COLD TRUTHS ABOUT CLASS, RACE, AND HEALTH

David R Williams and James Lardner

SUPPOSE YOU WERE PLAYING A GAME of word association, and someone said "health." If you answered "doctor" or "medicine" or "hospital," you would be thinking the way most Americans think. It is the way we have been taught to think. The job of the health reporter on TV, after all, is to cover the latest miracle drug or surgical procedure. A government agency with *health* in its name is one that sets the rules or pays the bills for medical treatment. In the world of charitable organizations, *health* generally means the search for a cure to a dreaded disease.

Medicine has worked wonders in the past two centuries. But medicine has not been the driving force in the progress of human health. Most of the gains in overcoming illness and extending life, researchers largely agree, can be traced to improvements in hygiene and nutrition and rising standards of living, not to health care per se. During the 1853–54 cholera epidemic in London, John Snow drew a map of cholera cases and noticed a cluster around a water pump on Broad Street. By removing the pump handle, he controlled the outbreak—three decades before Robert

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Koch discovered the bacterium that causes that disease. In Britain overall, the death rate from tuberculosis fell from four thousand per million in 1828 to four hundred per million in 1948, which is roughly when streptomycin and other treatments began to be applied on a wide scale. In the United States as well, the use of vaccinations, drugs, and surgical remedies typically came decades after a marked decrease in mortality from the conditions they were designed to address.

"It is one of the great and sobering truths of our profession that modern health care probably has less impact on the population than economic status, education, housing, nutrition and sanitation," Theodore Cooper, assistant secretary for health while Gerald Ford was president, observed in 1976. "The notion of high-quality medicine as the answer to illness," Cooper said, is "a fiction, a hoax."

Sadly, there is no better proof of this than the health record of the United States itself. In 2001 we had a higher per capita gross domestic product than any other country except Luxembourg, and devoted the highest proportion of our GDP to health care—13.9 percent, or nearly $4,900 per person. Our closest competitor, Switzerland, spent only 68 percent of that. The 293 million people who call themselves Americans now account for roughly half the money that goes for doctors, drugs, and other health expenses on a planet of nearly 6.4 billion human inhabitants. Line up the nations in order of longevity or infant mortality, however, and the United States does not even make the top twenty. The places we trail, in addition to the usual suspects—Sweden, Norway, Switzerland, and Canada—include Greece, Hong Kong, and Martinique.

today than they were in the 1950s—holds for overall mortality, heart disease, and cancer.

This summary record masks short-term shifts with interesting historical parallels. For example, the Council of Economic Advisers documented economic gains for blacks relative to whites during the 1960s and early 1970s, during and after the civil rights movement and the advent of expansionist government programs. Between 1968 and 1978, health indicators for blacks improved relative to whites. Economic progress stalled in the mid-1970s, and by the 1980s, health improvements for blacks also slowed.

While the press has largely ignored the issue of health disparities, sociologists, epidemiologists, public health experts, and demographers have been hunting for an explanation. In fact, the puzzle has begun to resemble one of those Agatha Christie–type whodunits in which the cloud of guilt keeps shifting from one suspect to another.

SUSPECT NO. 1: HEREDITY AND BIOLOGY

When race enters the picture, can a genetic explanation be far behind? Between groups of people who look different, could there be differences in physical characteristics that predispose them to the diseases they suffer more frequently? It seems logical, but the research tells a very different story. For example, rates of hypertension among people of West African ancestry vary sharply, depending on where they live. Blacks in West Africa are not especially prone to hypertension. (In fact, whites in the United States have higher blood pressure, on average, than West African

blacks.) Hypertension levels were highest among blacks in the United States and intermediate among three black Caribbean groups.

High blood pressure is only one of a number of health conditions that tend to develop in the second or third generation of immigrant populations, but are rarely found among immigrants themselves. In Latinos, the problems that follow this pattern—their frequency increasing with the length of stay in the United States—include infant mortality and low birth weight.

Genetics obviously can't explain this. In fact, genetics can't explain much of anything to do with race, which is a socially constructed rather than a biologically based concept to begin with. The fact that you and I know what race we belong to tells us more about the society we live in than about our physical makeup. Some white people are more similar genetically to black people than they are to other white people. Race is truly a pigment of our imagination.

SUSPECT NO. 2: ACCESS TO CARE

People without health insurance are far less likely to seek care, and less likely to get it if they seek it. About forty-five million Americans, or nearly 18 percent of the nonelderly population, were uninsured in 2003—up from forty million in 2000. Most of the increase is due to erosion of employer-based insurance, which covered sixty-six million people in 2000 and sixty-two million in 2003. Of the uninsured, twenty-six million were full-time workers and 56 percent of those were poor or near poor. The lower you go down the income ladder, the higher the rate of

uninsurance. In 2003, 36 percent of those under the poverty line and another 30 percent of those with less than double a poverty level of income had no coverage. While the uninsurance rate for whites was 13 percent, the rate for Asians was 20 percent; for blacks, it was 21 percent; and for Latinos, 34 percent.

Because poor people and people of color are more likely to lack insurance, they are also more likely to lack regular care. That, in turn, means that health problems often go undetected when they would be most amenable to successful treatment. Children may be especially vulnerable to these effects: among poor children under age six, 21 percent of those without insurance lack a regular source of care, compared with only 4 percent of those with insurance.

But insurance isn't the only determinant of access. Some communities, particularly those in isolated rural areas and inner-city neighborhoods, have too few providers generally or too few who will care for low-income people with or without insurance. For these reasons, an estimated thirty-six million Americans lack access to a primary care provider. Proximity to transportation, hours of service (including evenings and weekends for those who work), waiting times, and availability of translation/interpretation also affect access. Perhaps the most blatant inequalities are found where residential segregation by both income and race fosters multiproblem areas with unsafe housing, low-performing schools, high crime, and an absence not just of health care but of other civic services. Health-status measures in such areas can be as poor as, or poorer than, those in Third World countries.

Even when the availability of care is removed from the equation, though, the link between socioeconomic status and health

remains powerful. In fact, we owe much of our knowledge of this relationship to a body of research—the Whitehall Studies—in which health care was virtually a nonissue because the subjects all enjoyed access to Britain's no-questions-asked national health insurance. Since 1967, a team of researchers based at University College London has been engaged in a massive effort to track the health of more than eighteen thousand civil servants. Even among this fairly elite group—people with high job security, and the means to feed and house themselves decently—health outcomes turn out to follow income and rank closely.

SUSPECT NO. 3: QUALITY OF CARE

Obviously, not all health care is equal. In fact, in the United States today, it is shamefully unequal. At one extreme stand the emergency rooms and old-style outpatient clinics where patients wait on hard benches for hours to see a different provider each time they come, with little continuity or acknowledgment of barriers to communication, and a high chance of being used as "teaching material" for untrained students. At the other extreme are the new luxury wings of hospitals where the nurses and aides wear hotel livery, the latest films are shown, and gourmet meals are delivered. The differences are not just in ambience or bedside manner; lower-income patients may receive lower-quality treatment and die as a result. Imagine two car accidents, identical in all respects but one: Victim A has insurance, Victim B does not. Somewhere between the crash site and the intensive-care room, the health care system starts treating the two cases differently. The end result is a 37 percent better chance of survival for Victim A.

Here, too, class is compounded by race. Consciously in a few cases, unconsciously in many more, doctors and administrators make decisions that lead to substantially worse results for people of color. While African Americans suffer strokes as much as 35 percent more often than whites, they are less likely to receive major diagnostic and therapeutic interventions, be screened and treated for cardiac risk factors, given appropriate cardiac medications, or undergo bypass surgery. With or without insurance, minorities are less often screened for cancer (where they have a 30 percent higher death rate), placed on waiting lists for kidney transplants, or given state-of the-art treatment for HIV.

But as important as differences in quality of care are, they still don't explain all of the class or race differential in health status. So the search continues.

SUSPECT NO. 4: LIFESTYLE

If doctors aren't responsible, how about patients? To what extent can lower-income and minority people be said to bring their health troubles on themselves? In the 1970s, when Jimmy Carter was president, the government set forth an ambitious program known as Healthy People to establish goals and track improvements, with campaigns to promote healthy lifestyles as a major component. Commenting on the results of these efforts two decades later, the Department of Health and Human Services noted that "only the higher socioeconomic groups have achieved or are close to achieving the target, while lower socioeconomic groups lag further behind." This was true for major causes of death as

well as for such behaviors as smoking and receipt of preventive care. You don't need a huge research grant to figure out that the people running laps in the park at dawn are more prosperous, on the whole, than the people eating French fries at McDonald's. In fact, America is well on the way to transforming obesity from a disease of affluence to a disease of poverty.

If low-income Americans are less healthy, maybe it's because they pay less attention to the proselytizing. But we might do better to ask why. Not surprisingly, the reasons tie back to socioeconomic status. If the U.S. Department of Agriculture dietary guidelines are tough for middle- or upper-class people who shop in supermarkets and specialty stores well stocked with produce and fresh meat and fish, and who have the time and money to plan their meals, how much harder must they be for people who live in neighborhoods where most of the commercially available food comes from fast-food restaurants and high-priced delis and convenience stores? Many of those same neighborhoods, and the people who live in them, have more liquor stores and more smoking and alcohol ads targeted at them. And how realistic is it to recommend sixty minutes of daily exercise to someone who comes home exhausted from working two low-wage jobs, who once home has to care for children or elderly relatives, and who has no safe place to walk or run because crime in her neighborhood is uncontrolled?

"When you have eliminated the impossible," Sherlock Holmes liked to say, "whatever remains, *however improbable,* must be the truth." If we can't blame the problem on heredity or insurance or doctors or ourselves, what is it about socioeconomic status

itself that damages people's health? The British epidemiologist Richard Wilkinson (whose ideas are most recently articulated in *The Impact of Inequality: How to Make Sick Societies Healthier*) sees the problem as one of inequality translated into social structure—the sense of standing low on a tall ladder.

Among the developed nations, as Wilkinson points out, the least healthy tend to be the most unequal. Once a society achieves a basic threshold of prosperity, he argues, its overall health appears to depend less on national or per capita income than on the way income is apportioned. Thus, Greece, where GDP per capita is less than half that of the United States, outdoes us in longevity. By the same token, Costa Rica, a relatively egalitarian nation, has managed to achieve an average life expectancy of 77.3 years despite a per capita GDP less than a fifth of that in the United States.

Scholars have taken issue with some of Wilkinson's data, and, as he acknowledges, there are no global rules for collecting income and wealth statistics or measuring inequality. Since Wilkinson first advanced his theory, however, a number of other researchers have arrived at similar conclusions by different paths. Research teams in the United States have found correlations between inequality and health at the state and city levels. The 25 percent of metropolitan areas with the least income inequality have mortality rates significantly below the rates of the 25 percent with the greatest inequality. Inequality and poverty together, according to George Kaplan of the University of Michigan and his colleagues, appear to impose a statistical "burden of mortality" greater than that of lung cancer, AIDS, diabetes, suicide, homicide, and automobile accidents combined. While the reasons may be debatable, many health researchers see inequality as

a source of stress, which can weaken arteries and immune systems, making people more vulnerable to all manner of sickness.

Some view Wilkinson's focus on inequality as a distraction from what they see as the clearer and less sensitive question of poverty. But the poverty-versus-inequality debate itself can draw attention away from a point on which both camps now agree: in today's America, the economic givens of early childhood are frighteningly good predictors not only of access to health care, but of lifelong health as well. Using the Green Line of Washington's Metro system to illustrate, the epidemiologist Michael Marmot points out that in a forty-five-minute ride from Southeast DC to suburban Maryland, you can cover a fifteen-year gap in life expectancy "between poor blacks at one end of the journey and rich whites at the other."

Poverty, low social status, racial/ethnic disparities, and economic inequality are the Axis of Evil of health in today's affluent societies. Because their influence is deeper and more powerful than medicine or biological science can fully comprehend, we must look beyond medicine and biology for answers. To reduce health disparities, we need to incorporate questions of economic and social policy into our conception of health policy. Spending more on health care overall is obviously not sufficient; we already spend more than other nations, and more each year than the year before. Reducing disparities in access to care and quality of care would be more to the point; but reducing economic inequality (by investing more in education, child development, and the improvement of living standards, working conditions, and neighborhood environments) might make more of a health difference than anything we can do within the health care arena itself. To

put the proposition another way, as Americans learn to tolerate higher levels of economic inequality, we are not simply deciding to live with steep material differences. We are making our peace with the idea of large, and growing, gaps in health between economic winners and losers.