

Reducing Racial And Social-Class Inequalities In Health: The Need For A New Approach

Is it possible for the majority of Americans to see that inequality is a corrosive issue that is damaging all of us?

by **S. Leonard Syme**

ABSTRACT: It is well known that people in racial and ethnic minority groups and in lower social-class positions have higher morbidity and mortality rates from virtually every disease. To effectively deal with the problem, we will need to adopt a more appropriate conceptual model that focuses on the fundamental determinants of health, we will need to understand how important this is for all Americans as a society, and we will need to better deal with the issues people care about: their children, homes, jobs, safety, education, families, retirement, and future prospects. [*Health Affairs* 27, no. 2 (2008): 456–459; 10.1377/hlthaff.27.2.456]

PEOPLE IN RACIAL AND ETHNIC MINORITY GROUPS and in lower social-class positions have higher rates of illness and death from virtually every disease, and we have not made much progress in reducing these inequalities: they have remained approximately the same for the past fifty years. These facts suggest that the deprived circumstances experienced by people in disadvantaged positions result in a cumulative toll on health and well-being that is reproduced in successive generations over the years.

The purpose of this paper is to consider what might be done to reduce these inequalities. However, unless we are able to make some important and challenging changes in the way we approach this problem, there probably is not much that can be done to accomplish this admirable goal. There are at least three reasons for this difficulty. First, the problem of inequalities is going to require a focus on the fundamental social determinants of health, and the clinical model of disease that currently determines our funding and agenda makes it very difficult to look upstream to those fundamental determinants. Second, even if a way were found to look at fundamental societal factors, we might not care enough about these inequalities to take necessary action. And third, even if an appropriate conceptual model were accepted that would permit the examination of fundamental factors, and even if

Leonard Syme (lsyme@berkeley.edu) is a professor emeritus of epidemiology and community health in the School of Public Health, University of California, Berkeley.

inequalities were cared about, researchers and policymakers almost always focus on inappropriate issues anyway.

Focus On Fundamental Forces Versus Disease

With regard to the first problem, most of our research on health and well-being is focused on problems of the individual: the diseases that people have (such as coronary heart disease, cancer, and arthritis) and the risk factors they experience (such as hypertension, cigarette smoking, and hypercholesteremia). While this approach to diseases and risk factors is useful, it does not deal with the forces in our society that cause these problems in the first place. Thus, even if all of those at risk for disease could lower that risk, new people would continue to take their place, forever. Unfortunately, a consideration of such fundamental forces is usually outside of our training and expertise in the medical and public health worlds. For this reason, we rarely end up with a health promotion program that considers such “extraneous” issues as jobs, housing, security, institutional racism, legislation, and other matters about which many of us in the health world know little. If we really care about racial and social class inequalities in health, we will need to rethink our priorities and our exclusive focus on clinical problems.

Our research on San Francisco bus drivers provides an illustration of the difficulty imposed by a clinically oriented conceptual model.¹ This study of 2,000 bus drivers began by focusing on hypertension. When we finished this study, we observed that many of the drivers also had low back pain, respiratory difficulties, gastrointestinal problems, and alcohol issues. We then worked on each of these clinical problems, one at a time, but these efforts could have only a limited usefulness in terms of prevention. Even if all of the current drivers were helped, new drivers would soon exhibit the same disease profile as the old drivers because none of our work addressed the fundamental problem that was an important determinant of all of their disease problems. Because of our focus on specific disease issues, we did not recognize the problem common to all the complaints: the job. Subsequent research identified a bus schedule that could not be met as the primary determinant of most of the problems experienced by the drivers.² A focus on diseases and risk factors makes sense from a clinical perspective, but it makes little sense from a prevention perspective. If one looks exclusively at trees, it is difficult to see the forest.

Infectious disease epidemiologists developed a more appropriate conceptual model. Their model focused on waterborne, foodborne, airborne, and vectorborne diseases. This disease classification system is of little help in treating individual patients with disease, but it is exactly appropriate for preventing disease: this scheme helps us understand where in the environment disease is coming from, and it helps us direct intervention programs. We have no such classification scheme in the world of noninfectious diseases, which are, of course, major contributors to racial and social-class health inequalities.

“There is now beginning evidence to suggest that inequalities are harmful not only to the victims of inequity but to all of us.”

.....

If one sent a research or training grant application to the National Institutes of Health (NIH) to study poverty diseases or racism or nutritional deficiencies, the application would probably be returned because the NIH would not know to which disease-specific institute it should be sent. For this reason, we are not able to do appropriate research, and we are not training a new generation of young people who can do a better job than we have.

The Issue Of Caring (Or Not)

People do not really care about the problem of racial and social-class inequalities. They might give money to charity and even volunteer to help others now and then, but these activities do not, of course, deal with the fundamental issue. A more gentle way of expressing this idea is that we might care, but we do not know what to do about the problem. Short of some kind of cultural and economic revolution, it is not easy to visualize a solution to this problem. Epidemiologists quietly ignore it, because it does not make much sense to study a problem if there is nothing that can be done about it. In research, we typically hold constant social class and race in statistical analyses so that other issues can be studied. If we did not do this, social class and race would overwhelm everything else, and we would not be able to study other favorite subjects. So the most important determinants of disease are neglected while other less important issues are studied.

The beginnings of a transformation in this attitude of caring may have occurred in reference to Hurricane Katrina. It seemed that people really appeared to care about others who were caught up in this disaster. But then we recovered and went about our business as usual. It is important to think carefully about why Katrina got our attention so forcibly for that brief interval.

So, what to do? It might be that appeals to morality, social justice, and simple humanity are not enough to change our approach. They are important, but they might not be enough. It might be that a discussion of unfairness and inequity simply results in affirmative nods but no substantial and sustained action. It might be that racial and social-class inequalities in health need to matter on grounds that go beyond appeals to humanity and justice. There is now beginning evidence to suggest that these inequalities are harmful not only to the victims of inequity but to all of us. The United States ranks at the bottom of all industrialized countries in overall mortality, life expectancy, and infant mortality. We rank below such countries as Spain, Austria, Italy, and the United Kingdom but above such countries as Poland, Slovakia, Hungary, and Turkey. And the medical care costs of high-ranking countries are a fraction of those in the United States. The United States contains about 5 percent of the world's population, but the amount of money spent on

medical care is more than 50 percent of what the world spends. We in the United States spend more on medical care per capita than any country in the world, but our results are the poorest among industrialized nations of the world.³ We need to take this issue seriously and make it a focus of our work. Is it possible for the majority of Americans to see that inequality is a corrosive issue that is damaging all of us?

Poorly Focused Research

There is a third reason that also makes things difficult for us to reduce inequalities in health: we in the health field attend to inappropriate issues in our work because we are all disease and risk-factor experts. This expertise is problematic because it limits our ability to focus on the risk factors that are of interest to the people we are trying to help. People care about their families, homes, jobs, safety, education, retirement, and future prospects. We in the health field have health messages to offer people, but people have lives to lead. For this reason, many of our health promotion interventions fail to achieve their intended goals.⁴

TO DEAL EFFECTIVELY WITH SOCIAL-CLASS and race inequalities, we will need to go beyond the health statistics we are all familiar with. We will need to adopt a conceptual model that focuses on the fundamental determinants of health, we will need to understand how important this is for all of us as a society, and we will need to deal with issues people care about. Unfortunately, these are issues often not dealt with in our schools of public health or medicine or by major funding organizations. We need to do better.

NOTES

1. M.A. Winkleby et al., "Heightened Risk of Hypertension among Black Males: The Masking Effects of Covariables," *American Journal of Epidemiology* 128, no. 5 (1988): 1075–1083.
2. N. Krause et al., "Psychosocial Job Factors Associated with Back and Neck Pain in Public Transit Operators," *Scandinavian Journal of Environmental Health* 23, no. 3 (1997): 179–186.
3. S.A. Schroeder, "Shattuck Lecture: We Can Do Better—Improving the Health of the American People," *New England Journal of Medicine* 357, no. 23 (2007): 1221–1228.
4. B.D. Smedley and S.L. Syme, eds., *Promoting Health: Intervention Strategies from Social and Behavioral Research* (Washington: National Academies Press, 2000).