GRANT MAKERS IN HEALTH

unequal opportunities:

inequalities in the United States

A society's development is often judged by the quality of its population's health, whether there is fair distribution of health across the social spectrum, and the degree of protection people receive from disadvantages caused by ill health (WHO 2008). Over time, there has been greater acknowledgement that inequalities in social and economic structures of a society are interdependent and powerful determinants of health and mortality. These inequalities result in marked differences, variations, and disparities in the health status and outcomes of vulnerable, poor, and underserved individuals and groups (Kawachi et al. 2002).

The root causes of inequalities represent complex interactions among social, economic, environmental, and personal factors. Social inequality refers to people's lack of access to housing, health care, education, employment opportunities, political participation, and social status. It excludes people from full and equal participation in what a society considers valuable, important, personally worthwhile, and socially desirable (Preston 1992). Economic inequality relates to disparities in the distribution of economic assets and income. The term typically refers to inequality in material conditions such as income or total wealth between individuals or groups within societies or between nations. Differences exist between social and economic inequalities, though the two are closely linked.

This essay focuses on a selection of inequalities that has either continued to increase in magnitude or has stayed at relatively stable, though unacceptably high, rates across various populations. These inequalities range from social determinants related to race, education, and inequitable living conditions, to economic issues related to poverty and income inequalities. The antecedents, as well as numerous repercussions that can affect health status and outcomes, will be discussed. Additionally, several examples illustrate philanthropic initiatives and other potential opportunities for health funders to become involved in efforts focused on combating inequalities.

HIGHLIGHTING TRENDS IN INEQUALITIES

A number of trends underscore continued inequalities among groups, though some improvements in conditions over time have been noted. For example, racial and ethnic inequalities persist in social indicators such as infant mortality rates, where African Americans continue to be the most affected among all U.S. racial and ethnic groups. Rates in this group are almost 2.5 times higher than for whites (13.6 vs. 5.66, respectively, per 1,000 live births) (Mead et al. 2008). Life expectancy at birth has risen for all groups, including a narrowing in the gap between African Americans and whites. At the same time, however, African Americans still live 6-10 fewer years than the 78 years of average life expectancy among whites (Mead et al. 2008).

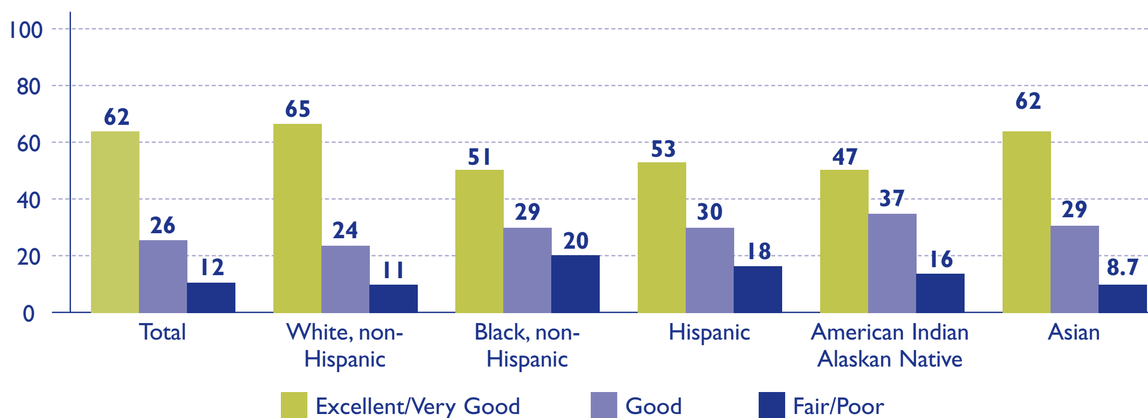
In relation to economic indicators, there have been slight overall improvements in income and poverty among most individuals. According to a recent 2007 U.S. Census Bureau survey, real median household income rose for the third year in a row, increasing from 1.3 percent between 2006 and 2007 (or $49,568 to $50,233) (DeNavas-Walt et al. 2008). Income inequality also decreased between 2006 and 2007, as measured by the shares of aggregate household income quintiles and the Gini index. Despite these improvements, incomes among the wealthiest U.S. households have doubled since 1980, while middle- and lower-income household earnings have mostly stayed flat (DeNavas-Walt et al. 2008).

The United States is unique among other industrialized countries in that it has the highest level of income inequalities and the sharpest growth in disparities in the past 25 years (Neckerman and Torche 2007). The United States also currently ranks below many industrialized countries in life expectancy and mortality rates (WHO 2008). Additionally, despite the fact that the United States spends over 50 percent more per capita on medical care than most countries in the world, health outcomes in the United States remain the poorest among most other industrialized countries (WHO 2008).

KEY CONTRIBUTORS TO SOCIAL INEQUALITIES

The social conditions in which people live and work are a powerful influence on the development and subsequent treatment of illnesses and other contributors to poorer health and socioeconomic outcomes. A social gradient exists in which disadvantaged minority populations and those at lower socioeconomic and educational levels often experience worse outcomes than their counterparts (Mechanic 2002).

FIGURE 1: SELF-REPORTED HEALTH STATUS AMOUNG ADULTS AGE 18+, 2005



Source: National Center for Health Statistics 2005

Social inequalities can affect many factors, including race, gender, education, social status, and health care. For the purposes of this essay, however, we will focus on the substantial inequalities related to race, education, and living conditions among various populations.

- ***Racial Inequality*** – Marked inequalities continue to occur according to race and ethnicity in this country and have remained relatively similar over the past 50 years (Syme 2008). These racial and ethnic inequalities have resulted from persistent experiences of social disadvantage, discrimination, and other historical trauma over time among minority populations. These inequalities occur independently of income, education, insurance status, and other factors (Smedley et al. 2002).

  Despite substantial improvements in the overall health of U.S. citizens over the last century, the health status and outcomes of minority groups continue to lag behind those of whites. In general, minority groups, with the exception of Asian Americans, are more likely to report their health status as "fair" or "poor" (Figure 1) (Adams et al. 2007). Leading causes of death and health status indicators, such as life expectancy, are also measures used to capture health inequalities among racial groups. For example, study findings have shown a 20-year gap in life expectancy between white men in the healthiest areas of the United States and black men in the unhealthiest areas (Deaton 2002).

  In terms of racial inequalities in income, research indicates that many minority groups have significantly lower income levels than whites (Mead et al. 2008). These income deficits can often be instrumental in increasing exposures to health risks or limiting the availability of social or economic opportunities. Unfortunately, even after adjusting for socioeconomic status, racial differences persist in employment rates, overall family wealth, education quality, and occupational health risks. Additionally, though the largest numbers of the severely poor are white, blacks and Hispanics are still disproportionately the most affected racial and ethnic groups (Thomas and Crouse Quinn 2008).

- ***Education*** – Education is the primary means of social and economic mobility in the United States. Unfortunately, the educational system in this country often does little to weaken class divisions. Of the nearly 50 million students enrolled in the public school system, one-third are from low-income families (Grantmakers In Health 2007a). Differences between poor and non-poor children's development and skills emerge as young as the age of three. Additionally, the quality of schools is often closely linked to family income and where one resides. Therefore, deficiencies in schooling reinforce these troublesome gaps and poorer outcomes for disadvantaged children.

  The level of education a person attains can facilitate or limit her ability to earn income and improve occupational and social status. In particular, educational deficits may limit individuals to lower-paid positions often associated with poorer, more stressful physical working conditions (Adler et al. 2007). Completing each degree from high school through graduate or professional programs also leads to greater income potential (Haskins et al. 2008).

For example, the annual income of a 25- to 34-year-old high school dropout is approximately $18,000; the annual income for a college graduate is $36,000. As time goes on, this income-earning disparity compounds. It is estimated that the average high school dropout earns $1 million less over a lifetime than a college graduate (Grantmakers In Health 2007a).

Evidence from a number of industrialized countries indicates that an additional year of education has the beneficial effect of reducing mortality rates at all ages by approximately 8 percent (Deaton 2002). By race, however, research indicates that minority populations are much less likely than whites to have advanced degrees (Mead et al. 2008). In particular, Hispanics are the least likely to attain a bachelor's degree or higher.

- ***Living Conditions*** – The social and physical conditions people live in tend to contribute to positive or negative community-level outcomes, including health status, social and economic opportunities, and community cohesion. Deeper processes and social structures often shape inequalities in living conditions. In particular, systematic policies, practices, and social norms that tolerate or promote unfair access and distribution of wealth, power, and other resources further constrain opportunities in some communities (WHO 2008). Often, the communities that shoulder a disproportionate amount of unequal outcomes are economically challenged, racially segregated, and more likely to have fewer resources within their local area (Prevention Institute 2002).

Individuals located in impoverished social and physical environments have greater exposure to numerous stressors and avenues by which they can become ill, suffer an injury, or engage in negative behaviors. Stress, especially when extreme or prolonged, also increases people's susceptibility (Altschuler et al. 2004). Disadvantaged populations often have little to no resources available to buffer or avoid the effects of these stressors. Furthermore, exposure to factors, such as neighborhood violence; overcrowded, dilapidated housing conditions; social isolation; and limited access to healthy foods, jobs, and adequate community resources, can increase individuals' stress levels and take a toll on health (Adler et al. 2007).

FACTORS INFLUENCING ECONOMIC INEQUALITIES

It is an unfortunate reality that no matter where you are in society, poorer individuals tend to be sicker and die younger than richer people. Many complex, interrelated factors contribute to economic inequality within societies. Some of these factors include poverty rates, income level, education, race, gender, and culture. Rates of morbidity and mortality are often inversely related to correlates of socioeconomic status, including income and education levels. Likewise, health, or the individual characteristics that determine health, plays a role in the achievement of socioeconomic position (Kawachi et al. 2002).

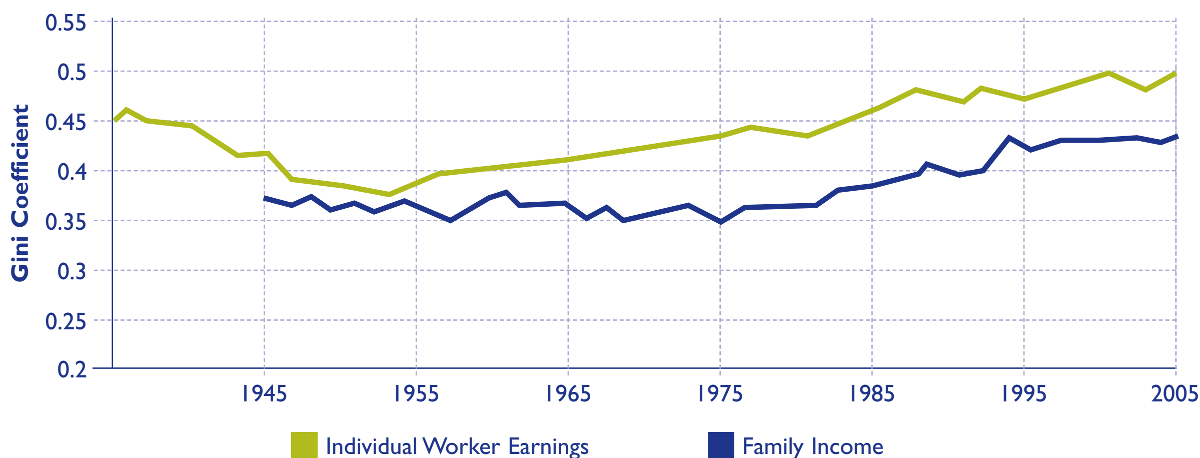
Absolute poverty refers to the inability to meet basic human needs such as shelter and food. It is defined using the poverty line as the threshold for the resources considered necessary to meet these minimum human needs. Based on the official poverty threshold of $21,203 for a family of four in 2007, approximately 12.5 percent of American households (or 37.3 million individuals) live in poverty (DeNavas-Walt et al. 2008). Many argue that the official threshold does not reflect the true cost of meeting basic needs and should be revised. If revised, more of the population would actually fall below the poverty line.

Income inequality is a measure of income dispersion with high levels of inequality associated with lower levels of social cohesion and support and poorer health. Within wealthy countries, income inequalities are considered more responsible for impacts on the health of their populations than average individual income levels. In the United States, both individual and family income inequality appear to be on the rise and are more extreme than in other advanced industrial countries (Figure 2).

Statistics indicate that the top 1 percent of American households received over 40 percent of the increase in household income in 2004 (Center on Budget and Policy Priorities 2006). Furthermore, the country's economic growth over the past 25 years has principally benefited the very rich with income gains among high-income households vastly surpassing those among middle- and low-income households (Grantmakers In Health 2007b). Family incomes for both whites and blacks also have risen over this time period, though there has been no progress in reducing the growing income gap between these two groups (Figure 3).

Reducing poverty is critical for enabling individuals to purchase items related to health, including health care and nutritious food, as well as for relieving stress related to daily challenges to make ends meet (Deaton 2002). Documented health improvements have resulted from people receiving enough income support to bring them to adequate standards of living (Mechanic 2002). Programs to provide a safety net for these populations include Social Security, Temporary Assistance for Needy Families, and the Earned Income Tax Credit. In comparison to other economically advanced countries, however, the U.S. government does the least in efforts to transfer and sustain poor families and move them out of poverty (Grantmakers In Health 2007b).

FIGURE 2: TRENDS IN INEQUALITY OF U.S. WORKER EARNINGS AND FAMILY INCOME, 1937-2005



Source: Haskins et al. 2008

There is considerable evidence to support the assumption of causality between better health and resources, such as income, occupation, and wealth, and the health benefits of poverty reduction (PolicyLink 2002). Health status for groups at the higher ends of the socioeconomic ladder is consistently higher than for those at the lower ends. At the same time, because of the proportional relationship between income and mortality, absolute reductions in mortality associated with each dollar of income are much greater at the lower end of the income distribution than at the top (Deaton 2002).

PHILANTHROPIC ROLES IN COMBATING INEQUALITIES

Inequalities affect numerous facets of social and economic life, providing many opportunities for health foundations to become involved. Because of the breadth of the issue, foundations can employ multipronged approaches utilizing a broad focus on inequalities; a narrower centering of attention on specific topics, strategies, and upstream approaches to the social and economic determinants of health; or various combinations of the two. The following examples highlight some of the contributions funders have made in efforts to combat inequalities affecting health.

The Rapides Foundation aims to increase the level of educational attainment and achievement as the primary pathway toward improved social, economic, and health status, as well as to improve economic opportunity and family income. The foundation has chosen targeted programs that seek to improve student achievement through proven long-term strategies, including teacher and administrative training and support, enhancing subject-specific knowledge, and increasing communities' ownership of schools. To increase community economic development, the foundation is also funding the Cenla Advantage Partnership, a regional nonprofit economic development organization, and the Entrepreneurial League System of Central Louisiana, which works to increase the number of business start-ups in the local community (Grantmakers In Health 2008).

In order to provide education and training to the public health workforce, funding from the Universal Health Care Foundation of Connecticut, Inc. has been used to develop a blueprint on integrating social justice into public health practice to address health inequalities in the state. The foundation has also supported efforts to create and promote a Connecticut-specific Health Equity Index as a way for public health directors to monitor and address health inequalities throughout the state.

A statewide social marketing campaign to combat poverty and income inequality was developed and implemented using funding from the Connecticut Health Foundation. This campaign aimed to educate the public, news media, and opinion leaders about the state's growing income asset divides, the impact of poverty and inequality on residents' health, and state budget choices essential to reducing poverty and inequality and enhancing health. The foundation has also provided funding to pretest a Social Determinants of Health Equity Index instrument, which will illuminate the conditions that perpetuate health inequities at the local level and inform the planning and advocacy efforts of a

community's health needs.

The Arizona Project received funding from The Nathan Cummings Foundation to address issues of economic and political inequality in Arizona, with special emphasis on health and health care. Project organizers identified and developed leaders of the Arizona Interfaith Network, equipping them with the research, organizing, and other skills necessary to advance its Human/Family Development agenda locally and statewide. The project supported individual and small group meetings, institutional assemblies, training sessions, and research actions. Efforts also focused on large-scale public meetings to develop leaders and create public dialogues about the conditions faced by low-wage workers, immigrants, and their families as related to health care and wages.

In addition to these specific types of strategies to combat social and economic inequalities, health funders can contribute through efforts such as:

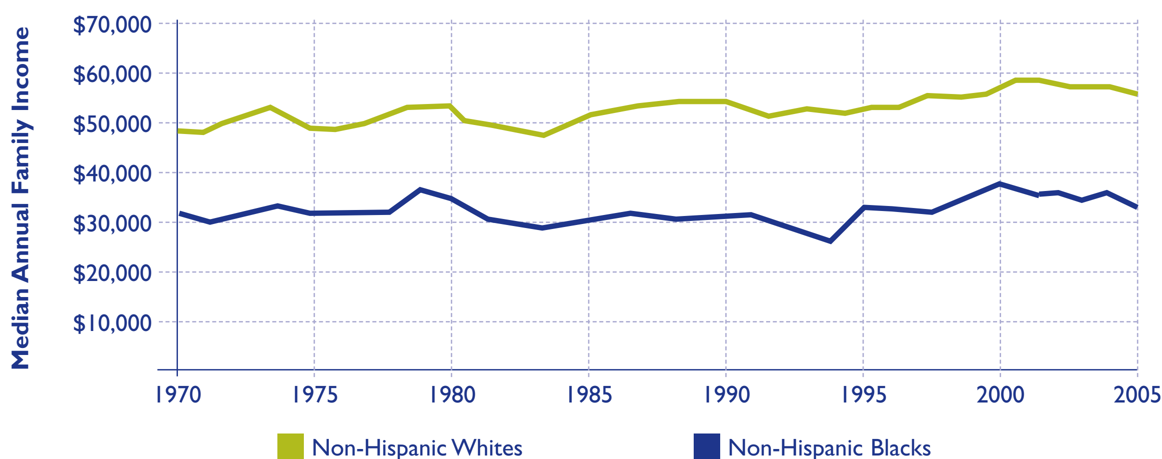
- increasing understanding, advocacy, and incorporation of equity and human rights perspectives into grantmaking efforts to raise awareness of issues such as discrimination or inequitable distributions of health care providers and facilities in disadvantaged communities;
- supporting the implementation of equitable health care financing to ensure that individuals with the least resources pay the least; and
- building public will to demand equality of opportunities for all people in both policy and institutional practices, as well as level the playing field for individuals to access and utilize quality resources and supports.

CONCLUSION

Most societies consider health inequalities to be fundamentally wrong. Inequalities contribute to poverty and gradients in health, which often result from poor social policies, inequitable economic conditions, and disadvantageous politics. Social inequalities that reinforce privilege among the wealthy and increase disadvantages among the poor also buttress the perpetuation of economic inequalities into subsequent generations (Neckerman and Torche 2007).

The work to improve the future health of our country and tackle inequalities must be a long-term, multipronged effort involving diverse stakeholders (including the individuals and communities most directly affected), investments, and significant changes in social and political policies and economic institutions and arrangements. Numerous opportunities exist for the participation of philanthropic organizations. Health funders can be instrumental in efforts to convene or educate policymakers, health professionals, and the general public regarding the social determinants of health and their contributions in amplifying health inequalities. Additionally, work must be done to continually measure the degree of inequalities existing within and among groups in order to design both targeted and broad-based strategies to improve conditions for those most adversely affected. Ongoing assessments must also be conducted on the impact of various interventions so that we can learn and strengthen our approaches to combat inequalities.

FIGURE 3: MEDIAN FAMILY INCOME OF WHITE AND BLACK ADULTS, AGES 30-39 (2004 DOLLARS)



Source: Haskins et al. 2008

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