Community Preventive Services

Do We Know What We Need to Know to Improve Health and Reduce Disparities?

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Healthy People 2010,[1] which lays out goals for the health of the U.S. population in the next decade, establishes two overarching aims: (1) to increase the quality and years of healthy life, and (2) to eliminate health disparities. Unfortunately, these aims are often in conflict. Many improvements in health care, including preventive care, that increase quality and years of healthy life will increase, not decrease, disparities. New technologies and information about prevention are more available to those with more education, income, and other resources. This differential access allows the more advantaged to enjoy the benefits more rapidly compared to the rest of the population. Thus, while improved health care and prevention have contributed to dramatic drops in mortality over time, these benefits have not been equally conferred, and larger gradients in mortality exist now than did earlier.

Health promotion efforts are contributing to this combination of increasing disparities in light of improving overall health. For example, the more educated have quit smoking in far greater numbers than those with less education. As a result, there are now greater disparities by education in smoking rates, as well as increasing disparities in smoking-related illnesses and mortality. This oft-repeated pattern poses a dilemma to those who wish to accomplish both aims set in *Healthy People 2010*.[1] One response to this dilemma is to move upstream to address more "fundamental" causes of disease and disparities.[2] These factors may be particularly important in affecting morbidity and mortality among those with fewer personal resources. The reports of the Task Force on Community Preventive Services (the Task Force)[3–5] target areas where improvements could act both to improve health and to reduce disparities. One domain—the provision of culturally competent health care—would improve the quality of care received by those who are from disadvantaged groups. The other domains—neighborhood living conditions, early childhood education, employment and working conditions, and civic involvement—should have broad effects on health for those who, in the absence of an intervention, will have less access to education, occupational opportunities, housing, and community resources.

Given the importance of these social domains for health and reducing disparities, it is disappointing that the Task Force could conclude relatively little about effective interventions within them. The absence of sufficient data led to limited findings in each of the reports in the current issue. There were some positive findings regarding the impact of rental vouchers on improved household safety, and on the impact of early childhood education on cognitive and school-related outcomes, but no conclusions could be reached about the impact of mixed-income housing on any outcome, of rental vouchers on youth risk behavior or on mental or physical health, of early childhood education on child health screening, or of culturally competent health care on any outcome. As the authors point out, this is not because there is evidence that these interventions are not effective. Rather, it is that there is insufficient evidence to conclude whether they are or are not effective. Similar problems have occurred in other domains that the Task Force has addressed. In the area of oral health, for example, Capilouto[6] noted that more than three fourths of the studies examined failed to meet criteria for inclusion.

It is understandable that there are not better data on community interventions. Randomized trials, which provide the strongest data, are challenging to conduct on community-level variables where there may be discomfort about random assignment and problems in the scope of units to be randomized. At the same time, we need to press for better studies. Far too many interventions are implemented without a correspondingly strong evaluation, losing an opportunity to inform communities and policymakers about what is worth doing. The Task Force identified nearly 200 interventions. How will communities or policymakers decide which are worth the investment? The Task Force's careful and thorough approach reveals just how little we can currently conclude. This calls into question popular wisdom that we do not need research because we know what works—we just need to do it. Unfortunately, we do not know what works. We especially lack

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data on cost–benefit ratios that would help to set priorities.

This call for better data is not intended to stifle action on policies that should work. In the absence of definitive studies, we will have to make do with supportive research and theory. We can learn some things from interventions even if they are not randomized experiments. However, social interventions are expensive, and policymakers will want to know that the costs can be justified by expected results. To address these questions, we need more definitive data than now exists.

There may be creative approaches to randomizing exposure to social innovations. Such interventions often involve providing scarce resources. In such circumstances there may be agreement that a lottery (i.e., random assignment) is the fairest way to allocate such resources, which provides an opportunity for evaluation. This approach was taken, for example, in Moving to Opportunity,[7] which is yielding valuable information about the impact of housing and neighborhoods on health and well-being. In other instances, time delays in implementation may allow for random assignment. For example, the PROGRESA program,[8] a massive antipoverty program in Mexico, could not be implemented at the same time in all areas. It was phased in, allowing random assignment of villages, and yielding powerful data on the impact of the program on health and well-being. Undertaking rigorous evaluation requires creativity, political skill, and resources. While asking researchers to be more rigorous, we must also ask private and public funders to provide the resources to allow for adequate evaluation. We need this so that over time we will have better guidelines for policy and intervention. Given the upsurge in interest in social determinants of health and the number of interventions being undertaken in many communities, it would be a major loss if a decade from now we still could not say which interventions will be most effective in improving health and reducing disparities.

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