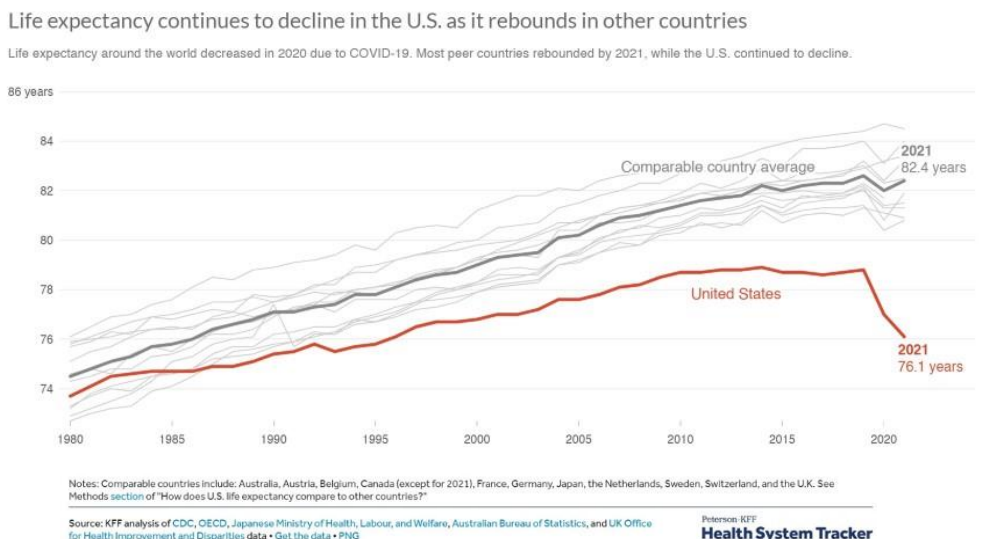
A comprehensive analysis comparing the health outcomes of the United States with 16 similar high-income countries reveals a significant health disadvantage for the US (Figure 1 Pg.3) (Rakshit et al., 2022; Woolf & Aron, 2013). The findings consistently show higher mortality rates and inferior overall health compared to its peer nations (Woolf & Aron, 2013). Currently The World Health Organization has Turkey, Israel, Chile, Kuwait and others totaling 39 nations with higher life expectancy at birth. Other sources such as the United Nations and others estimate life expectancy lower and rank the US 44th or even further down (Conceicao, 2022; Rakshit et al., 2022; WHO, 2023).

The disparity in life expectancy is especially striking, with the gap widening over time, particularly among women (Astone et al., 2016; Woolf & Aron, 2013). This health disadvantage affects various domains, including adverse birth outcomes, injuries, HIV/AIDS, obesity, heart disease, and disability (Woolf & Aron, 2013).

It is important to note that even advantaged Americans experience worse health outcomes compared to similar groups in other countries (Schwandt et al., 2021; Woolf & Aron, 2013).

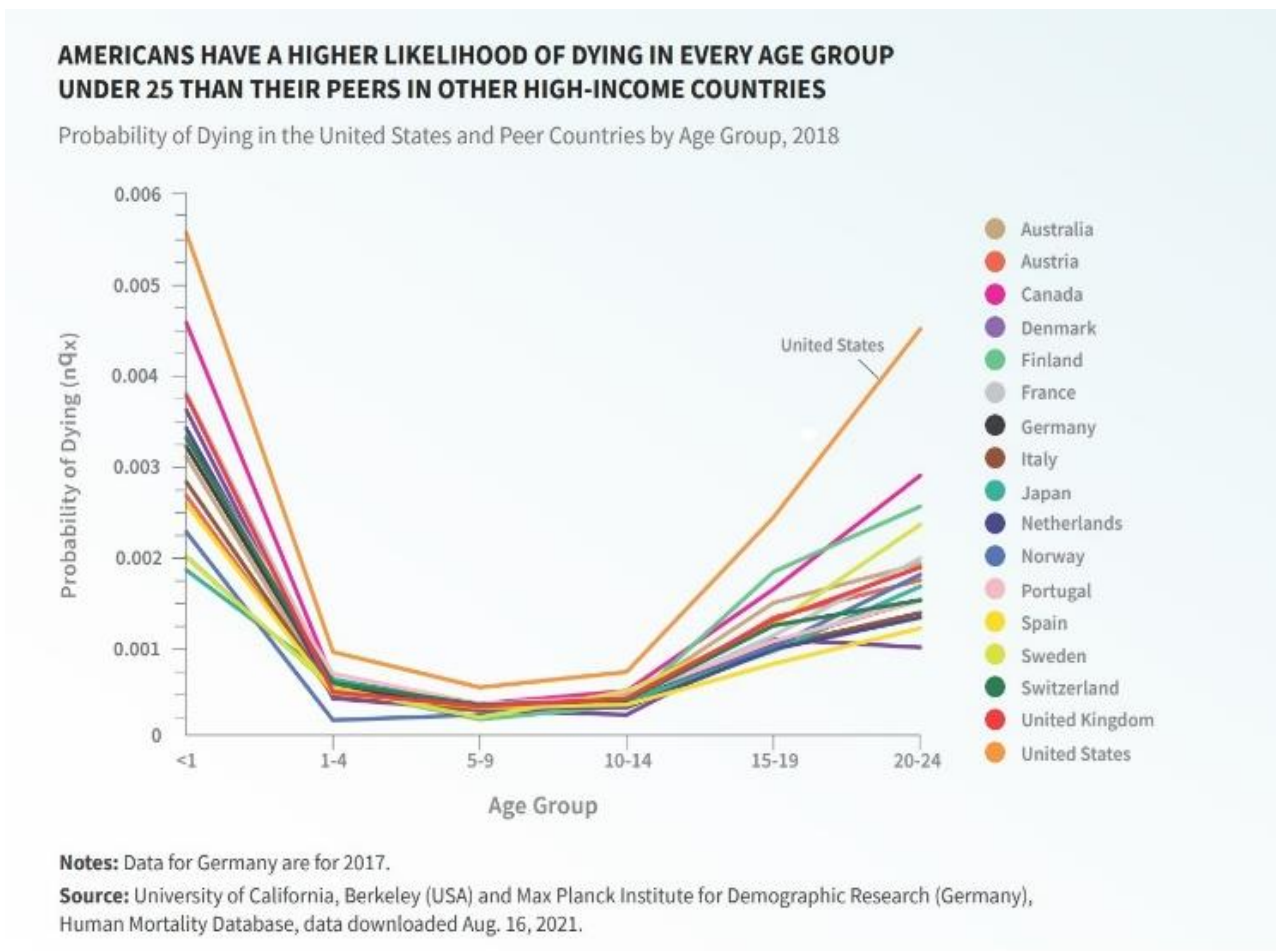
The United States has the worst mortality rates for all age groups under 25 compared to other high-income countries (Figure 2 Pg.4) (Rogers et al., 2022). A rise in all-cause mortality among young and middle-aged adults since 2010 has contributed to an overall life expectancy decline (Woolf & Schoemaker, 2019). Mortality rates have risen across different racial and ethnic groups, with certain causes of death showing larger relative increases among women (Astone et al., 2016).

Figure 1: (Rakshit et al., 2022)



Progress in reducing mortality from heart disease, cancer, and HIV infection has been reversed (Elo, 2009; Masters et al., 2018; Woolf & Schoomaker, 2019). While mortality rates among infants, children, and older adults have decreased between 1999 and 2017, midlife mortality rates, particularly among young and middle-aged adults (25-64 years), have seen an alarming rise (Acciai & Firebaugh, 2017; Woolf & Schoomaker, 2019). Causes of mortality that have increased in this age group include drug overdoses, alcoholic liver disease, and suicides (Adamy, 2023; Woolf & Schoomaker, 2019). The rise in cause-specific mortality rates before 2010 has slowed the decline in overall mortality and eventually led to an increase in all-cause mortality after 2010 (Acciai & Firebaugh, 2017).

Figure 2: (Rogers et al., 2022)

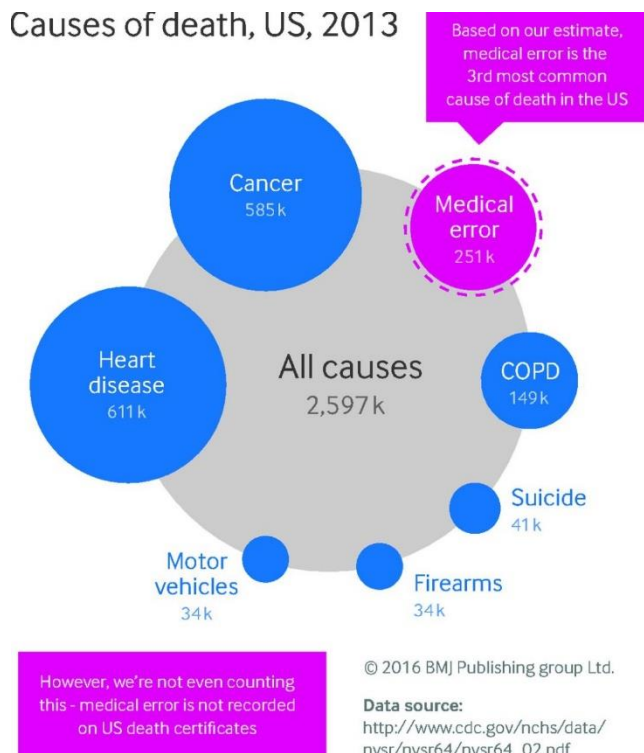


The Healthcare System: High Costs, Fragmentation, and Neglected Preventive Care:

The US healthcare system faces significant challenges characterized by high costs, privatization, and fragmentation. The cost of medical care is exorbitant, leading to bankruptcy even for insured individuals (Himmelstein et al., 2009). Only a small portion of interventions such as the introduction of a national health care system in the UK, immunizations and disease management efforts can be attributed to an increase in life expectancy or a decrease in mortality gradients over time (Evans et al., 1994; Kravitz et al., 2005).

Media portrayal of medical stories often sensationalizes them, presenting heroic battles or breakthroughs, while pharmaceutical advertising further influences perceptions (Bezruchka, 2023; Christakis & Zimmerman, 2006). The profit-driven nature of healthcare leads to overspending, unnecessary tests and procedures, and doctors influenced by financial incentives. Adverse medical events are common, and mortality rates can decrease as seen during doctors' strikes in Los Angeles County (Cunningham et al., 2008; Kravitz et al., 2005). Hospital admissions themselves increase the risk of harm and death (Makary & Daniel, 2016; Newhouse, 1993; Panagioti et al., 2019). In a paper by Makary & Daniel they found medical error to be the 3rd leading cause of death in the US (Figure 3 Pg.5) (Makary & Daniel, 2016).

Figure 3 (Makary & Daniel, 2016)



The contribution of medical care for averting mortality on conditions amenable to medical care is on the order of 10% (Kaplan & Milstein, 2019). Access to primary care doctors does contribute to increased life expectancy but is undervalued in the US (S. Basu et al., 2019). Although Public health efforts include social spending they lack clear direction and face challenges in implementing preventive measures (Zimmerman, 2021) .

Individual Behaviors and Societal Factors:

Individual behaviors play a role in shaping health outcomes in the United States across various domains. Behaviors such as smoking, unhealthy diet, low physical activity, alcohol and drug use, unsafe sexual practices, and injurious behaviors are interconnected and can lead to long-term health conditions (Woolf & Schoemaker, 2019).

It is important to recognize that individual behaviors are influenced by societal and environmental factors. Access to healthy food, safe neighborhoods, exposure to advertising and marketing, violence, and stress all contribute to behavior choices. For instance, limited access to fresh and nutritious food in food deserts can contribute to unhealthy diets. Safety concerns in unsafe neighborhoods may discourage physical activity (Woolf & Aron, 2013).

Interestingly, even individuals in the U.S. who engage in healthy behaviors, possess higher education levels, and identify as White often experience worse health outcomes compared to similar groups in other countries (Figure 4 Pg. 7) (Schwandt et al., 2021; Woolf & Aron, 2013). This challenges the notion that individual behaviors, including diet, and education alone guarantee good health. It highlights the significant role of broader social and systemic factors, including healthcare access and quality, socioeconomic inequalities, and cultural influences, in shaping health outcomes (Woolf & Aron, 2013).

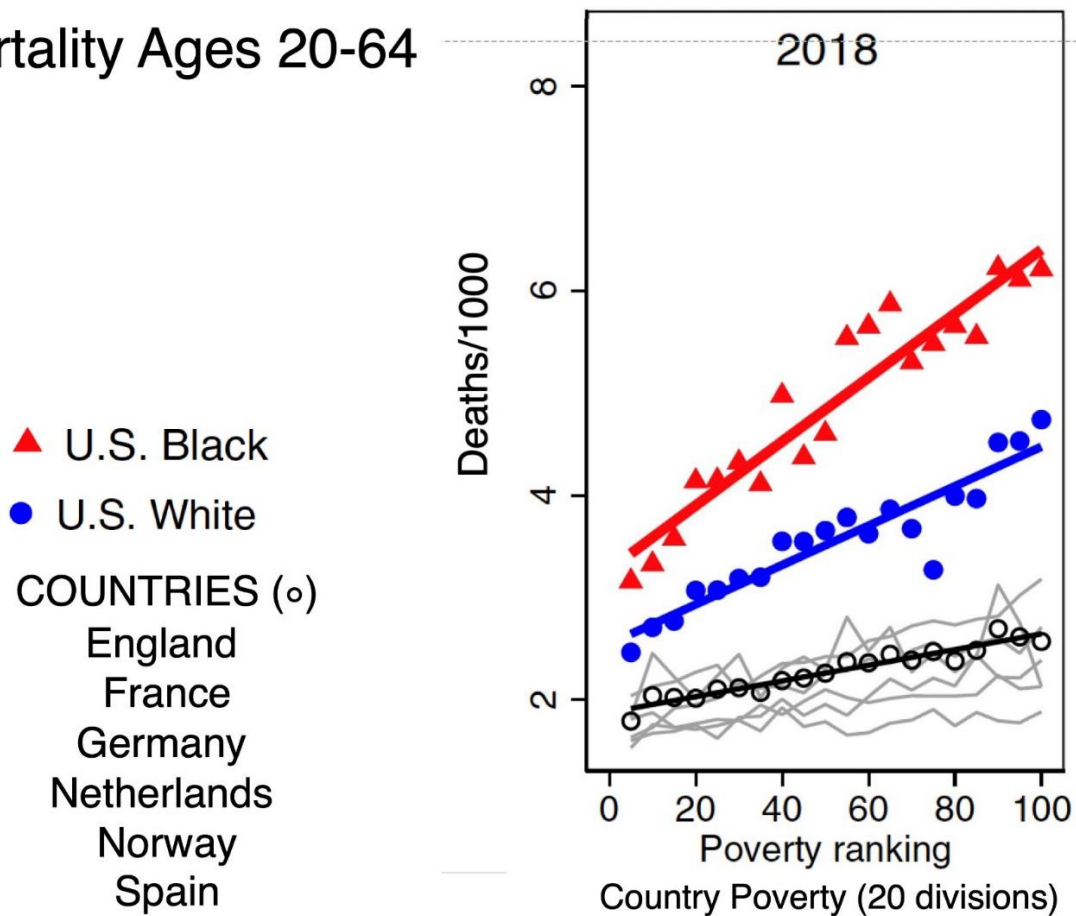
How Socioeconomic Factors Shape Population Health

Socioeconomic factors have a profound influence on population health. The quality of social and economic relations, as well as the psychosocial impacts they generate, significantly shape health outcomes (Holt-Lunstad et al., 2010). Additionally, critical periods during human development, such as prenatal and early childhood stages, have long-lasting effects on health (Bezruchka, 2015).

Socioeconomic gradients in health status exist, reflecting variations within the income distribution. These gradients have persisted over the past century, even as causes of death

Figure 4: (Schwandt et al., 2021)

Mortality Ages 20-64



have changed (Evans et al., 1994; Hertzman & Boyce, 2010; Wilkinson & Pickett, 2011). Countries with flatter health-wealth curves tend to have higher average health outcomes, highlighting the benefits of greater equality for overall population health, including for affluent individuals (Evans et al., 1994).

Efforts to reduce poverty and improve living standards have contributed to overall improvements in health outcomes over the centuries. Classifications of those who are poor can vary on the use of different metrics. Some absolute metrics fail to classify people as poor if they are making a certain income even though they may be living near the bottom end of the distribution in that area. This effect of the relative position underscores the pervasive impact of socioeconomic factors on health (Bezruchka, 2023; Wilkinson & Pickett, 2011).

Beliefs about Health

A 1997 study showed that lay people tend to underestimate the structural causes of health and illness, focusing more on individual factors. The reasons for this could be a feeling of disbelief or unease, conceptual difficulties, or a response to the influence of epidemiology and health promotion. Some lay accounts may be influenced by the emphasis on individualized risk factors and the lowering of risk thresholds (Blaxter, 1997).

A study done in 2006 emphasizes the importance of disseminating information to improve college students' health and academic performance, addressing various risk behaviors such as injuries, obesity, and sexually transmitted diseases. The author also highlights the potential impact of information on behavior change, emphasizing the need to identify effective sources and target marketing strategies accordingly (Vader et al., 2011).

While the majority of the broader U.S. population believes that increased healthcare spending leads to better health, lower-income groups exhibit more skepticism, and there is a general lack of awareness regarding the gap between healthcare spending and actual health outcomes (Merrill et al., 2018). Health knowledge among high school students predominantly originates from school and parents (Lloyd et al., 2013).

In a study, Seattle-based doctors in 1985 identified smoking, diet, and personal behaviors as the most significant factors promoting health (Sobal et al., 1985). Previous studies at the University of Washington have shed light on the limited understanding among medical professionals. The conclusion of this analysis suggests that physicians see wealth affecting health by access to healthy food, shelter and healthy environments (Lowenstein, 2020). Regarding health determinants and awareness of US health status, a study done on college seniors in Seattle found a considerable awareness of downstream health factors. Downstream factors are reactionary interventions, such as access to health care and individual conditions. These downstream interventions attempt to mitigate negative health outcomes, not produce positive ones. This examinations showed participants believing that some European nations and Japan had achieved higher life expectancy because of universal and affordable healthcare (B. Basu, 2020). This study hopes to build on what students in higher learning institutions believe produces health.

Understanding the poor health status of the U.S. compared to other nations is crucial for graduate students in public health and public affairs. It challenges the prevailing belief that the US must have the best health and if people do not then individual responsibility for health outcomes are primarily this cause. This emphasizes the role of individual factors and stresses the need for medical interventions. By recognizing the impact of societal and environmental determinants, graduate students can contribute to developing interventions and policies that address these broader factors.

Identifying the factors contributing to health differences as measured between nations by comparing the U.S. health with other countries and recognizing the impact of socioeconomic gradients on health outcomes informs research and policy decisions. It is of importance given the knowledge possessed by this group of graduate professionals can influence high level policy decisions (Weimer & Vining, 2015).

Thus, this project hopes to answer the question: what do MPA and MPH students believe produces health of a population.

METHODS

I developed a semi-structured interview guide and conducted a pilot test with several Master of Public Health (MPH) and Master of Public Administration (MPA) students at the University of Washington. Participants were selected by convenience sampling. Human subjects approval was obtained.

The interviews were audio recorded and transcribed ([see appendix for interview guide](#)).

To identify potential participants for both student groups, I employed several recruitment strategies. These included approaching classmates and other students located within the vicinity of the school's study areas, common areas, and lounges. This allowed me to leverage the convenience of their proximity to the research setting in order to extend an invitation to participate in the study.

The data collection for the study took place between December 2022 and late February 2023, during which I conducted a total of 11 interviews with participants who agreed to participate in the study. Among these participants, there were 5 MPA students and 6 MPH students. Content coding was used to do a thematic analysis.

RESULTS

After an analysis of the transcripts from the 11 interviews conducted, no discernible difference could be identified between the MPA and MPH Groups. The participants unanimously agreed that healthcare is the most important indicator of the health of a population. In addition, they strongly believed that individual behaviors and circumstances play a vital role in determining the overall health of a population. The participants' unwavering conviction regarding the impact of poverty, individualism, and social services on population health clearly demonstrated the position that these factors play a significant role in determining healthcare access and individual behaviors.

1. Health care is the primary predictor of health in a population.

Participants were asked specifically to talk about the correlation that exists between health and wealth, the theme that emerged centered around biomedicine and the ability to expend money and resources on healthcare services.

- MPA: "If I don't have income and like insurance stuff, I want to go see the doctor I can't."
- MPH: "This is because of access to health care resources."
- MPA: "We have created a system where access to the care that can keep you healthy, whether it be like preventative or in response to an illness or whatever. It is really out of reach for a lot of people."
- MPH: "More disposable income to spend on healthcare and health care services and more free time for doctor visits."

Both MPA and MPH students stressed the importance of healthcare as the major determining factor that produces the correlation between health and wealth. This was the majority consensus by far. Other participants talked about stress and other determining factors related to some of the poorest people in our society. Some participants referenced homelessness or the stress of living paycheck to paycheck as being important reasons why health and wealth are so highly correlated. Some participants also stressed the built environment and pollution. Participants believe that many factors complicate the ability to understand why health and wealth are correlated, but that these other, more tangential factors can be highly mitigated or eliminated with enough access to biomedical interventions.

2. Individual behaviors or circumstances are major predictors of population health outcomes and are specifically a concern among the very poor.

When prompted to discuss the possible reasons for the correlation between health and wealth, both MPA and MPH participants discussed the importance of individual behaviors such as diet.

- MPA: "Healthier outcomes come from a more focus on health and having more access to nutritious food and having time to worry about what you're putting in your body."
- MPH: "They also have access to better quality foods which can you know result in better health."
- MPA: "Fruits and vegetables are usually very expensive."
- MPH: "I am passionate about like the power of how food can be so health inducing."

To paraphrase other quotes there was a focus on the bottom end of the wealth distribution. Participants were primarily concerned with people who could not afford a diet considered healthy, this included the homeless. An MPA participant had spoken about the issues of high costs of specific healthy foods only, indicating that only the very poor would be excluded from buying them. An MPH participant was also concerned about the quality of the foods, indicating that price equals quality, and quality then equals health, with the poorest quality being consumed by the poorest people.

When participants were prompted to discuss broader populations and groups of people and what measurements they would use to predict the health of that group all participants again stressed the importance of biomedical markers such as blood pressure, body mass index, hemoglobin A1c, a marker of diabetes control, along with personal behaviors and circumstances.

- MPH: "Understanding and acknowledging identities and proportion of identities understanding the identities of different groups"
- MPA: "How much they go outside or exercise on the job"
- MPH: "Need health care records like average BMI, development of a public health surveillance data system."
- MPA: "I would want to measure how much fresh fruits get consumed, measuring how much the grocery sells vegetables."

Despite the somewhat different prompts, one to consider health and wealth, the other to consider key measurements, the answers of both MPA and MPH participants were similar and continued to stress biomedicine and individual behaviors.

Overall, biomedical markers, health care, and individual circumstances were the major predictors of health by all participants, regardless of their educational focus. Secondary, all participants indicated that the poorest among us, those who cannot afford food, quality food, and healthcare suffer poor health outcomes because of their lack of economic power to buy those things.

Searching all transcripts for the terms "health care," "health care access," "doctor," and other related terms showed that both MPA and MPH participants used them in equal proportions. Similarly, searching for terms such as "affordability," "access," "poverty," and other related terms revealed that both groups used these terms in equal proportions.

3. In the United States our individualistic culture is negatively affecting health of the population.

These participants pursuing degrees in public health or public policy often talked about complex social determinants that impact health outcomes. The determinants go beyond individual behaviors and medical interventions, and instead, include broader societal factors such as the responsibility of protecting each other as a debt owed to the society that we live in. Unfortunately, as these students pointed out, there is often a lack of this feeling of responsibility, and this has led to a measured decline in health in the US compared to other western nations. As a result, not only do health disparities exist in specific individuals, but our overall health has also declined. Despite the amount of discussion about healthcare and individual behaviors that mainly affect the very poor, other themes did emerge:

When participants were prompted to talk about the outcomes of the recent Coronavirus pandemic specific for the US population:

- MPA: “You gotta care about other people, in this country has fostered a culture that what’s best for me”
- MPH: “Like everyone just came together and like we had a better sense of community in the country, and if we actually cared about one another.”
- MPA: “Because the US is so unbelievably individualistic that that’s what was pushed to resolve the pandemic when in a lot of countries that do have more collectivist cultures take steps to protect loved ones.”
- MPH: “the politicization of COVID in the US made it really difficult for there to be like unified response.”

Although statements about better access to healthcare and the importance of vaccinations were still very prevalent, both MPA and MPH participants talked about the importance of social factors. The terms "collectivism" and "unification" and the care for others were expressed in both groups and scattered throughout each prompt but was an important factor particularly for the pandemic response. The subtheme of the importance of societal factors was the lack of it in the US, and a recognition of poor population health outcomes because of this.

4. The prevalence of social programs correlates with a healthy population.

All participants spoke generally about the lack of social programs as a core problem. No particular specific reason was discussed other than returning to the main themes about supporting the very poor and providing free health care services.

- MPA: “I think there’s less of a stigma in accessing these like government programs”
- MPH: “greater emphasis on safety nets that you know may relate to serve individuals that are unhoused”
- MPA: “I think we believed in larger government interventions, public health is a large part of that, right”
- MPH: “You know like social programs like reparations”

The participants mostly focused on the importance of providing social services and government programs to help those in need. They believed that more taxpayer money should be spent by the government to offer direct assistance to people. It was clear that they believed in ensuring that everyone had access to basic necessities such as housing and food, without specifically mentioning the concept of equal treatment for all.

DISCUSSION

Both graduate student groups showed a lack of awareness regarding the importance of socio-economic and political structures in shaping population health outcomes. Each discussion centered on health care and individual behaviors, failing to acknowledge some broader determinants of health. All participants did mention the complexities that influence health outcomes, but no attention was given to specifics. This oversight shows a lack of comprehensive understanding of the mechanisms that produce health.

Economic inequality and lack of social support significantly impacts access to basic needs. The discussions failed to recognize how these factors contribute to health disparities within the population. With no mention of social and economic gradient, or the significance in the slope of the gradient, both groups revealed a lack of awareness to address the root causes of the poor health of Americans.

Importance of Equitable Resource Distribution

No participant discussed the persistence of economic inequality and poor social conditions that not only affect socially disadvantaged groups but undermine the health of the entire

population. All participants focused more narrowly on food programs and housing services for the poorest members of the community. There was no mention of the nature of the gradients existing at each position on the line. There was no mention of how middle-class and upper-middle-class educated Americans suffer less good health than their counterparts in more equal nations. By neglecting this crucial aspect, the participants highlighted their lack of support for collective responsibility of society in promoting health and well-being, believing that all negative societal outcomes could be mitigated with a good diet and healthcare.

By emphasizing the role of healthcare and individual behaviors, both graduate student groups failed to recognize the significance of addressing structural inequalities and implementing policies that reduce disparities. Achieving improved population health requires a broader perspective that encompasses social services, policies, and strategies aimed at mitigating socioeconomic disparities.

Limitations

This study is purely qualitative and lacks more comprehensive mixed methods that can provide a statistical reference to criticize any divergence or acknowledge any convergence in the results.

This is a small study with inadequate sample representation. This study used convenience sampling, which lacks randomization thus cannot be generalizable.

Despite these limitations, this research offers valuable insights into complex thinking and general awareness. This research shows the subjective beliefs of MPA and MPH students. The interview style and contrasting groups examine contextual factors between different groups of graduate students.

CONCLUSION

Improving health education is crucial for addressing population health disparities and promoting a comprehensive understanding of the social and economic determinants of health. Public health and policy education programs should emphasize the significance of socioeconomic gradients and their impact on health. By providing a comprehensive comparison of other nations that have achieved better health outcomes, future professionals can gain valuable insights into different strategies and policies that contribute to improved population health. This approach allows for a deeper understanding of the economic factors that influence health in different countries. By incorporating such education into the curriculum, individuals can develop a broader perspective on population health and contribute more effectively to health improvement efforts.

Another critical aspect is the emphasis on maternal care and early childhood programs. Prioritizing maternal health and providing comprehensive support for mothers and young children can have long-term positive effects on population health. If students critically investigate the evidence on the imperative of early childhood programs, we can address the root causes of health disparities and improve overall public health.

Tax policies play a vital role in reducing economic inequalities and promoting a healthier society. By educating health and policy professionals on progressive tax programs, institutions of higher learning can contribute to an equitable distribution of the tax burden, with the wealthy contributing their fair share. Such policies may include higher tax rates for high-income individuals and corporations, closing loopholes that allow for tax avoidance, and implementing wealth taxes. The revenue generated from these measures can be used to fund social welfare programs, education, and infrastructure projects that benefit everyone and create opportunities for upward mobility. Moreover, targeted tax credits and incentives can be introduced to support low-income individuals and families, encouraging economic stability and reducing disparities. By adopting tax policies that prioritize economic equality, societies can take significant strides toward reducing income and wealth gaps, fostering social cohesion, and creating a more just and inclusive society.

In order to effectively implement these strategies and achieve meaningful improvements in population health, it is crucial to recognize the impact of social determinants of health and integrate the viewpoints of future professionals. The fresh insights, diverse backgrounds, and innovative ideas of these professionals can inform health improvement plans at the national and state levels. By educating them in social services, income support programs, and community development initiatives, we can create a more supportive and equitable environment for individuals and communities. Their perspectives can shed light on emerging challenges, propose creative solutions, and drive positive change in the healthcare and social service sectors, addressing both healthcare services and the underlying social factors that influence health outcomes. Through this integrated approach, we can work towards creating a more equitable and healthier society for all.

Health policy education curriculum

To strengthen health policy education and address population health disparities, curricula in health policy education programs should be reviewed and enhanced. It is crucial to emphasize the understanding of social and economic determinants of health, with a specific focus on socioeconomic gradients. Additionally, a comparative analysis of health outcomes across nations, rather than limiting the analysis to the US population alone, is necessary to gain valuable insights into different strategies and policies contributing to improved population health.

In order to foster a comprehensive understanding of public health, it is recommended to integrate public health education into the high school curriculum. By incorporating public health topics into various subjects such as science, biology, social studies, and physical education, students can develop a foundational knowledge of population health, disease prevention, and health promotion. This multidisciplinary approach to health education ensures that students receive a well-rounded understanding of public health principles and practices.

It is important to acknowledge the influence of the media in shaping public opinion and political narratives. While the media plays a crucial role in disseminating information, it is essential to be aware of potential biases and agendas that may exist within media outlets. Recognizing the media's impact on public perception and policy decisions allows for a more critical analysis of the information presented, promoting a well-informed and balanced understanding of health-related issues.

The decline in life expectancy in the United States calls for urgent action in the realm of public health. By implementing these recommendations, we can foster a transformative shift towards addressing population health disparities, promoting health equity, and ultimately reversing the trend of declining life expectancy.

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APPENDIX

<u>Interview Protocol:</u>
<i>Exploration questions:</i>
<ul style="list-style-type: none">• Why are health and wealth so highly correlated.
<ul style="list-style-type: none">• How do you Feel COVID went in the US
<ul style="list-style-type: none">• Why do you think countries like Japan, South Korea, Spain, Norway and Switzerland have could have far better life expectancy than the US?
<i>Insight Questions:</i>
<ul style="list-style-type: none">• What do you need to measure the health of a population, what would you want to know?
<ul style="list-style-type: none">• Blue or liberal states have different health outcomes from red or conservative states, why do you think these differences exist?
<ul style="list-style-type: none">• How do popular media like news and entertainment affect population health?
<i>Action questions:</i>

- Around the 1960s the US population lived longer than any other, how do we return to that status?

- How could we have been better prepared to handle COVID?

- How should we treat population health and individual health differently?

Ordered questions:

Q1: Why are health and wealth so highly correlated?

Q2: Blue or liberal states have different health outcomes from red or conservative states, why do you think these differences exist?

Q3: How do you feel COVID went in the US

Q4: How could we have been better prepared to handle COVID?

Q5: Why do you think countries like Japan, South Korea, Spain, Norway and Switzerland have could have far better life expectancy than the US?

Q6: How do popular media like news and entertainment affect population health?

Q7: What do you need to measure the health of a population, what would you want to know?

Q8: Around the 1960s the US population lived longer than any other, how do we return to that status?

Q9: How should we treat population health and individual health differently.