



In the Literature

EVIDENCE INTO POLICY AND PRACTICE? MEASURING THE PROGRESS OF U.S. AND U.K. POLICIES TO TACKLE DISPARITIES AND INEQUALITIES IN HEALTH AND HEALTH CARE

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Faced with mounting evidence of wide disparities in health status and health care across different population groups, policy-makers in both the United States and United Kingdom seek to close the gaps. Yet there is little proof of the effectiveness of current policies and interventions aimed at tackling these problems.

A Commonwealth Fund-supported study analyzes the two countries' efforts to identify what works and track progress. In "[Evidence into Policy and Practice? Measuring the Progress of U.S. and U.K. Policies to Tackle Disparities and Inequalities in U.S. and U.K. Health and Health Care](#)," (*Milbank Quarterly*, Mar. 2006), lead author and former Harkness Fellow (2002–03) Mark Exworthy, Ph.D., of the University of London and colleagues suggest these new tracking efforts reflect heightened interest among government and health officials to act on disparity data. The report outlines various U.S. and U.K. measurement mechanisms now in place and details the challenges faced in devising and using such tools.

U.S. Mechanisms

The range of tools used to track the battle against disparities seems as wide as the problems themselves. In the United States, mechanisms include national public health goals and report cards compiled at every level of the health system.

For example, the federal government's Healthy People 2010 initiative aims to eliminate health disparities as part of its overall mission to improve health status

and increase lifespan for all Americans. Indicators focus on 10 goals—such as physical activity, obesity, tobacco use, and access to care—and the program's built-in tracking mechanism sets targets, then assesses progress toward the objectives.

An increasingly common way of measuring the progress of health policies is the report or scorecard. Federal agencies, state and local governments, as well as individual health plans, have all produced report cards that identify and monitor health disparities. For example, the *National Health Care Disparities Report*, published in 2003 by the federal Agency for Healthcare Research and Quality, documented disparities in access to care as well as the use, cost, and quality of services. It aimed to guide policy-making in designing strategies to eliminate disparities, but became controversial after key findings—including the notion that health care disparities are a national problem—were omitted from the final report.

To produce a state report card, researchers in 2005 analyzed health policies for all 50 states in terms of capacity, infrastructure, and activity relating to health care disparities. They found substantial variation among geographic regions. Thirteen states showed a substantial difference in insurance coverage by race and ethnicity, and nearly half the states used three or fewer racial/ethnic categories in their data collection systems.

On the local level, in 2002, the San Francisco Department of Health published the first local public health report, tracking six

indicators of maternal and infant health across three racial and ethnic groups. The results highlighted the enormous challenges facing the city’s policymakers and practitioners in reducing disparities.

The final example of report cards concerns health plans, which are increasingly focusing on disparities among people with the same health coverage. One study of eight health care plans found disparities across groups of 5 percentage points or more on specific HEDIS clinical quality measures. These report cards may encourage initiatives by the insurers to address disparities, say the authors. Aetna, for instance, says it plans to use its data to develop educational and treatment programs to narrow the gap.

U.K. Mechanisms

“National inequality targets”—including goals for life expectancy and infant mortality—were first set by the U.K.’s Labour government in 2001. These targets are linked to specific interventions—such as strengthening primary care in disadvantaged and underserved areas, boosting flu shot rates, improving maternal nutrition, and providing better postnatal education and early development support. A special government research group monitors change across the indicators. A report published in 2003 showed “significant” or “slight” improvement on half of 12 indicators tracked.

At the local level, organizations can choose to use indicators and monitor their progress, but the fact that this is not obligatory makes it difficult to ensure accountability and make comparisons. Separately, an independent regulatory agency—the Healthcare Commission—reviews health providers’ progress toward national goals, such as reducing levels of heart disease. A recent report noted progress but also documented regional variations in care and called for more resources dedicated to those in most need.

Conclusions

In both countries, measurement tools are relatively new and not yet widely used. Therefore, the researchers note, it is too soon to predict how well any of these mechanisms work in helping policymakers and practitioners translate data about disparities into effective interventions. Many obstacles hamper this effort, including inadequate or poor-quality data, the high costs involved in data collection, coordination problems associated with efforts undertaken at different system levels, and fear of public disclosure.

Ultimately, coherent and coordinated strategies to reduce disparities will depend on the validity of these measurement mechanisms. “In both the United States and the United Kingdom, keeping track of progress in tackling these seemingly intractable problems is essential to assessing the extent to which evidence has been translated into policy and practice,” the authors conclude. “Both countries, however, still have a long way to go.”

Facts and Figures

- Life expectancy for an African American male in the U.S. is 66 years, compared with 74 for a white male. In the U.K., the gap in life expectancy at birth for men between the richest 10 percent of areas and the poorest 10 percent is six years; for women, the gap is three years.
- In the United States, 34 states have an office of minority health, although their budgets vary significantly.
- In the U.K., more disadvantaged individuals—in terms of income, education, and employment—have lower than expected use of health services.