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Commentary

Health inequalities by class and race in the US: What can we learn from the patterns?

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Throughout most of the world, the term "health inequalities" generally refers to differences in health by social class, unless specified otherwise. In the United States, however, the most comparable term, "health disparities", has generally referred to differences in health by race or ethnic group. Historically, public health data in the U.S. have been reported by race and far less frequently by class, reflecting a deeply-rooted belief that we have an essentially classless society. That notion may seem preposterous to anyone familiar with the wide and widening economic inequalities within the US. Nevertheless, the belief that this is a classless society is pervasive. It reflects long- and deeply-held beliefs in the U.S. as "the land of opportunity," where hard work and ability almost always pay off, and, conversely, those who are unsuccessful must not have worked hard or been smart enough. Inadequate consideration of socioeconomic factors is a massive obstacle to understanding the role of non-medical influences on health. Also, it reinforces scientifically unfounded assumptions about the role of genetic differences in racial or ethnic disparities in health, a convenient justification for accepting racial disparities in health, wealth, and well-being as inevitable.

The patterning of health by race/ethnicity and class in the U.S

Large and persistent racial or ethnic disparities in health in the U.S. have repeatedly been documented, with Blacks and American Indians generally having the worst, and Whites generally the best health; Latinos (particularly some subgroups) and some Asian subgroups also have worse health on some measures (The Office of Minority Health, 2010). Although less information on socioeconomic inequalities in health has been available routinely in the U.S. than in many other affluent countries, recent data have demonstrated that, as in Europe, health inequalities by class in the U.S. more often than not follow stepwise gradient patterns, with health improving incrementally with higher income or educational levels (the standard socioeconomic measures in the U.S.) (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; Minkler, Fuller-Thomson, & Guralnik, 2006). Gradients are seen both overall and within racial or ethnic groups – often among non-Latino Whites and Blacks (hereafter: Whites and Blacks), and less consistently among Latinos. Striking gradients in self-rated adult health according to educational attainment have been observed *within* Blacks, Latinos, American Indians/Alaskan Natives, Native Hawaiians/Pacific Islanders, other Asians, and Whites, examining each racial/ethnic group separately (Braveman et al., 2010).

The incremental socioeconomic gradients within multiple different racial/ethnic groups make it clear that socioeconomic inequalities cannot be reduced to racial/ethnic differences, although conflating class with race still is widespread in U.S. health

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research. For many health outcomes, large racial/ethnic differences have disappeared or markedly diminished after controlling for socioeconomic factors (Braveman, et al. 2005; Glymour, Avendano, Haas, & Berkman, 2008; LaVeist, Thorpe, Galarraga, Bower, & Gary-Webb, 2009; Louie & Ward, 2011). Some racial/ethnic differences in health have persisted, albeit attenuated, after adjustment for socioeconomic factors. Black–White disparities in preterm birth – a predictor of infant mortality, child development, and adult chronic disease – are a notable example. Overall, the incidence of preterm birth is around twice as high among Black compared with White babies (Institute of Medicine, Committee on Understanding Premature Birth and Assuring Healthy Outcomes, & Board on Health Sciences Policy, 2007). Among both Blacks and Whites, preterm birth rates decline with higher maternal educational attainment or income, but at each socioeconomic level, a Black–White disparity persists. The relative Black–White disparity, however, is highest among births to higher-education/-income women and lowest among women of lowest income or education levels (Braveman, 2011). Furthermore, despite being generally less advantaged socioeconomically than Whites, Black immigrants to the U.S. from Africa or the Caribbean have relatively favorable birth outcomes, more like those of U.S.-born Whites than those of (U.S.-born) African Americans (Acevedo-Garcia, Soobader, & Berkman, 2005; David & Collins, 1997).

Explaining the patterns

What could explain the observed patterns by class and race, in general and for preterm birth? A large body of international literature points to multiple material and psychosocial advantages/disadvantages associated with income, education, wealth, occupation, and other markers of socioeconomic position that could plausibly explain the observed socioeconomic gradients. Material advantages would include having sufficient economic resources to be able, for example: to experience less stress in meeting daily needs for transportation, child care, or food for one's family; or to afford a nutritious diet or to live in a neighborhood with healthier food choices, low crime rates, and more accessible recreational options. Psychosocial advantages of higher socioeconomic position could include, for example, control over one's work (Marmot, Bosma, Hemingway, Brunner, & Stansfeld, 1997) or perceiving oneself in a relatively high position in a social hierarchy (Singh-Manoux, Adler, & Marmot, 2003); conversely, psychosocial disadvantages could include feelings of discrimination or social exclusion (Williams & Mohammed, 2009). Disparities in both material and psychosocial advantages during women's entire lives, particularly during childhood, are plausible contributors to both socioeconomic and racial disparities in preterm birth (Lu & Halfon, 2003).

The observed patterns make a genetic explanation for the racial disparities in preterm birth doubtful. The better outcomes among Black immigrants and the wider racial disparity among more socioeconomically advantaged women suggest social phenomena. Gene–environment interactions cannot be ruled out, but the policy implications would be to address the features of the social environment triggering the expression of otherwise latent deleterious genes.

The worse health on most health measures seen among Blacks and American Indians reflects in part their disproportionate representation among lower income/wealth and education groups, and in disadvantaged neighborhoods, which would be expected to have worse health based on unfavorable socioeconomic conditions at the individual, household, and neighborhood levels. The disproportionate representation of Blacks, Latinos, and American Indians among the socioeconomically disadvantaged reflects what has been called "structural racism" – a self-perpetuating form of bias built into structures and institutions, even when conscious intent to discriminate is no longer present. For example, a legacy of racial residential segregation continues to track many Blacks and Latinos into neighborhoods not only with directly unhealthy influences on nutrition and physical activity, but also with poor employment opportunities and poorly performing schools. Because educational attainment shapes employment opportunities, racial segregation propagates the inter-generational transmission of poverty and the ill health that accompanies it (Osypuk & Acevedo-Garcia, 2008; Williams & Collins, 2001). Unmeasured socioeconomic differences also are likely to contribute to the racial disparities, given that current income and educational attainment (the only socioeconomic factors widely measured in US health research) capture only part of individuals' socioeconomic experiences; they do not describe, for example, accumulated wealth, neighborhood socioeconomic conditions, or childhood socioeconomic experiences. Blacks and Latinos are worse off than Whites on these factors, which could have important health effects (Braveman et al., 2005; Kennickell, 2009; Subramanian, Chen, Rehkopf, Waterman, & Krieger, 2005).

Evidence also suggests that additional psychosocial disadvantages related to racial discrimination may contribute to racial or ethnic inequalities in health that persist after considering socioeconomic measures. Experiences of discrimination may include not only overt incidents of intentional bias, but subtler experiences that can take a psychological toll such as chronic vigilance, internalization of discriminatory stereotypes, and vicarious experiences (Nuru-Jeter et al., 2009; Williams & Mohammed, 2009). The larger relative racial disparity in preterm birth among more educated/affluent women may reflect the stress of chronic vigilance against racial discrimination experienced by highly educated Black women, whose work places them in a largely White world (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008).

Lessons learned from exchanging experience

The purpose of the symposium '*Health, Wealth and Ways of Life*' was to exchange lessons from the experience of three very different countries: the U.S., U.K., and Sweden. What lessons can be gleaned from the issues discussed here? The prevailing approach for improving health and reducing health disparities in the U.S. has rested on investment in medical care and urging people to adopt healthier behaviors. This approach has failed. Despite spending more on medical care than any other nation, we continue to rank low among industrialized nations on key health indicators. A well-designed study found that across the socioeconomic spectrum, "the US population in late middle age is less healthy than the (socioeconomically) equivalent British population for diabetes, hypertension, heart disease, myocardial infarction, stroke, lung disease, and cancer" (Banks, Marmot, Oldfield, & Smith, 2006). Furthermore, our socioeconomic and racial/ethnic disparities in health generally have not narrowed; some have widened.

What lessons can our colleagues in the U.K. and Sweden glean from the U.S. experience? The global economic crisis is prompting many European nations to cut back social programs. The U.S. example should serve as a cautionary tale to those contemplating the dismantling of safety nets. In addition, Europe is becoming increasingly ethnically diverse. The combination of increasing ethnic diversity with economic crisis can be socially toxic, with potentially grave policy implications. Hopefully, an awareness of how destructive racialization has been in the U.S. – as well as in Europe and elsewhere – will cement Europeans' resolve to avoid that happening.

The main lesson we in the U.S. should learn is that we need to broaden our focus beyond medical care and convincing individuals to behave better. Medical care is undoubtedly important once people become sick, but has little impact on who becomes sick in the first place; and our emphasis on high-technology, for-profit medicine probably further diminishes the contribution that medical care can make to health in the U.S. Relying on informing and exhorting individuals to adopt healthier habits also seems unproductive. Public informational campaigns to improve health behaviors appear to have actually widened disparities, as the more socially advantaged have the resources to respond to the educational messages with the desired behavior changes (Kanjilal et al., 2006). The U.S., U.K. and Swedish experiences indicate that while individual responsibility also is important, many people face obstacles to health that can only be lessened through societal action. We must address the living and working conditions that can constrain or enable healthy behaviors as well as access to medical care, and that may influence health more directly through diverse health-damaging exposures, including pathways involving stress. The lack of social safety nets in the U.S., particularly for families with young children, and our large inequalities in education, may play a substantial role in explaining our poor health performance compared with other affluent nations.

Many public health experts in the U.S. – including my colleagues who participated in the Symposium – share these views, but we are a long way from societal consensus on these issues. It will be a steep uphill climb, and in that difficult ascent, it will be very important for us to continue to be able to point to successful approaches in the U.K., Sweden, and other countries, to help us craft compelling arguments for change at home. A crucial first step toward necessary change here will be acknowledging that we are indeed a "class" society, where underlying economic and social resources and opportunities systematically sort people into healthy and unhealthy living and working conditions, based largely on the skin color and wealth of the families into which they are born.

References

Acevedo-Garcia, D., Soobader, M. J., & Berkman, L. F. (2005). The differential effect of foreign-born status on low birth weight by race/ethnicity and education. *Pediatrics, 115*(1), e20–e30.

Banks, J., Marmot, M., Oldfield, Z., & Smith, J. P. (2006). Disease and disadvantage in the United States and in England. *Journal of the American Medical Association, 295*(17), 2037–2045.

Braveman, P. (2011). Black-White disparities in birth outcomes: is racism-related stress a missing piece of the puzzle? In A. J. Lemelle, W. Reed, & S. Taylor (Eds.), *Handbook of African American Health: Social and Behavioral Interventions.* (pp. 155–163) New York: Springer.

Braveman, P. A., Cubbin, C., Egerter, S., Chideya, S., Marchi, K. S., Metzler, M., et al. (2005). Socioeconomic status in health research: one size does not fit all. *Journal of the American Medical Association, 294*(22), 2879–2888.

Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: what the patterns tell us. *American Journal of Public Health, 100*(S1), S186–S196.

David, R. J., & Collins, J. W., Jr. (1997). Differing birth weight among infants of U.S.-born blacks, African-born blacks, and U.S.-born whites. *New England Journal of Medicine, 337*(17), 1209–1214.

Dominguez, T. P., Dunkel-Schetter, C., Glynn, L. M., Hobel, C., & Sandman, C. A. (2008). Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. *Health Psychology, 27*(2), 194–203.

Glymour, M. M., Avendano, M., Haas, S., & Berkman, L. F. (2008). Lifecourse social conditions and racial disparities in incidence of first stroke. *Annals of Epidemiology, 18*(12), 904–912.

Institute of Medicine, Committee on Understanding Premature Birth and Assuring Healthy Outcomes, & Board on Health Sciences Policy. (2007). *Preterm birth: Causes, consequences, and prevention*. Washington, DC: The National Academies Press.

Kanjilal, S., Gregg, E. W., Cheng, Y. J., Zhang, P., Nelson, D. E., Mensah, G., et al. (2006). Socioeconomic status and trends in disparities in 4 major risk factors for cardiovascular disease among US adults, 1971–2002. *Archives of Internal Medicine, 166*(21), 2348–2355.

Kennickell, A. B. (2009). *Ponds and streams: Wealth and income in the U.S., 1989 to 2007*. Finance and economics discussion series. Washington, DC: Federal Reserve Board.

LaVeist, T. A., Thorpe, R. J., Jr., Galarraga, J. E., Bower, K. M., & Gary-Webb, T. L. (2009). Environmental and socio-economic factors as contributors to racial disparities in diabetes prevalence. *Journal of General Internal Medicine, 24*(10), 1144–1148.

Louie, G. H., & Ward, M. M. (2011). Socioeconomic and ethnic differences in disease burden and disparities in physical function in older adults. *American Journal of Public Health, 100*(7), 1322–1329.

Lu, M. C., & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: a life-course perspective. *Maternal and Child Health Journal, 7*(1), 13–30.

Marmot, M. G., Bosma, H., Hemingway, H., Brunner, E., & Stansfeld, S. (1997). Contribution of job control and other risk factors to social variations in coronary heart disease incidence. *Lancet, 350*(9073), 235–239.

Minkler, M., Fuller-Thomson, E., & Guralnik, J. M. (2006). Gradient of disability across the socioeconomic spectrum in the United States. *New England Journal of Medicine, 355*(7), 695–703.

Nuru-Jeter, A., Dominguez, T. P., Hammond, W. P., Leu, J., Skaff, M., Egerter, S., et al. (2009). "It's the skin you're in": African-American women talk about their experiences of racism. An exploratory study to develop measures of racism for birth outcome studies. *Maternal and Child Health Journal, 13*(1), 29–39.

Osypuk, T. L., & Acevedo-Garcia, D. (2008). Are racial disparities in preterm birth larger in hypersegregated areas? *American Journal of Epidemiology, 167*(11), 1295–1304.

Singh-Manoux, A., Adler, N. E., & Marmot, M. G. (2003). Subjective social status: its determinants and its association with measures of ill-health in the Whitehall II study. *Social Science and Medicine, 56*(6), 1321–1333.

Subramanian, S. V., Chen, J. T., Rehkopf, D. H., Waterman, P. D., & Krieger, N. (2005). Racial disparities in context: a multilevel analysis of neighborhood variations in poverty and excess mortality among black populations in Massachusetts. *American Journal of Public Health, 95*(2), 260–265.

The Office of Minority Health. (2010). *Data and statistics: Racial and ethnic profiles*. U.S.: Department of Health and Human Services.

Williams, D. R., & Collins, C. (2001). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Reports, 116*(5), 404–416.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of Behavioral Medicine, 32*(1), 20–47.