

# ERIC Notebook

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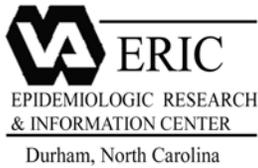


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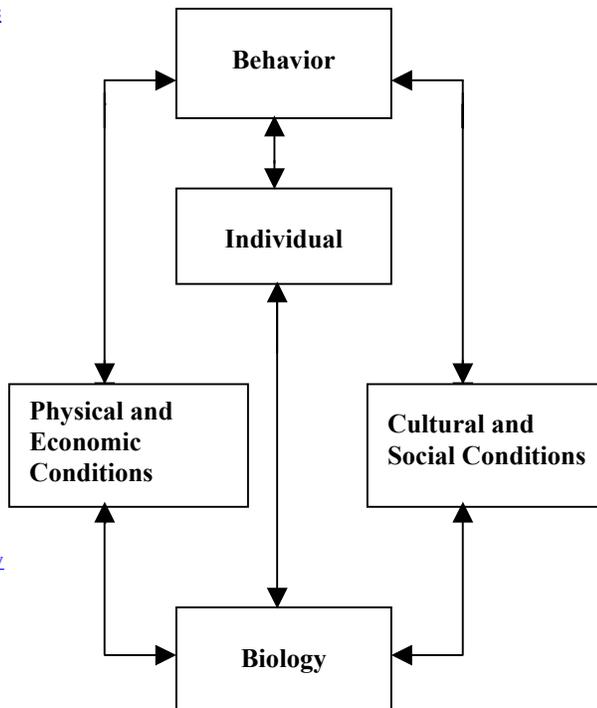
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## Contextual Dimensions of Health Disparities

Individual behaviors are embedded in social networks and in living and working conditions within the community.<sup>1</sup> Many of the individual, modifiable risk behaviors that contribute to differences in health, such as smoking, obesity, and physical inactivity,<sup>2</sup> are affected by factors in the overall environment.<sup>3</sup> For example, use of tobacco is influenced by parental education, family income, peer behaviors, anti-smoking education, availability and cost of cigarettes,<sup>4</sup> tobacco marketing,<sup>5</sup> and policies against smoking.

### Determinants of health disparities



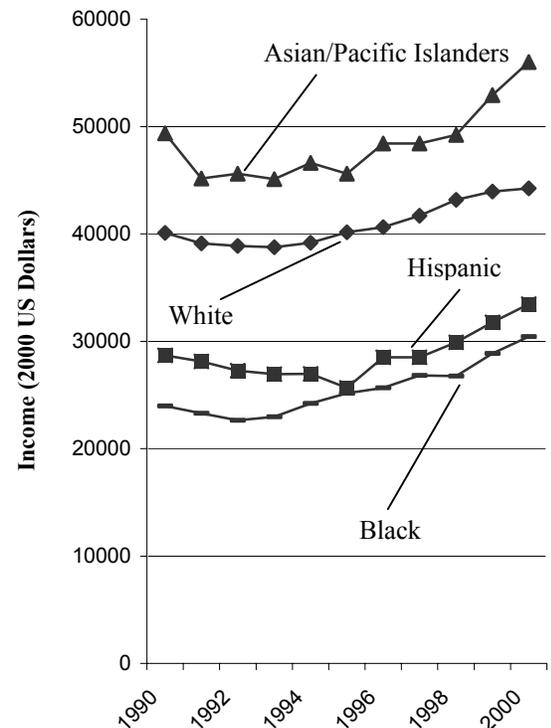
Source: US Department of Health and Human Services<sup>3</sup>

### Socioeconomic Inequalities

One of the most powerful determinants of health and health behaviors is socioeconomic status (SES). SES concerns the relative distribution of power, wealth, and opportunities,<sup>6</sup>

and is usually indexed by educational attainment, income, and occupation.<sup>7</sup> Dramatic disparities in socioeconomic status exist between racial/ethnic groups. For example, in 2000, 11 percent of Hispanics had completed 4 or more years of higher education, compared with 17 percent of African Americans, 26 percent of Whites, and 44 percent of Asian/Pacific Islanders.<sup>8</sup> There are striking differences in median household income by race/ethnicity (see figure below).<sup>9</sup> In 2001, unemployment rates for Whites, Hispanics, and African Americans were 4.2, 6.6, and 8.7 percent, respectively.<sup>10</sup> In 1995, the median net worth for White households was nearly seven times that of African American and Hispanic households.<sup>11</sup> Inequalities in SES influence social, behavioral, and environmental determinants of health and shape the various health disparities observed across racial/ethnic groups.

Median household income by race/ethnicity, 1993-2000

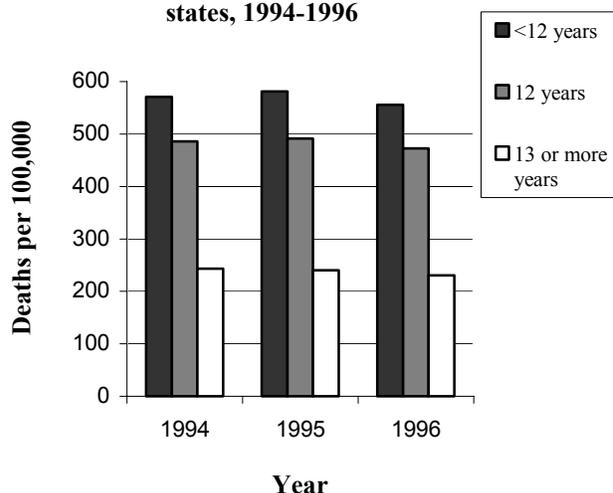


Source: US Census Bureau<sup>9</sup>

## SES and Disparities in Health

More than a quarter-century ago, a comprehensive review of over 50 studies related to social class and disease found that individuals in lower social class groups had higher morbidity and mortality rates for almost every disease or illness.<sup>12</sup> Low birth weight is more common and infant mortality rates are higher among babies born to less educated mothers.<sup>13</sup> Persons with lower income or education have a higher prevalence of risky health behaviors, such as physical inactivity and cigarette smoking, and higher mortality rates for heart disease, lung cancer, and diabetes.<sup>13</sup>

**Death rates for persons 25-64 years of age by educational attainment, selected US states, 1994-1996**



Source: National Center for Health Statistics<sup>13</sup>

The distribution of SES in the community is also an important determinant of health. A recent study by Lynch *et al.*<sup>14</sup> found that metropolitan areas with high income inequality had higher mortality rates compared with metropolitan areas with low income inequality, after adjustment for per capita income. Also, the environmental justice movement within the United States has brought national attention to the disproportionate level of pollutants and the placement of landfills and hazardous waste in low SES neighborhoods.<sup>15</sup>

### Access to Resources and Services

In addition to physical, chemical, and microbiological exposures, people in low SES neighborhoods experience a lack of resources and services that affect overall health in the community.<sup>16</sup> For example, schools within low wealth, often minority communities lack educational resources offered in other communities, and many low SES communities do not have adequate grocery stores (to facilitate healthy eating

habits) and recreational facilities (for safer, more convenient physical activity).<sup>16</sup> Also, low-income neighborhoods typically have poorer basic municipal services, such as law enforcement, fire protection, and sanitation, as well as more limited health care facilities. Inadequate resources for these services contribute to a number of unhealthy behaviors in the community, including crime, vandalism, illicit drug use, and delays in seeking medical care.<sup>16</sup>

The US system of health care financing exacerbates rather than reduces other effects of SES, since people with low income or education are less likely to have adequate health insurance coverage,<sup>13</sup> and poorer communities do not attract physicians.<sup>17</sup> People without health insurance receive less preventive care and delay medical visits until medical problems are considered emergencies.<sup>18</sup> Inadequate access to quality health care and delayed medical visits are important risk factors for poor health.<sup>13</sup>

### Geographic Access to Health Care Services

Use of health care services is also affected by perceptions of area safety<sup>16</sup>, distance to health care facilities, availability and cost of transportation, travel time, and other geographical factors.<sup>19</sup> Persons may not seek care due to the considerable distance to the nearest health care facility and experience delays in obtaining emergent and non-emergent care. Without adequate transportation, access to health care becomes even more difficult. Persons living in small, rural areas particularly face barriers to accessing health care services.<sup>19</sup> In an analysis of rural and urban access to health care services, Edelman and Menz<sup>20</sup> found that the average distance that rural households had to travel to health care facilities was nearly twice that of urban households. Limited access affects the adequacy of preventive and primary care services that rural residents receive. HIV patients living in rural areas are more likely than HIV patients living in urban areas to report as severe barriers to care long distances to medical care and lack of personal and public transportation to health care services.<sup>20</sup>

### Social Capital in America

Social capital refers to the “civic engagement or norms of reciprocity and trust among community members.”<sup>22</sup> In 1988, James Coleman described the following three forms of social capital:<sup>23</sup>

1. **Structural obligations, expectations, and trustworthiness** arise from a system of mutually exchanged goods and services within the community.
2. **Information channels** based in social relationships contribute to the transfer of information in the community.

3. **Norms and effective sanctions** are standards and rules that promote the interest of the whole community.

### **Social Capital and Health**

Communities with greater social capital often have lower rates of homicide and population mortality.<sup>7</sup> There are several mechanisms by which social capital may influence health outcomes and behaviors. For example, mutual assistance in the community provides resources, including child care and transportation and money for accessing health care services.<sup>23</sup> Information channels based in citizen groups promote involvement in political activities that affect decisions about education, public safety, urban development, placement of hazardous facilities, regulation of health care services, and social welfare policies.<sup>24</sup> At the municipal and neighborhood level, social capital in the form of effective norms and sanctions helps to maintain a safe, healthy environment and discourages harmful behaviors.<sup>24</sup>

### **Racism**

Racial/ethnic and socioeconomic disparities in the United States are a reflection of historical and contemporary racism. Racism is “an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and others through this domination.”<sup>25</sup> Three forms of racism have been described: interpersonal, internalized, and institutional.<sup>26,27</sup>

**Interpersonal racism** refers to prejudices and acts of discrimination that individuals are subjected to based on their race or ethnicity.<sup>27</sup>

**Internalized racism** refers to the acceptance of negative images and stereotypes held by others.<sup>25</sup> These beliefs are directed both internally toward the individual and at others in the same racial/ethnic group as well.<sup>26</sup>

**Institutional racism** refers to formal and informal policies, practices, and customs that result in differences in access to resources and opportunities based on an individual’s race or ethnicity.<sup>27</sup> This form of racism consists of the enduring legacy from past racism and is apparent in laws, practices, environmental conditions, and differences in access to education, wealth, and power.<sup>26</sup>

### **Racism and Health**

Racism has contributed to the deprivation of goods, services, power, rights, opportunities, and privileges that are important determinants of overall health.<sup>27</sup> For example, discriminatory hiring practices limit employment opportunities, and discrimination in medical services can affect diagnosis and treatment.<sup>28</sup>

Pervasive discrimination and racism contribute to higher rates of disease<sup>29</sup> and the development of unhealthy behaviors and stressful conditions.<sup>30</sup> Experiences of discrimination can cause stress, with adverse affects on individual health. Individuals who internalize racism are at greater risk for self-alienation, depression, low self-esteem, and substance abuse.<sup>30</sup> Racism is thus a major factor in differences in incidence, prevalence, mortality, and the burden of disease and other conditions across racial/ethnic groups.<sup>31</sup>

### **Racism and Biology**

During the past two centuries the ideological foundation for racism has been the concept of biological race, an “unscientific, societally constructed taxonomy that is based on an ideology that views some human population groups as inherently superior to others on the basis of various physical or external characteristics.”<sup>32</sup> While persons classified in different “racial” groups do indeed differ in genetically determined characteristics, such as skin color, facial features, and body build, the assumption that variation in these readily visible characteristics is related to genes that influence personality, industry, intelligence, and health is flawed.<sup>32</sup> Despite the erosion of its biological foundations, race remains an important social, cultural, and historical construct in understanding the influence of racism and discrimination on health in American society.<sup>33</sup>

### **Racism and the Law**

Notwithstanding the ideals of equal rights proclaimed by the Declaration of Independence over two centuries ago, the American legal system has sanctioned the most blatant forms of racism directed against various groups. For example, in 1787 the US Constitution counted slaves as only three-fifths of a person,<sup>34</sup> and despite land protections guaranteed by the Treaty of Guadalupe-Hidalgo in 1848, many Mexicans were forced off their land.<sup>34</sup> The Chinese Exclusion Act of 1882 blocked immigration of Chinese laborers and disallowed naturalization of Chinese persons.<sup>35</sup> Congress repeatedly violated the civil rights, treaty rights, and human rights of American Indians.<sup>36</sup> Throughout the South, the disfranchisement of African Americans was manifested through laws prohibiting voting and access to many public facilities and institutions.<sup>37</sup>

### **Racism and Housing**

One mechanism for the pervasive effects of racism is residential segregation. Restrictive covenants, urban development policy, lending practices, law enforcement, and widespread discrimination have created and maintained residential and school segregation

throughout the country.<sup>28</sup> Despite the passage of the Fair Housing Act of 1968, discrimination and racism persist in housing practices in the United States.<sup>38</sup> As described by Massey<sup>38</sup>, a 1977 study by the US Department of Urban Housing and Development (HUD) found that housing was made available to Whites more often than to African Americans in the rental and sales market. More recently, in 2000, HUD found that Whites were more likely to be shown homes in predominantly white neighborhoods compared with African Americans, and Whites were more likely to receive information about available rental units compared with African Americans and Hispanics.<sup>39</sup>

Many American neighborhoods and cities remain highly segregated.<sup>38</sup> In 1990, in large metropolitan cities, such as Detroit, Chicago, and New York, most African Americans lived in neighborhoods that were predominantly African American. Enforced segregation isolates people from resources available in more affluent areas and renders them more vulnerable to the placement of undesirable facilities.<sup>30</sup>

### Racism and the Armed Forces

Although the US armed forces were segregated and unequal for most of their history,<sup>40</sup> racial/ethnic minorities have been actively involved in United States military service since the 18<sup>th</sup> century.<sup>41-44</sup> During the Revolutionary War, nearly 5,000 African Americans served in the military.<sup>43</sup> Many American Indian tribes fought in the War of 1812.<sup>41</sup> More than 400,000 African Americans served in World War I, and over 1 million served during World War II.<sup>43</sup> Over 40,000 American Indians served in the military during World War II and the Vietnam War,<sup>41</sup> and nearly 80,000 Hispanic Americans served in the military during the Vietnam War.<sup>42</sup> Approximately 25,000 Japanese-Americans served in the US military during World War II.<sup>44</sup> In 2000, approximately 34 percent of US military personnel were racial/ethnic minorities.<sup>45</sup>

The beginning of desegregation of the armed forces essentially began during World War II. In 1948, President Truman issued an Executive Order requiring equal treatment and opportunity in the armed forces; however, formal segregation was not dismantled until the end of the 1950's.<sup>40</sup>

### Conclusion

The elimination of health disparities is of great importance for minority and low-income persons and the overall health of the nation. In this Notebook, we have explored how SES, social capital, racism, and discrimination in the United States contribute to disparities in health. Understanding the pathways by which these and other factors produce health disparities is

important in taking measures to eliminate health disparities in the nation.

### Helpful Web Sites:

MacArthur Network on SES & Health  
<http://www.macses.ucsf.edu/>

Race, Healthcare, and the Law  
<http://academic.udayton.edu/health/>

World Bank Group, Social Capital for Development  
<http://www.worldbank.org/poverty/scapital>

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### Additional Readings on the Topic:

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