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Health Disparities in the USA

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日本の健康格差：医療者は何をすべきか

Health disparity in Japan: What should medical practitioners do?

東京大学 大学院保健社会行動学　近藤　尚己

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近藤　尚己
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対象者　医師・後期研修医（卒後 3 年目以上）・初期研修医（卒後 1-2 年目）・学生・その他
Target　Doctor・Senior resident(3+years after graduation)・Resident(1-2 years after graduation)・Medical student・Other

Health disparities among populations in the USA have been well documented for many years. The causes are complex and include racial/ethnic, socioeconomic, geographic and genetic factors, among others. Awareness of the problem has been improved thru rigorous research and analysis and has been highlighted as a key issue to address in order to improve the USA's comparative world health rankings. The role of implicit bias among physicians and other healthcare providers is also a dimension that contributes to disparate medical treatment. (Wayne J. Riley)

公衆衛生では、健康は多重レベルの要因で決まると考える。すなわち、遺伝子や生活習慣という個人レベルの要因から、人間関係、所得、職業、ひいては政策や文化、景気動向といったマクロな要因までが重層的に作用して健康に影響を与える。社会的なマクロな要因が整わなければ、自身の健康に気遣うだけのゆとりは生まれない。臨床現場では多くの医師が治療のアドヒアランスが低い、健康意識の低い患者に悩まされた経験があるだろう。そのような患者の多くは貧困や失業、孤立など社会的なストレスを抱えている。日本でも、近年、生活不安を抱える人が増え、健康格差の拡大が懸念されている。

貧困層が不健康であることには確固たるエビデンスがある。貧困であれば、まっとうな生活を営むために必要なバランスの取れた食事や運動、そして最低限の医療へアクセスできない。そのような物質的側面だけでなく、貧困による社会的孤立や経済不安からくるストレスが我々の身体や行動様式に様々な影響を与えることが知られている。したがって、例えば生活保護制度などで貧困層にお金を配れば健康格差がきれいに解消されるというようなことは望めない。健康格差を是正するには、ストレス下にある人々がどのような行動様式をとるのか、といった学際的な行動科学の知見を活かして、健康を意識しなくても、「おのずと」健康的な行動がとれるような環境整備や「しかけ」作りが求められる。

医療の役割は大きい。医療機関は、地域や患者の社会背景を客観的に踏まえて（すなわち地域診断および患者の社会的診断）、医療の質の絶え間ない改善を行うべきだろう。社会背景についての標準問診票の作成や医療機関を中心とした地域疫学調査などの活動が日本でも広がってきている。そのための全国規模の医療機関ネットワークも昨年立ち上がった。国勢調査を含め、社会調査のほとんどで、社会弱者のデータ収集が年々困難になってきている。そのような人々は調査に関心がなかったり、そもそも住所がなかったりするためだ。一方医療機関には、そのような患者のデータが豊富に存在する。社会弱者が体をこわして最後に運び込まれる場所だからだ。社会弱者の健康状況を把握するためにも、医療機関というフィールドは極めて重要である。

いまこそ、医療関係者と疫学や公衆衛生の研究者、そして地域の保健活動の担い手がタッグを組んで健康格差対策に取り組むべき時だろう。

Public health considers health to be determined by multilevel factors. They comprise individual-level factors (i.e., genomic and behavioral factors) and more social factors (e.g., interpersonal relationships, income, occupations), as well

as more macrosocial conditions (e.g., culture, governmental policies, economic fluctuations). If those social conditions are not adequate, it is very difficult for individuals to have sufficient motivations for promoting their own health. In clinical settings, medical practitioners are distressed every day by non-adherent chronic disease patients. Many of them are socially stressed due to poverty, unemployment, and isolation. Consequently, health disparity between the rich and the poor is widening in Japan, similar to many other countries.

The link between the poor and inadequate health cannot be denied. Poverty impedes the access to quality food, exercise opportunities, and necessary medical care. In addition to these materialistic issues, psychosocial stresses due to financial concerns and social isolation are known to affect our health condition and behavioral patterns to a considerable extent. Hence, simply establishing an income redistribution system, such as social security subsidies for the poor, is not good enough. To amend health disparity issues, we should design a social environment in which any people, regardless of their social statuses, can unconsciously select healthier choices and improve their health conditions. Improving our cross-disciplinary knowledge base of human behavior, especially for those who are under chronic stresses, should help design those "architectures" in our society.

The role of medical practitioners is enormous. Medical institutions in each communities should continuously improve their quality of cares according to the needs of local residents and patients in light of their social backgrounds. Those activities are being started in Japan. A good example would be a nation-wide initiative to make a standard interview sheet on patients' social backgrounds. A national network for clinical health promotion was established last year. Medical institutions have great advantages in collecting data of the socially vulnerable people. Although those people are less likely to participate in such health/epidemiologic surveys on their own initiative, there are still lots of opportunities to collect the data concerning those people in hospitals, as they visit ERs at the very last minute they become seriously sick.

It is time physicians, epidemiologists, public health practitioners, and citizens should collaborate and tackle the issues of health disparities prevalent in Japan. (Naoki Kondo)