



Linda S. Gottfredson,
Professor, School of
Education
*University of
Delaware, Newark, DE,
USA 19716*

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journal:
[Re: Thinking More
Deeply About Health
Disparities](#)

In their editorial, "Left Behind: The US Hurricane Puts the Health Effects of Poverty and Race in Plain View" (BMJ 2005; 5: 440), Atkins and Moy ask Americans to think more deeply about how to create more equitable and healthier communities. Their six strategies for better health care might indeed improve overall health in communities of all sorts, but they would do little to narrow race and class disparities in health.

Although health disparities within nations are still routinely attributed to differences in wealth and social status, health scientists have noted for decades that differences in material resources and access to health care cannot explain three remarkable facts about group disparities in health: (a) disparities are ubiquitous, regardless of country, health system, decade, disease, organ system involved, and treatability of disease, (b) health is better at successively higher levels of socioeconomic status, even beyond the level of resources required for good health and health care, and (c) health disparities increase when health information and medical care become more widely available (as happened, for instance, when the media alerted the public to the dangers of smoking and when Great Britain instituted free national health care in the 1950s).¹

Investment in better health care matters, of course, and it raises average levels of health in all groups. But it simultaneously creates greater variation (disparities) in health, because some individuals are better able to capitalize on the new resources. Health literacy research and related studies have shown that an individual's mental resources are critical for effectively exploiting available care. Persons who learn and reason poorly practice healthy behaviors less often, seek less preventive care (even when free), know fewer signs and symptoms of disease, and adhere less effectively to treatment regimens. Good health also depends in large part on apt self-care: preventing illness and injury, and exercising independent judgment in the daily self-management of chronic diseases such as diabetes and hypertension.

A seminal study of health literacy in two urban hospital outpatient populations (N=2659) found, for example, that 26% of patients did not understand information about when a next appointment was scheduled and 42% did not understand the directions for taking medicine on an empty stomach.² Another found that half of insulin-dependent clinic patients with "inadequate" health literacy did not know the signs of high blood sugar, low blood sugar, or what to do about them.³ The US Department of Education's 1993 National Adult Literacy Survey (NALS) documented very large race and class differences in

success at performing comparably elementary reading and reasoning tasks in daily life.⁴

Epidemiologists point to variation in both exposure and susceptibility in explaining patterns of disease. So, too, do health disparities depend on differences in both access to care and relative ability to exploit it. Reducing health disparities therefore requires not just making health care more equally available, but also reducing the cognitive hurdles which, for many individuals, stymie its effective use.

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4. Kirsch IS, Jungblut A, Jenkins L, Kolstad A. Literacy in America: a first look at the results of the National Adult Literacy Survey, 1993. Princeton, NJ: Educational Testing Service.

Competing interests: None declared