Racial Inequalities in Health: The Social Determinants of Disease

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Issue #1

Racial/Ethnic Disparities in Health Exist

African American Mortality

For the 15 leading causes of death in the United States in 2001, Blacks had higher death rates than whites for:

1. Heart Disease
2. Cancer
3. Stroke
5. Accidents
6. Diabetes
7. Flu and Pneumonia
9. Kidney Diseases
10. Septicemia
12. Cirrhosis of the liver
13. Homicide
14. Hypertension
15. Pneumonitis

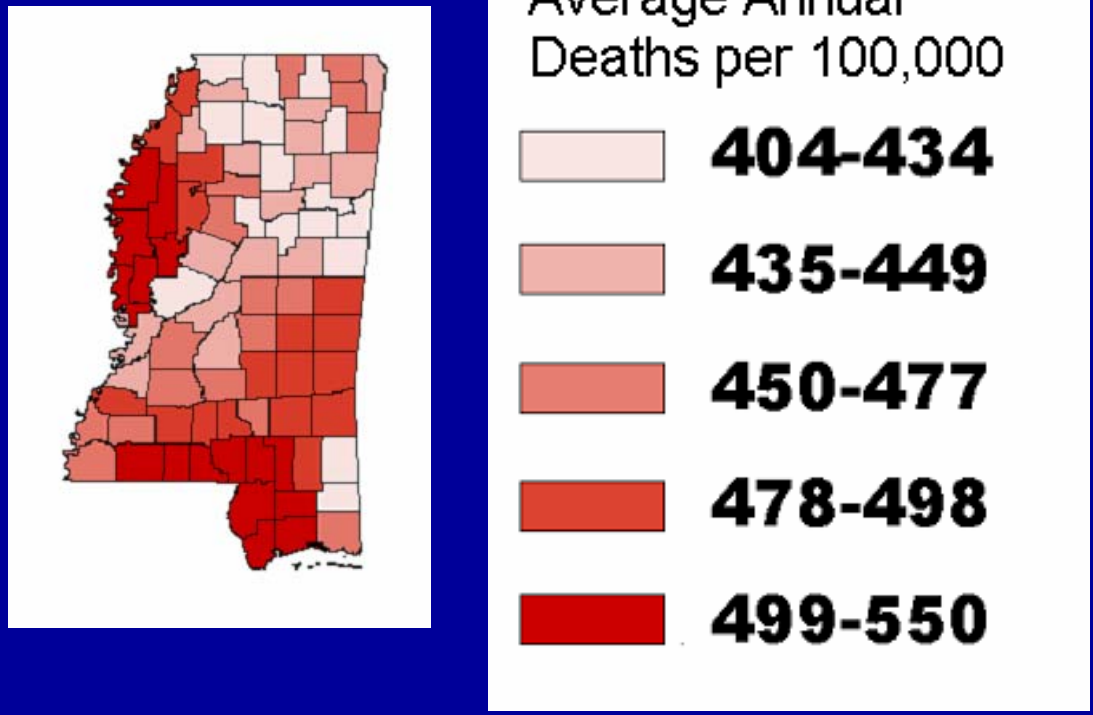
Blacks had lower death rates than whites for:

4. Respiratory Diseases
8. Alzheimer's Disease
11. Suicide

Source: NCHS 2003

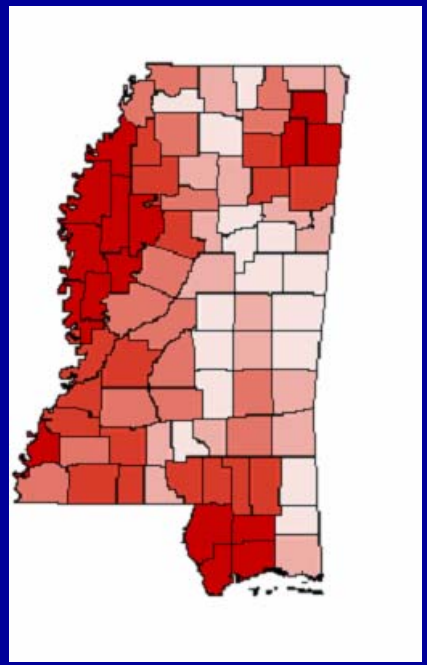
Heart Disease Death Rates Mississippi, 1991-1995

White Women



Heart Disease Death Rates Mississippi, 1991-1995

Black Women



Average Annual
Deaths per 100,000

548-611

612-651

652-678

679-720

721-830

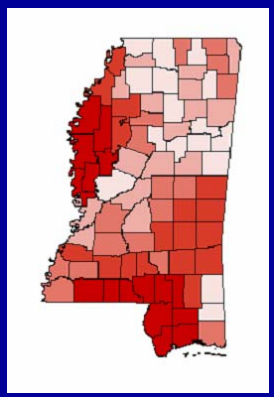
Heart Disease Death Rates Mississippi, 1991-1995

Women

WHITE

Average Annual
Deaths per 100,000

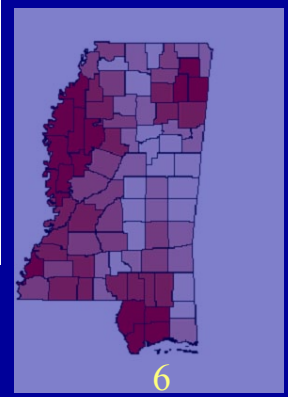
- 404-434
- 435-449
- 450-477
- 478-498
- 499-550



BLACK

Average Annual
Deaths per 100,000

- 548-611
- 612-651
- 652-678
- 679-720
- 721-830



Hispanic Mortality

- **For the 15 leading causes of death in the United States in 2001, Hispanics had higher death rates than whites for:**

6. Diabetes	**12. Cirrhosis of the liver**
14. Hypertension	**13. Homicide**

- **Hispanics had equivalent rates of kidney disease and lower death rates than whites for:**

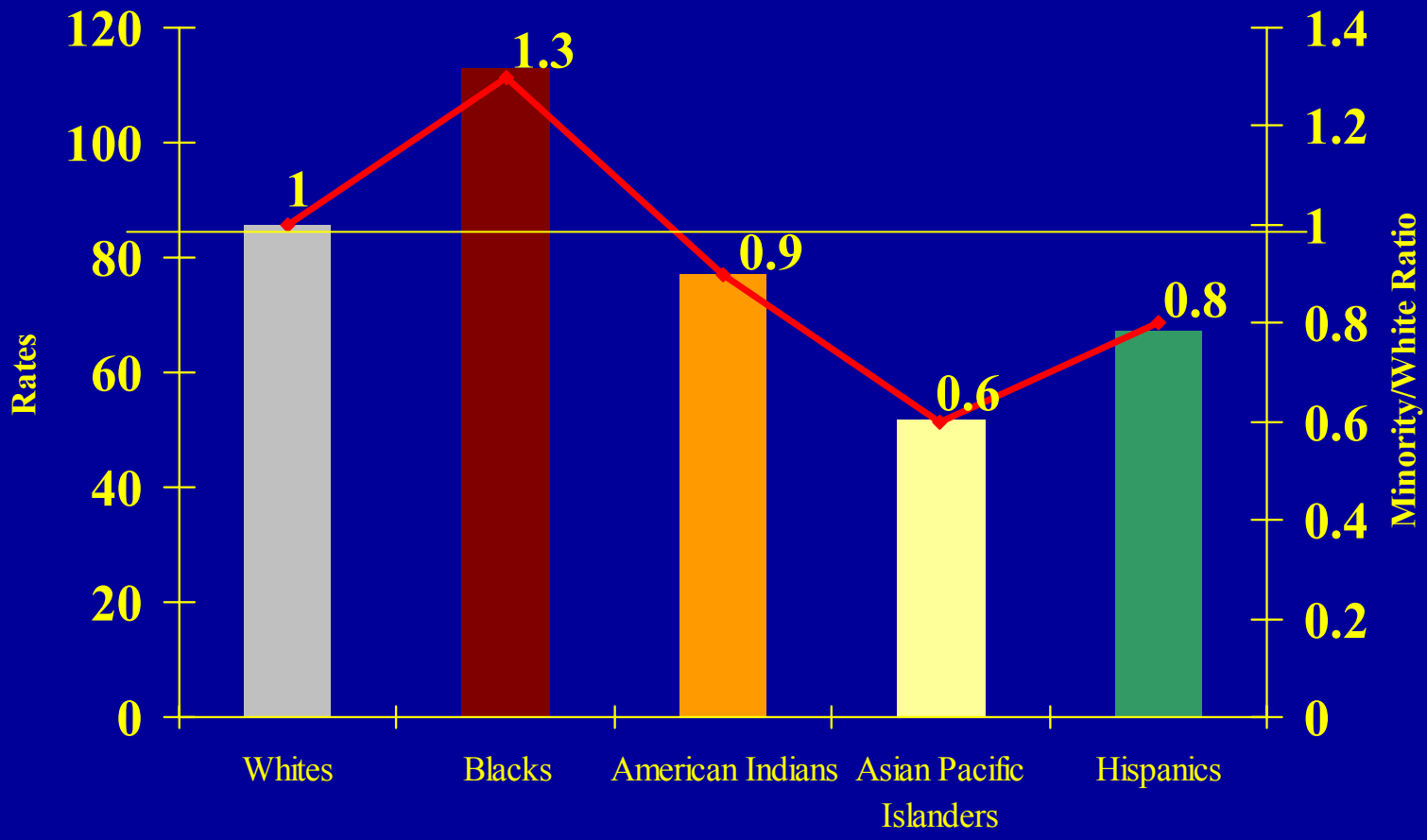
1. Heart Disease	**2. Cancer**
3. Stroke	**5. Accidents**
4. Respiratory Diseases	**7. Flu and Pneumonia**
8. Alzheimer's Disease	**10. Septicemia**
11. Suicide	**15. Pneumonitis**

Source: NCHS 2003

Issue #2

Methodological issues linked how racial/ethnic data are measured, analyzed, and/or presented, affect our knowledge of the existence and magnitude of racial/ethnic differences in health.

Age-Adjusted Mortality rates for 1998-2000



Rates per 10,000 population

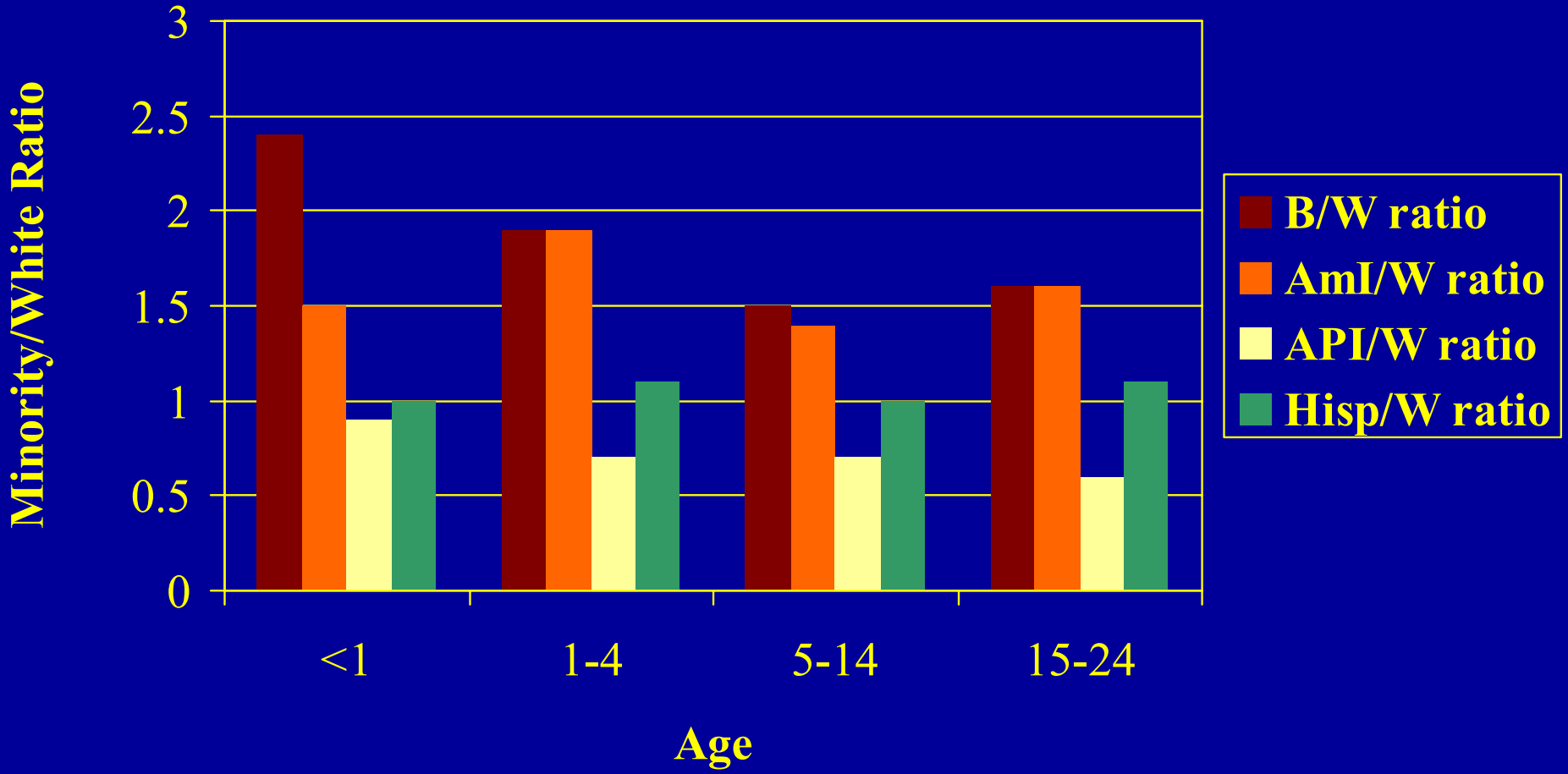
Source: National Center for Health Statistics, 2003

The Limits of Age Adjustment

- Age-adjustment is a routine and widely used statistical procedure to make rates of health events comparable across various population groups that may differ in their age structures.
- An age-adjusted rate is a weighted average of age-specific rates, with the weights being determined by the age structure of the age standard.
- In 2000, the median age varies for whites (37.7 years), American Indians (28.0), Native Hawaiians and other Pacific Islanders (27.5), Hispanics (25.8), blacks (30.2) and Asians (32.7).
- NCHS: age-adjusted rates are relative indicies for comparison but not actual measures of risk.

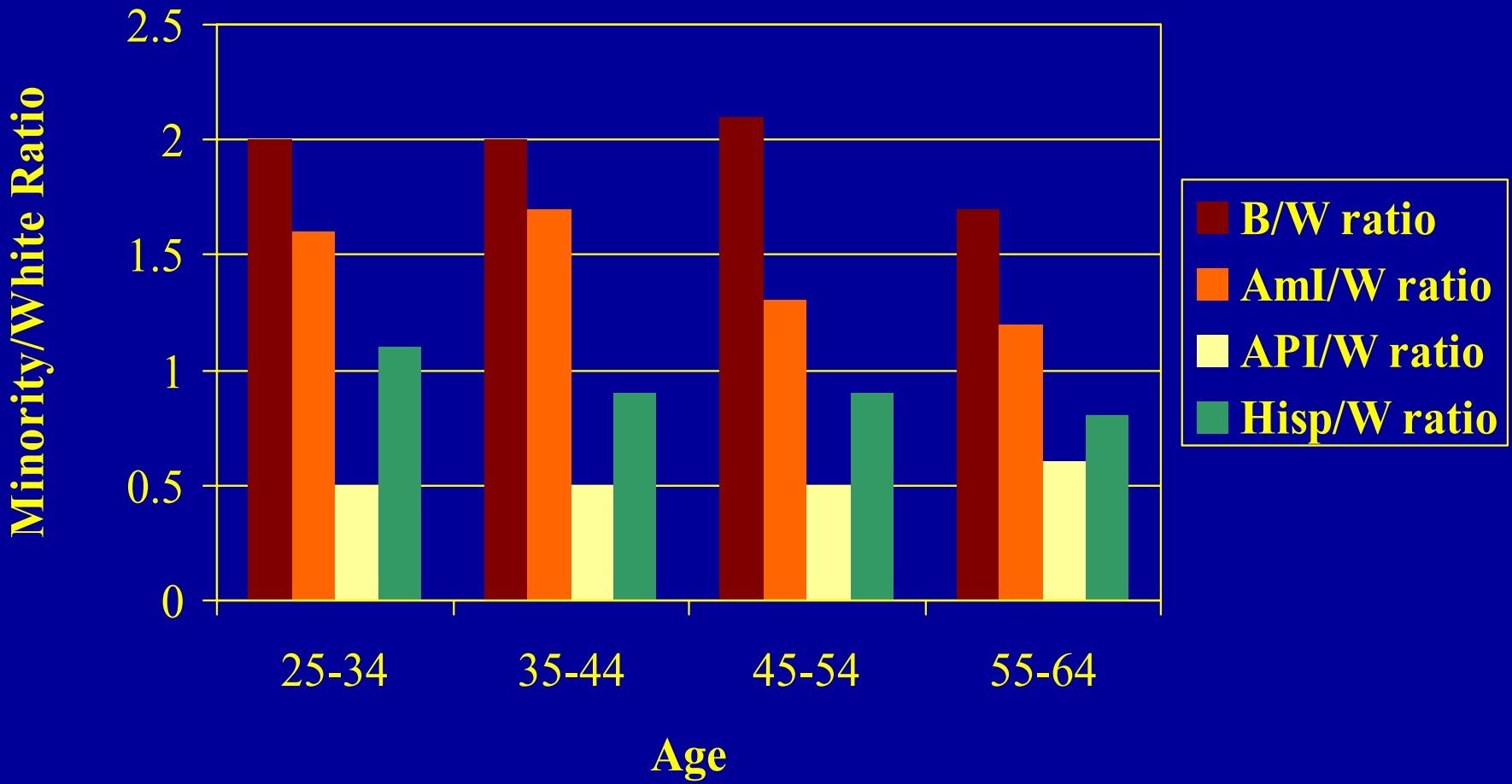
There Is a Racial Gap in Health in Early Life:

Minority/White Mortality Ratios, 2000



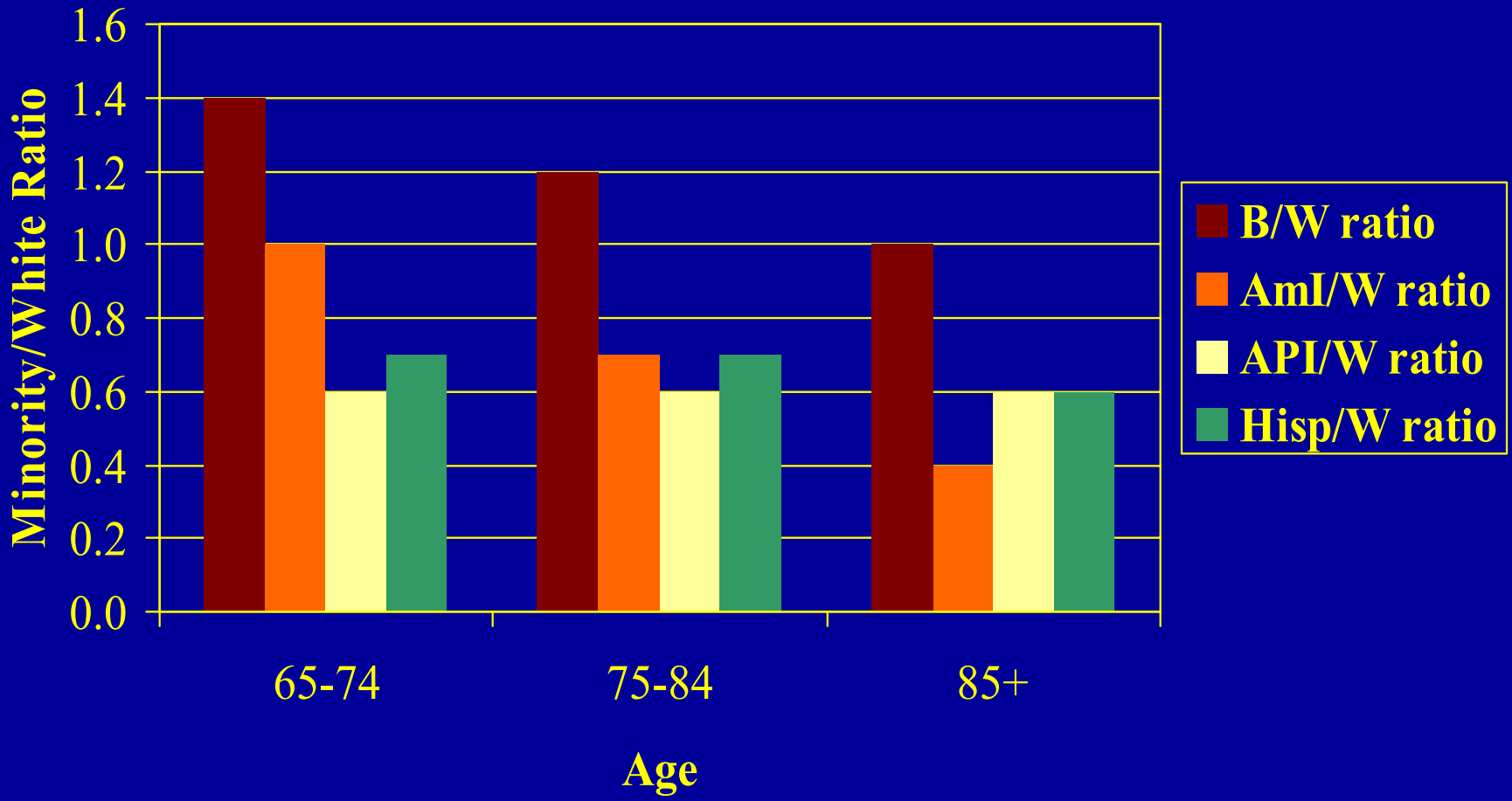
There Is a Racial Gap in Health in Mid Life:

Minority/White Mortality Ratios, 2000



There Is a Racial Gap in Health in Late Life:

Minority/White Mortality Ratios, 2000



Summary, Age-Specific Profiles -I

- For Blacks, (in contrast to an age-adjusted rate 30% higher than that of whites), African Americans have mortality rates that are at least twice as high as those of whites between ages 1-4 & ages 25-54, at least 50% higher at ages 5-24 and more than 40% higher at ages and 55-74.
- For American Indians, (in contrast to an age-adjusted rate that is lower than that of whites) death rates that are higher than those of the white population for ages 1-4 and ages 15-64, and equivalent between ages 5-14 and 65-74.

Summary, Age-Specific Profiles- II

- For Hispanics, (in contrast to an age-adjusted rate that is lower than that of whites) mortality rates are comparable to those of whites up through age 14, slightly higher in young adulthood (ages 15-34) and lower beyond age 35.
- For the API population, age-adjusted and age-specific data are consistent. However, the combination of Asians and Pacific Islanders into a single subgroup skews the elevated rates of mortality for Pacific Islanders.

Mortality Rates from All Causes 1950-1998

Year	Adjusted for 1940 Std. Million[1]				Adjusted for 2000 Std. Million[2]			
	White	Black	Diff (B-W)	B/W	White	Black	Diff (B-W)	B/W
1950	8.0	12.4	4.4	1.5	14.1	17.2	3.1	1.2
1960	7.3	10.8	3.5	1.5	13.1	15.8	2.7	1.2
1970	6.8	10.4	3.6	1.5	11.9	15.2	3.3	1.3
1980	5.6	8.4	2.8	1.5	10.1	13.1	3.0	1.3
1990	4.9	7.9	3.0	1.6	9.1	12.5	3.4	1.4
1998	4.5	6.9	2.4	1.5	8.5	11.4	2.9	1.3

[1]NCHS 2000; [2]NCHS 2001; Deaths per 1,000 population

Validity of Race on Death Certificate

	Race on Death Certificate	
Race on CPS	% Discrepant	% White
White	0.8	99.2
Black	1.8	1.1
American Indian	26.4	25.0
Asian/Pacific Islander	17.6	12.1

Sorlie et al., 1992

Validity of Hispanic Ethnicity on Death Certificate

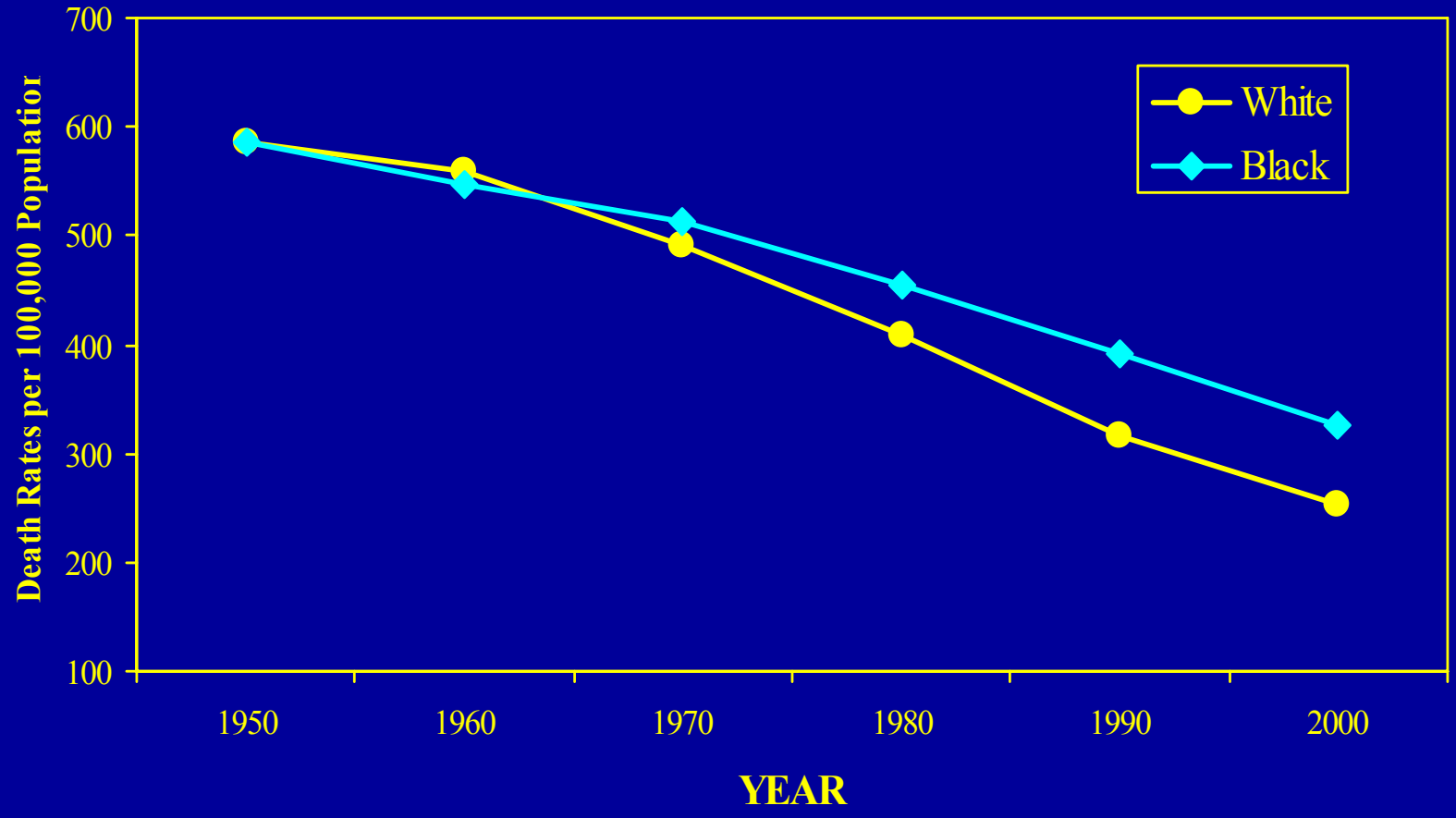
	Hispanic on Death Certificate	
Hispanic on CPS	% Discrepant	% Non-Hispanic
Mexican	15.1	5.8
Puerto Rican	14.1	11.3
Cuban	20.0	13.3
Other Hispanic	52.4	31.7
Any Hispanic	10.3	10.3
Non-Hispanic	0.2	99.8

Sorlie et al., 1992

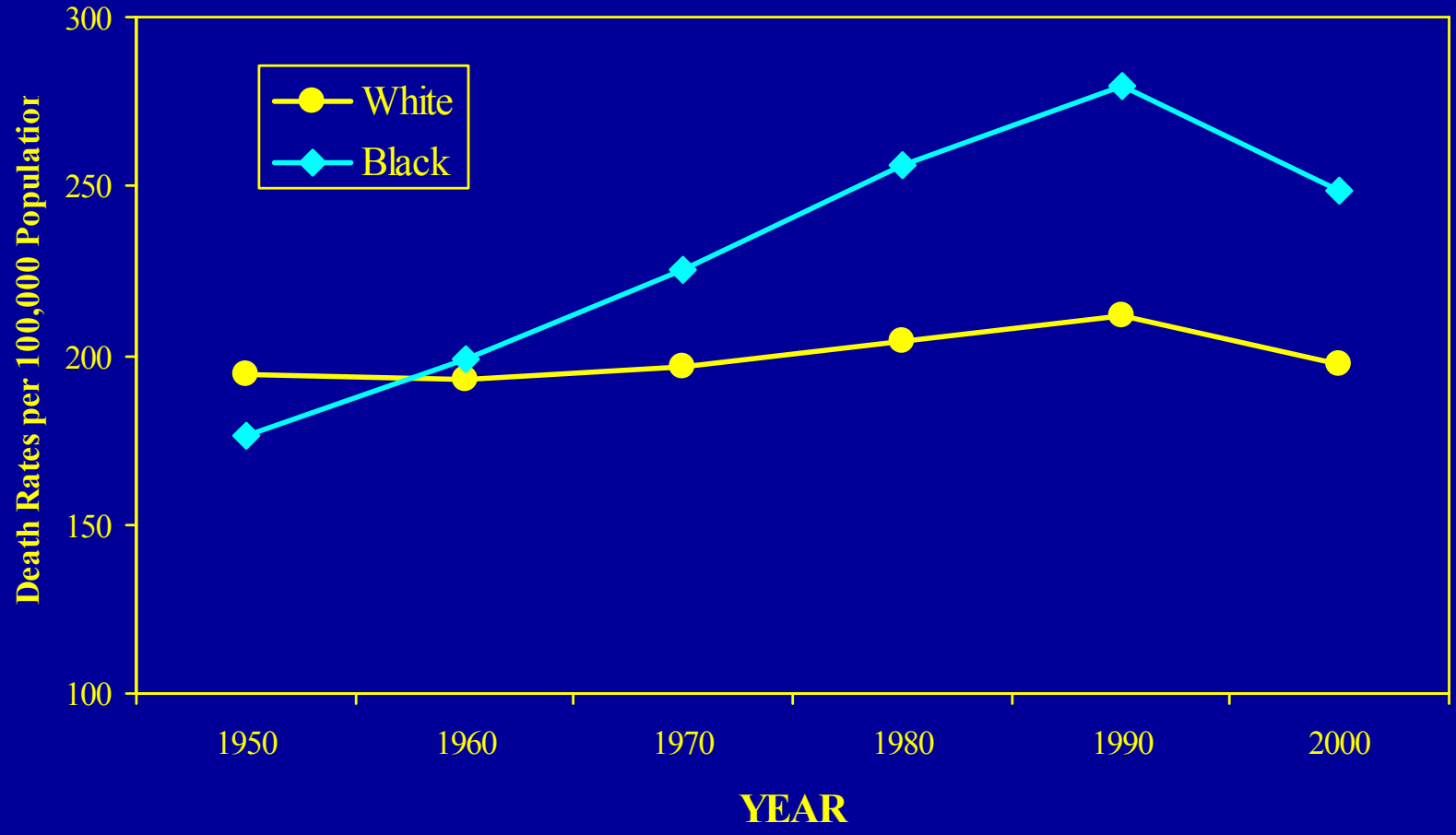
Issue #3

Racial Disparities In Health Are Persistent Over Time

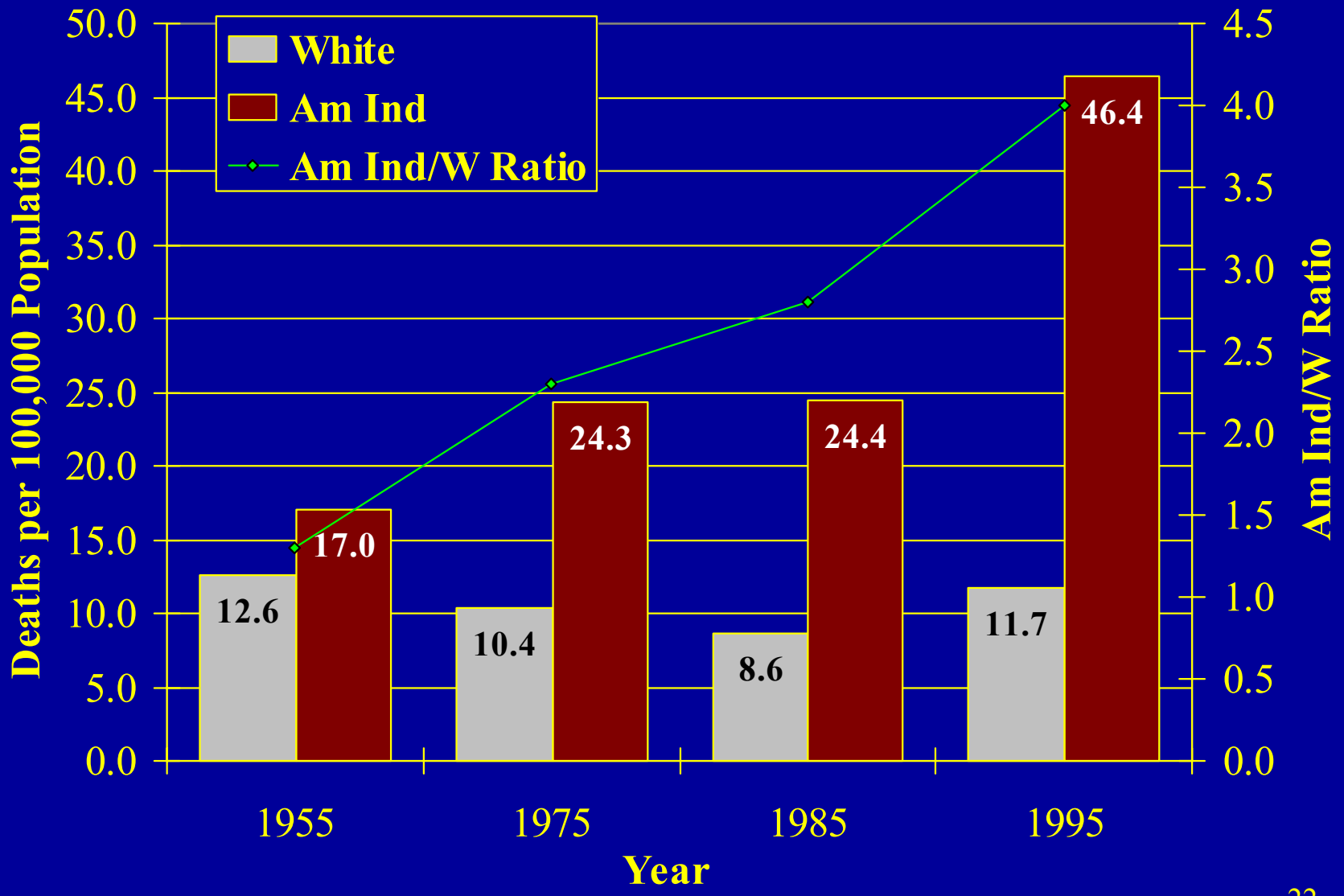
Age-Adjusted Heart Disease Death Rates for Blacks and Whites, 1950-2000



Age-Adjusted Cancer Death Rates for Blacks and Whites, 1950-2000

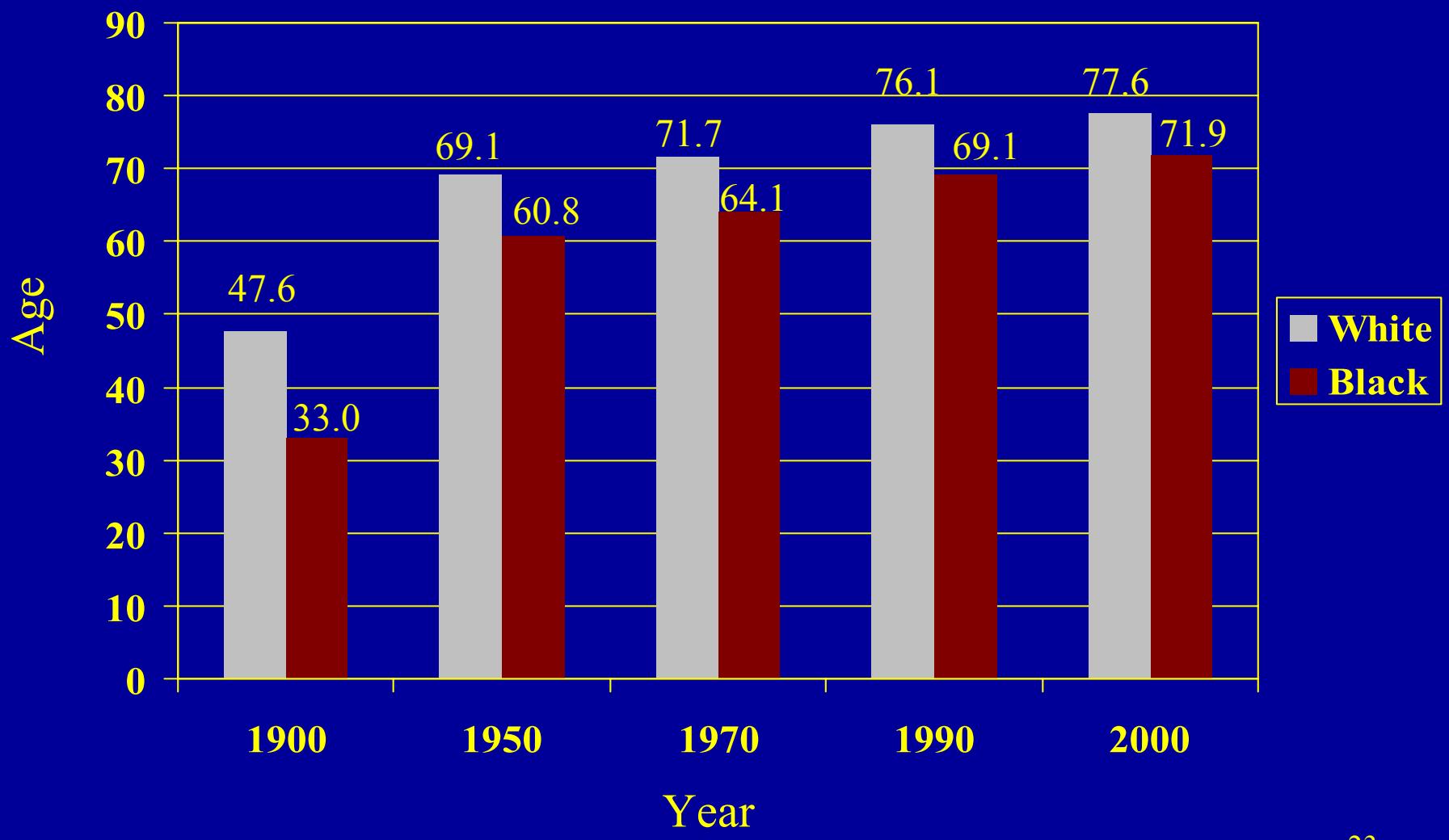


Diabetes Death Rates 1955-1995



Source: Indian Health Service; Trends in Indian Health 1998-99

Life Expectancy at Birth, 1900-2000



Excess Deaths for Black Population

Year	Avg.No/Day	Avg.No/Year
1940	183	66,900
1950	144	52,700
1960	139	50,900
1970	198	72,200
1980	221	80,600
1990	285	103,900
1998	265	96,800

TOTAL Premature Deaths, 1940-1999 = 4,272,000

Levine et al. 2001

The Persistence of Racial Disparities

- We have FAILED!
- In spite of:
  - -- a War on Poverty
  - -- a Civil Rights revolution
  - -- Medicare & Medicaid
  - -- the Hill-Burton Act
  - -- Major advances in medical research & technology

We have made little progress in reducing the elevated death rates of blacks and American Indians relative to whites.

Issue #4

Race is Primarily A Social Category

What is Race?

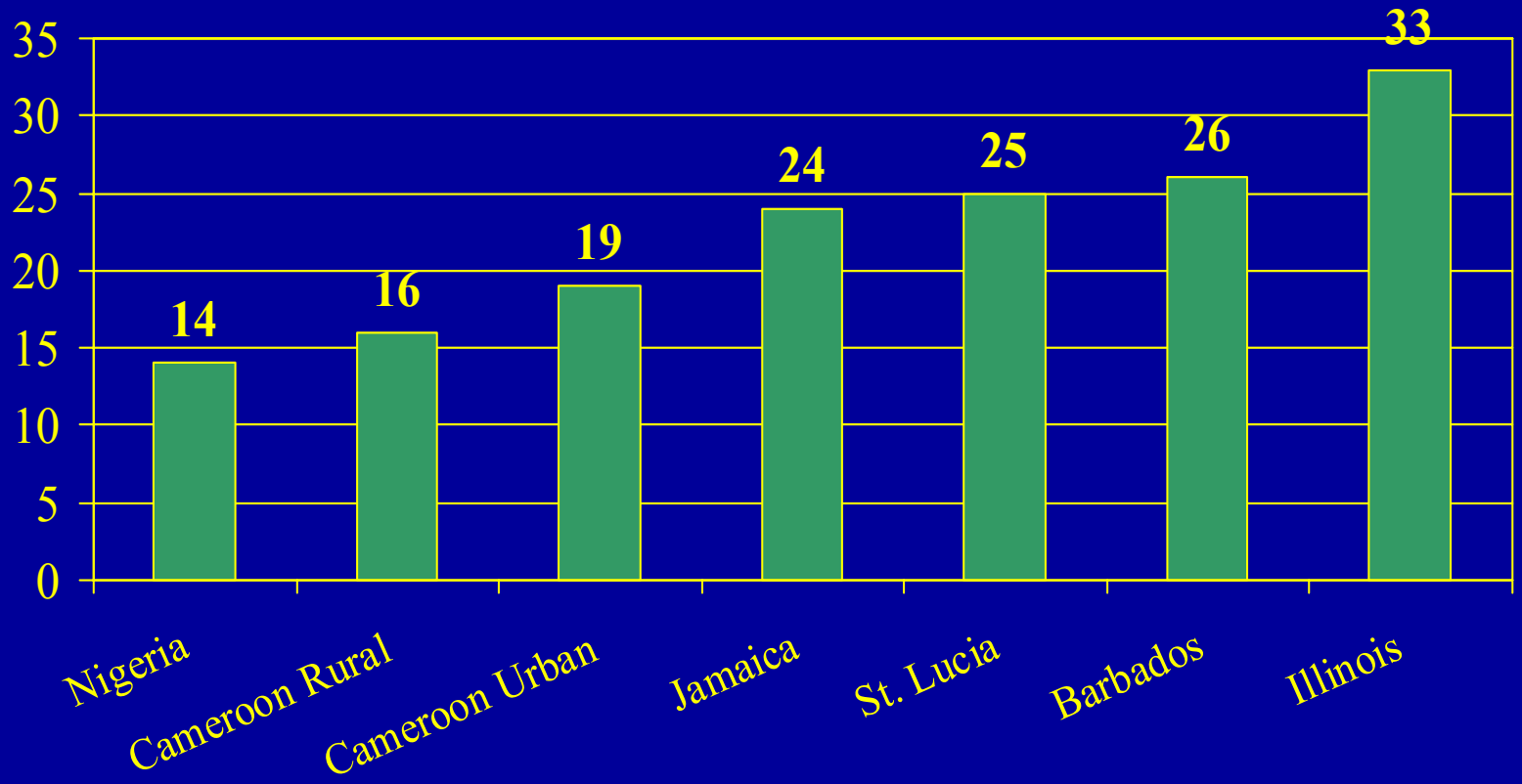
"Pure races in the sense of genetically homogenous populations do not exist in the human species today, nor is there any evidence that they have ever existed in the past… Biological differences between human beings reflect both hereditary factors and the influence of natural and social environments. In most cases, these differences are due to the interaction of both."

American Association of Physical Anthropology, 1996

Why Study Race?

"Race is "a social concept that changes over time. …Research documents the role and consequences of race in primary social institutions and environments, including the criminal justice, education and health systems, job markets, and where people live…Refusing to acknowledge the fact of racial classification, feelings, and actions, and refusing to measure their consequences will not eliminate racial inequalities. At best, it will preserve the status quo."

Hypertension, 7 West African Origin Groups (%)

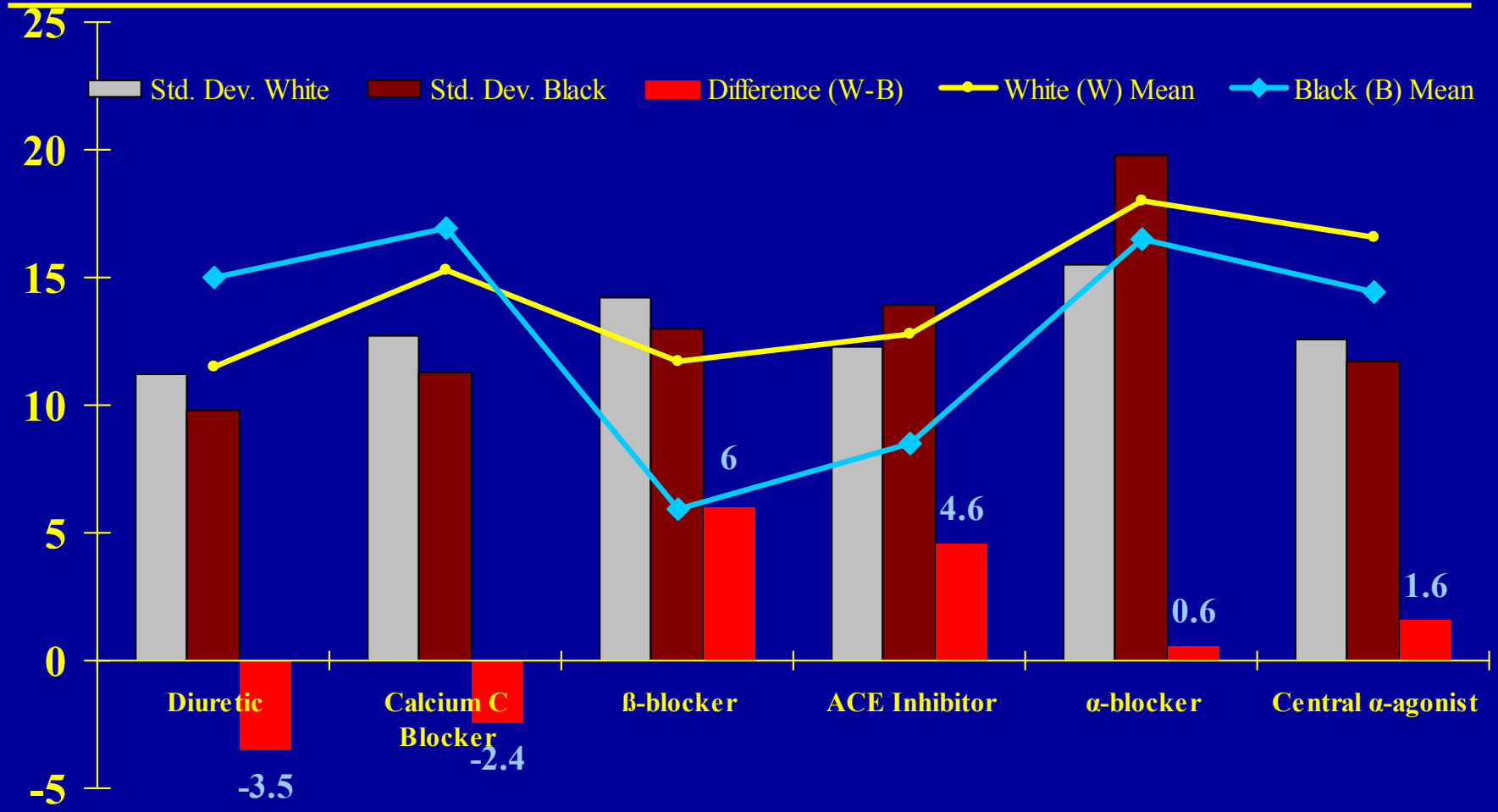


Source: International Collaborative Study of Hypertension in Blacks, 1995

A Closer Look at Conventional Wisdom

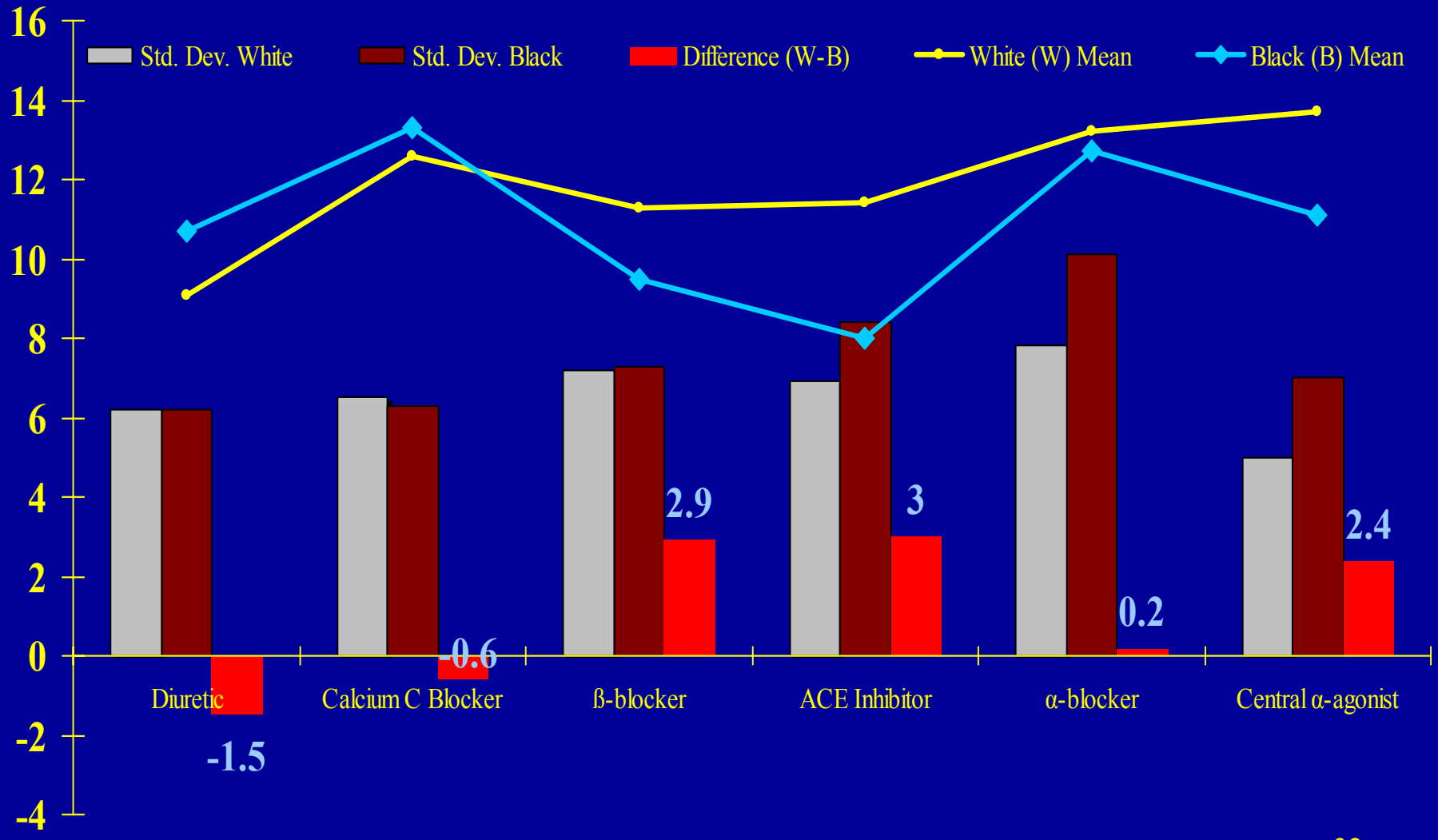
- **Blacks and whites differ in their responses to antihypertensive medications**
- **White patients respond better to beta Blockers and ACE inhibitors**
- **Black patients respond better to Diuretics and Calcium Channel Blockers**

Decrement in Systolic B.P. with Antihypertensive Tx



Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

Decrement in Diastolic B.P with Antihypertensive Tx



Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

Overlap in Antihypertensive Drug Response

Percent of Blacks & Whites with Similar Responses to Medications

Medication	Systolic	Diastolic
Diuretics	86%	90%
Calcium C Blocker	93%	95%
β-Blocker	83%	90%
ACE Inhibitor	86%	81%
α-Blocker	88%	87%
Central α-Agonist	92%	78%

Source: Sehgal, 2004. Meta Analysis of 15 Clinical Trials.

Skin Color in the Clinical Context

- **This meta analysis of 15 clinical trials reveals that the overwhelming majority of blacks and whites have similar responses to all of the common antihypertensive medications**

- **Thus, simply knowing a patient's race provides precious little guidance to a clinician in the selection of antihypertensive medications**

Research Opportunity

As research on the human genome moves forward, there will be increasing need for comprehensive, detailed, and rigorous characterization of the risk factors/resources in the social/physical environment that may interact with biological predispositions to affect health risks.

Issue #5

Processes Linked To Migration Affects Current and Future Patterns Of Racial/Ethnic Differences In Health

Pattern I: Immigration

- **Hispanics and Asian Americans tend to have equivalent or better health status than whites**
- **Immigrants of all racial/ethnic groups tend to have better health than their native born counterparts**
- **With length of stay in the U.S., the health advantage of Asian and Latino immigrants declines**
- **Latinos and Asians differ markedly in their levels of human capital upon arrival in the U.S.**
- **Given the low SES profile of Hispanic immigrants and their ongoing difficulties with educational and occupational opportunities, the health of Latinos is likely to decline more rapidly than that of Asians and to be worse than the U.S. average in the future**

Acculturation, Assimilation and Health

Research on Latinos reveals that as length of stay increases in the U.S. the following also increase:

- infant mortality
- adult mortality
- low birth weight
- poor health practices
- multiple indicators of morbidity

Vega & Amaro 1994; Finch et al. 2002

SES and Asian Immigrants

Group	College Grads %	White Collar Job %
1. Asian		
a. India	64.9	48
b. Taiwan	62.2	47
c. Philippines	43.0	28
d. Japan	35.0	39
e. Korea	34.4	25
f. China	30.9	29
g. Vietnam	15.9	17
h. Cambodia	5.5	9
i. Laos	5.1	7
2. All Foreign Born	20.4	22
3. Native Born		
a. All U.S. Born	20.3	27
b. Asian (U.S. Born)	35.9	34
c. White (Non-Hisp.)	22.0	29
d. Black (Non-Hisp.)	11.4	18

Rumbaut, 1996

SES and Black and Hispanic Immigrants

Group	College Grads %	White Collar Job %
1. Hispanic Immigrants		
a. Mexico	3.5	6
b. Dominican Repub.	7.5	11
c. El Salvador	4.6	6
d. Cuba	15.6	23
e. Nicaragua	14.6	11
2. Black Immigrants		
a. Africa	47.1	37
b. Jamaica	14.9	22
c. Haiti	11.8	14
3. All Foreign Born	20.4	22
4. Native Born		
1. All U.S. Born	20.3	27
2. Black (Non-Hisp.)	11.4	18
3. White (Non-Hisp.)	22.0	29
4. Puerto Rican	9.5	17
5. Mexican (U.S. Born)	8.6	16

Rumbaut, 1996

Research & Policy Opportunities

What are the relevant factors and what is the relative contribution of each to shaping the relationship between migration status/generational status and health for racial/ethnic minority populations?

What interventions, if any, can reverse the downward health trajectory of immigrants with length of stay in the U.S.?

Issue #6

SES Plays An Important But Complex Role In Racial/Ethnic Differences In Health

Pattern 2: Socioeconomic Disadvantage & Geographic Marginalization

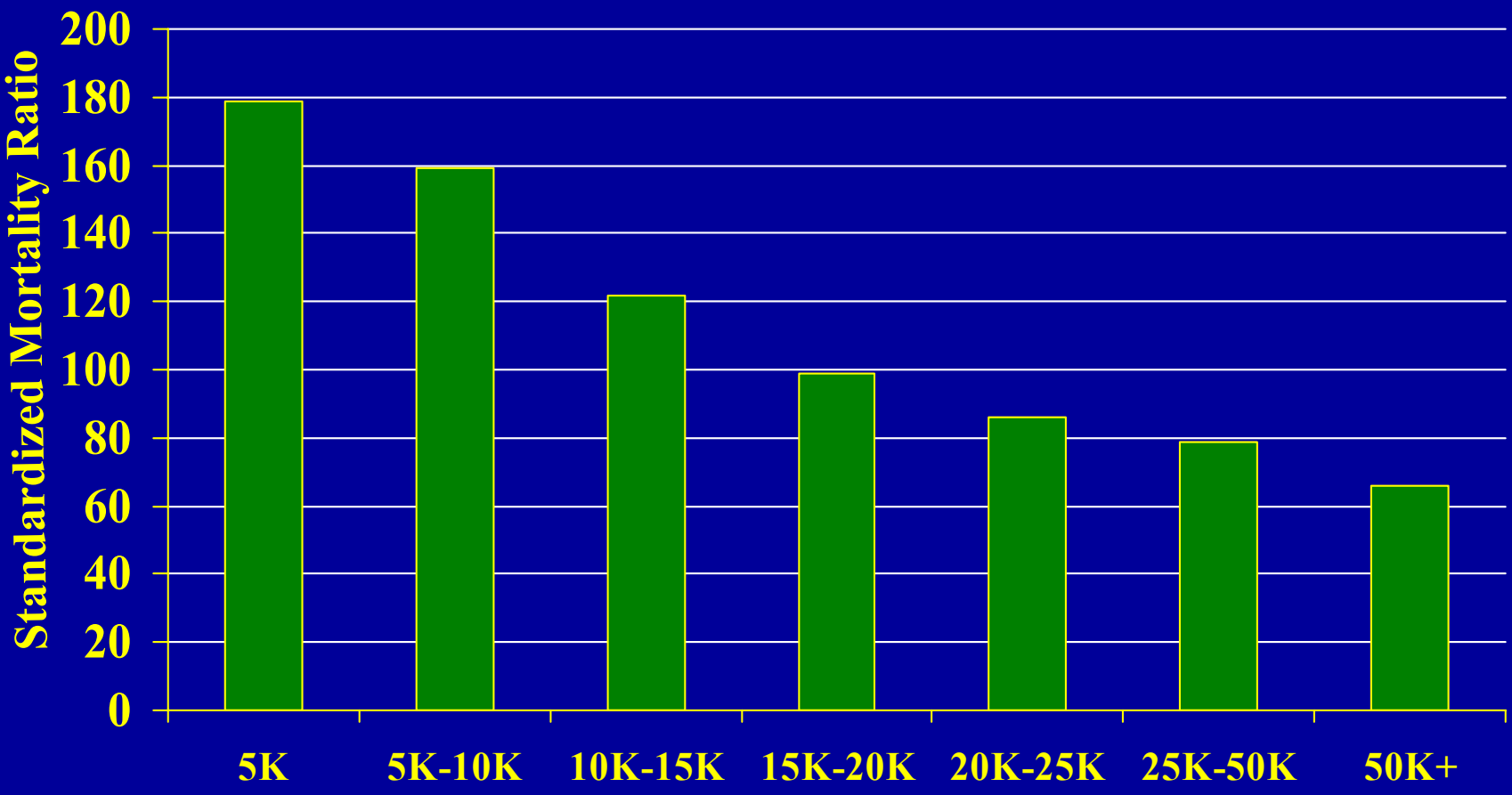
- African Americans, American Indians, (and Native Hawaiians and other Pacific Islanders) tend to have poorer health outcomes than whites across the life course
- These differences are remarkably persistent across place and time
- Racial disparities in health persist in the context of overall improvements in health

SAT Scores by Income

Family Income	Median Score
More than $100,000	1129
$80,000 to $100,000	1085
$70,000 to $80,000	1064
$60,000 to $70,000	1049
$50,000 to $60,000	1034
$40,000 to $50,000	1016
$30,000 to $40,000	992
$20,000 to $30,000	964
$10,000 to $20,000	920
Less than $10,000	873

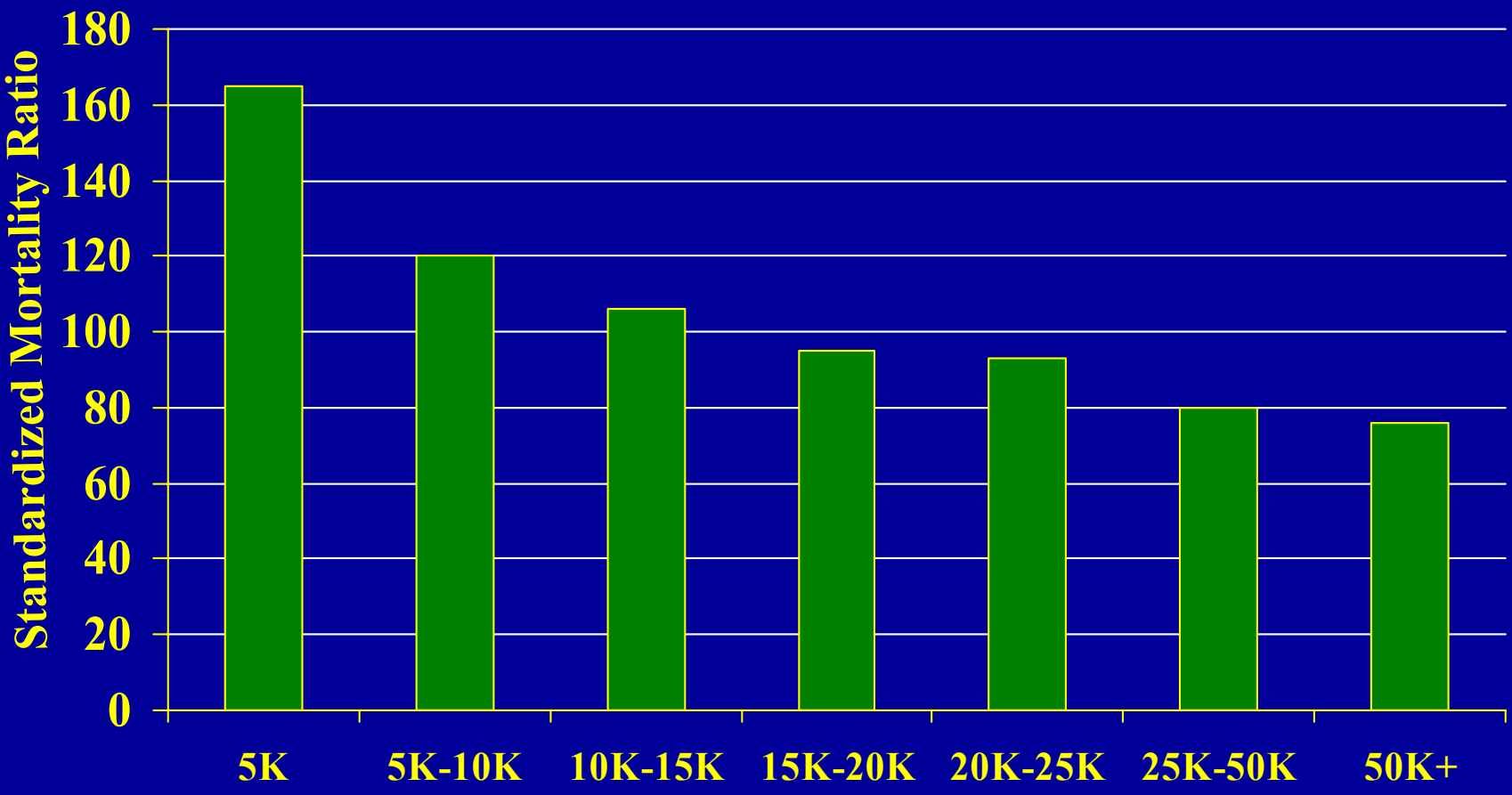
Source: (ETS) Mantsios; N=898,596

Mortality by Income,White Males, 1979-85



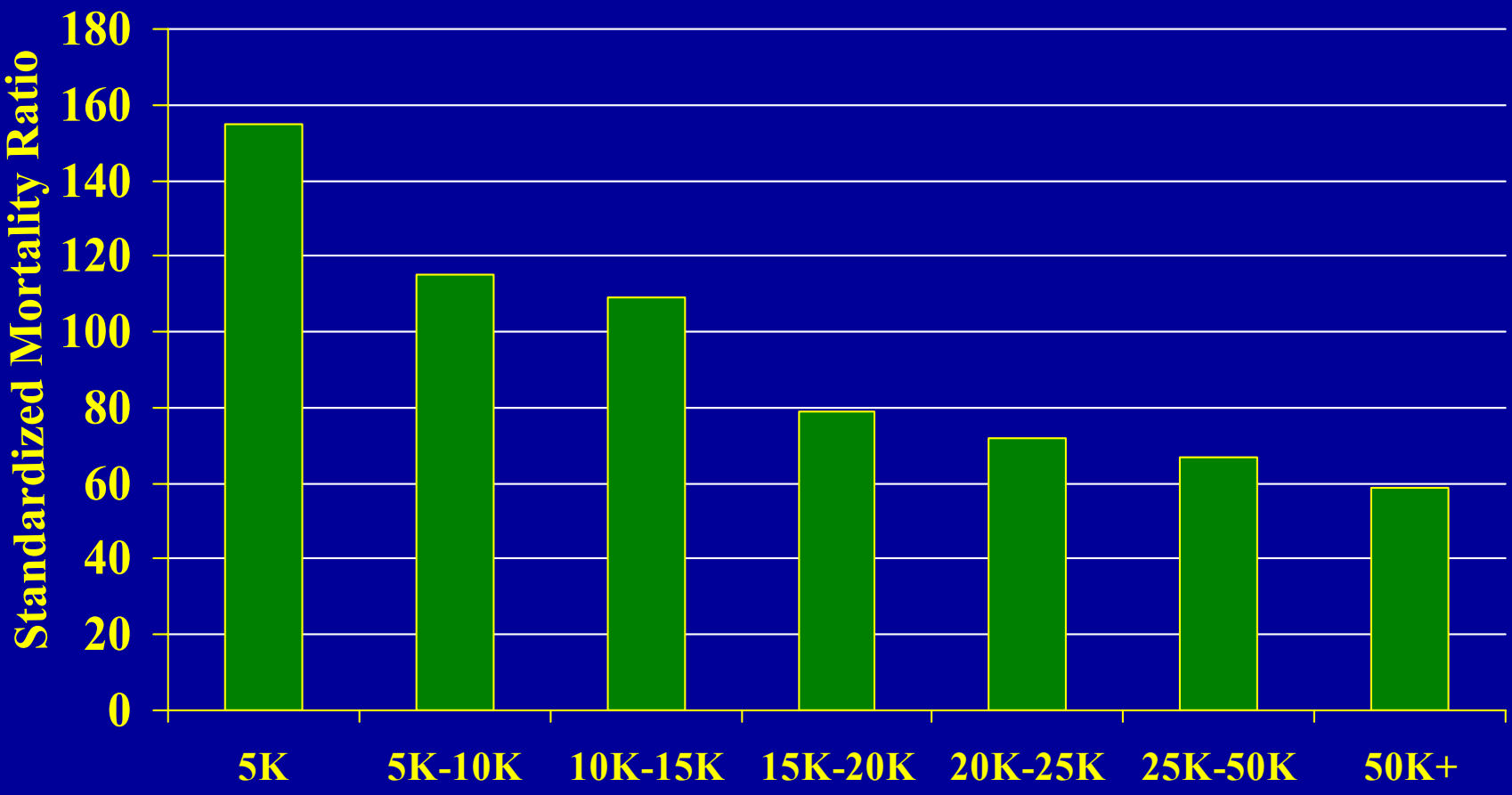
Source: Rogot et al. 1992; 1980 Dollars; Aged 25-64

Mortality by Income,White Females, 1979-85



Source: Rogot et al. 1992; 1980 Dollars; Aged 25-64

Mortality by Income, Black Males, 1979-85



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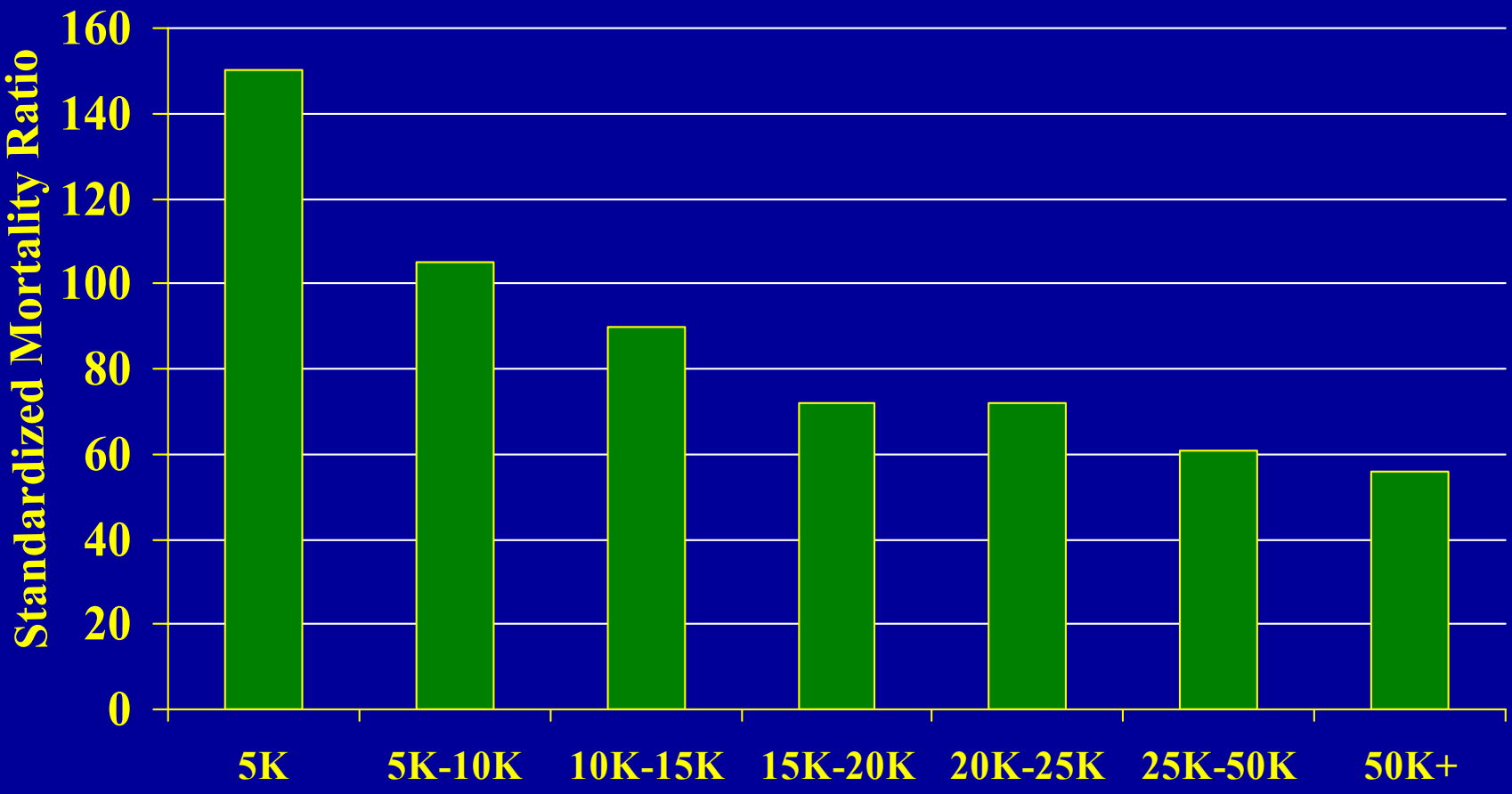
Mortality by Income, Black Females, 1979-85



Source: Rogot et al. 1992; 1980 Dollars; Aged 25-64

Percent of persons with Fair or Poor Health by Race, 1995

Race/Ethnicity	Percent	Racial Differences		
		B-W	H-W	B-H
White	9.1	8.2	6.0	2.2
Black	17.3			
Hispanic	15.1			

Poor=Below poverty; Near poor+<2x poverty; Middle Income = >2x poverty but <$50,000+

Source: Parmuk et al. 1998

Percent of Women with Fair or Poor Health by Race and Income, 1995

Household Income	White	Black	Hispanic
Poor	30.2	38.2	30.4
Near Poor	17.9	26.1	24.3
Middle Income	9.2	14.6	13.5
High Income	5.8	9.2	7.0
SES Difference	24.4	29.0	23.4

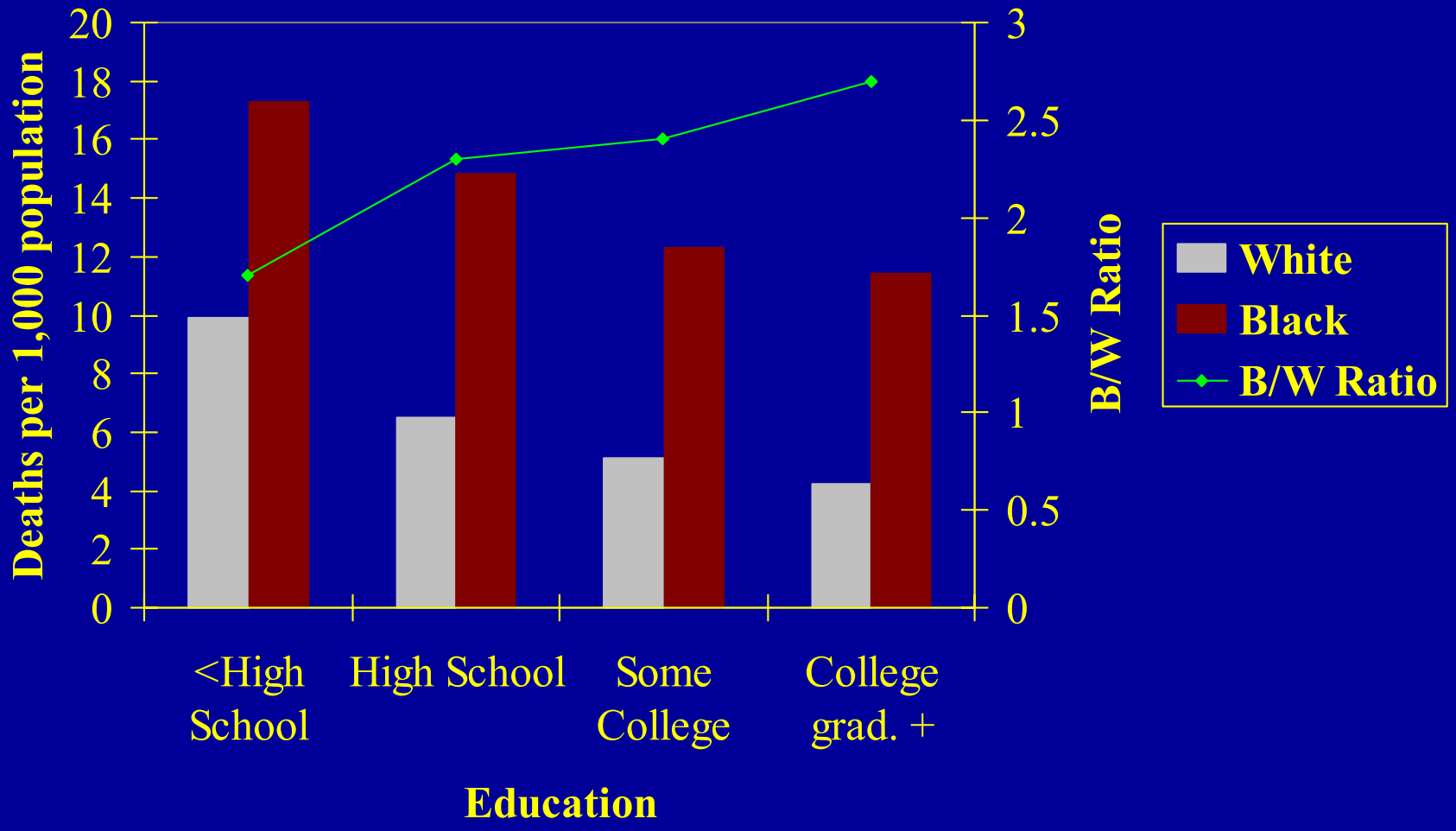
Poor=below poverty; Near Poor=<2x poverty; Middle Income=>2x poverty but <$50,000; High Income=$50,000+

Source: Pamuk et al. 1998

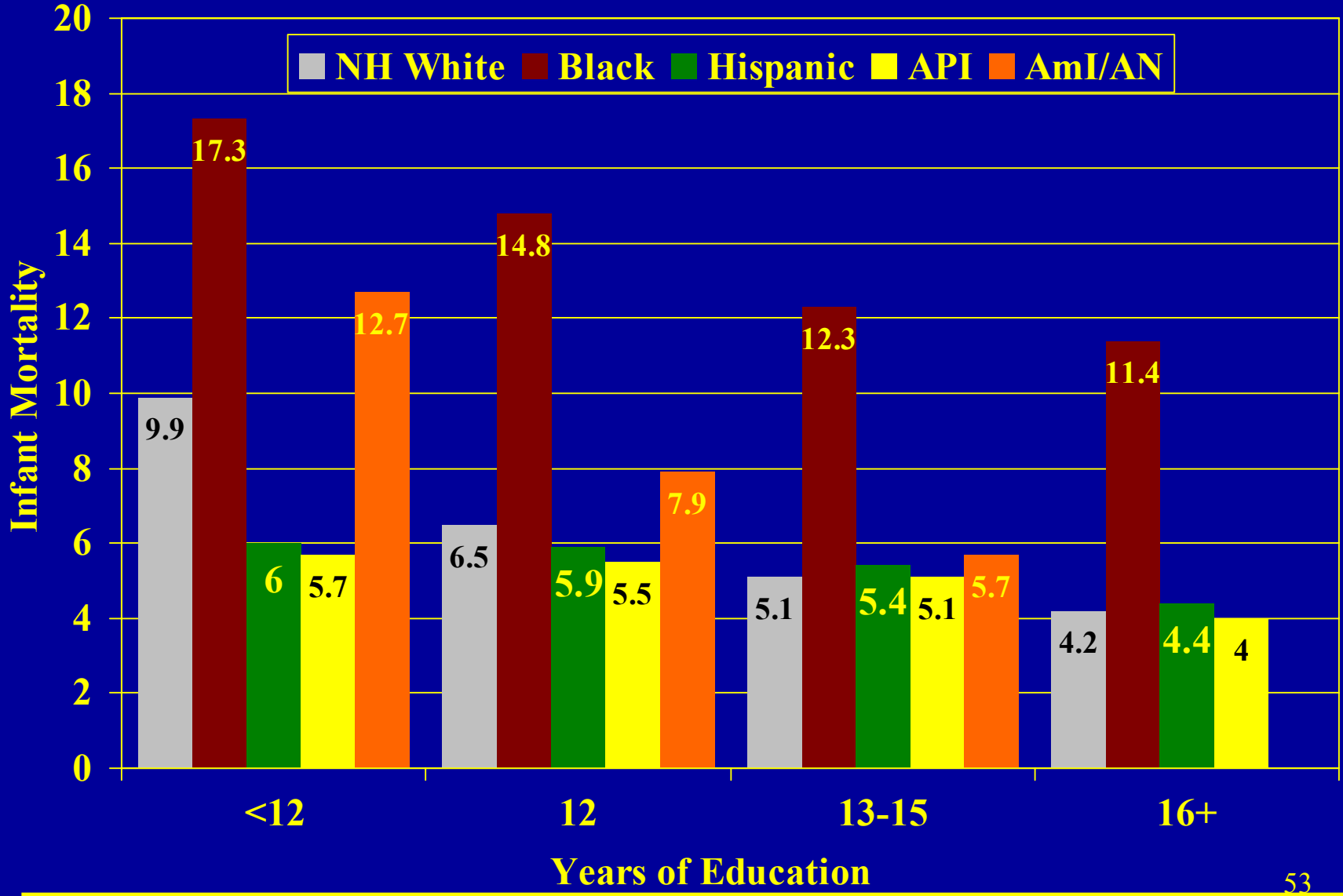
Race/Ethnicity and SES

- Race and SES reflect two related but not interchangeable systems of inequality
- In national data, the highest SES group of African American women have equivalent or higher rates of infant mortality, low birth-weight, hypertension and overweight than the lowest SES group of white women

Infant Death Rates by Mother's Education, 1995



Infant Mortality by Mother's Education, 1995



Why Race Still Matters

1. All indicators of SES are non-equivalent across race. Compared to whites, blacks receive less income at the same levels of education, have less wealth at the equivalent income levels, and have less purchasing power (at a given level of income) because of higher costs of goods and services.
2. Health is affected not only by current SES but by exposure to social and economic adversity over the life course.
3. Personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health of minority group members in multiple ways.

Race/Ethnicity and Wealth, 2000
Median Net Worth

Income	White	Black	Hispanic
All	$79,400	$7,500	$9,750
Excl. Hm. Eq.	22,566	1,166	1,850
Poorest 20%	24,000	57	500
2nd Quintile	48,500	5,275	5,670
3rd Quintile	59,500	11,500	11,200
4th Quintile	92,842	32,600	36,225
Richest 20%	208,023	65,141	73,032

Orzechowski & Sepielli 2003, U.S. Census

Wealth of Whites and of Minorities per $1 of Whites, 2000

Household Income	White	B/W Ratio	Hisp/W Ratio
Total	$ 79,400	9¢	12¢
Poorest 20%	$ 24,000	1¢	2¢
2nd Quintile	$ 48,500	11¢	12¢
3rd Quintile	$ 59,500	19¢	19¢
4th Quintile	$ 92,842	35¢	39¢
Richest 20%	$ 208,023	31¢	35¢

Source: Orzechowski & Sepielli 2003, U.S. Census

Race and Economic Hardship 1995

African Americans were more likely than whites to experience the following hardships [1]:

1. **Unable to meet essential expenses**
2. **Unable to pay full rent on mortgage**
3. **Unable to pay full utility bill**
4. **Had utilities shut off**
5. **Had telephone shut off**
6. **Evicted from apartment**

[1] After adjustment for income, education, employment status, transfer payments, home ownership, gender, marital status, children, disability, health insurance and residential mobility.

Bauman 1998; SIPP

Issue #7

Racism Also Contributes To Racial/Ethnic Differences In Health

Racism: Potential Mechanisms

- Institutional discrimination can restrict socioeconomic attainment and group differences in SES and health.
- Segregation can create pathogenic residential conditions.
- Discrimination can lead to reduced access to desirable goods and services.
- Internalized racism (acceptance of society's negative characterization) can adversely affect health.
- Racism can create conditions that increase exposure to traditional stressors (e.g. unemployment).
- Experiences of discrimination may be a neglected psychosocial stressor.

Perceived Discrimination:

Experiences of discrimination may be a neglected psychosocial stressor

MLK Quote

"..Discrimination is a hellhound that gnaws at Negroes in every waking moment of their lives declaring that the lie of their inferiority is accepted as the truth in the society dominating them."

Martin Luther King, Jr. [1967]

Discrimination Persists

- Pairs of young, well-groomed, well-spoken college men with identical resumes apply for 350 advertised entry-level jobs in Milwaukee, Wisconsin. Two teams were black and two were white. In each team, one said that he had served an 18-month prison sentence for cocaine possession.

- The study found that it was easier for a white male with a felony conviction to get a job than a black male whose record was clean.

Source: Devan Pager; NYT March 20, 2004

Percent of Job Applicants Receiving a Callback

Criminal Record	White	Black
No	34%	14%
Yes	17%	5%

Source: Devan Pager; NYT March 20, 2004

Every Day Discrimination

In your day-to-day life how often do the following things happen to you?

- You are treated with less courtesy than other people.
- You are treated with less respect than other people.
- You receive poorer service than other people at restaurants or stores.
- People act as if they think you are not smart.
- People act as if they are afraid of you.
- People act as if they think you are dishonest.
- People act as if they're better than you are.
- You are called names or insulted.
- You are threatened or harassed.

Everyday Discrimination and Subclinical Disease

In the study of Women's Health Across the Nation (SWAN):

-- Everyday Discrimination was positively related to subclinical carotid artery disease (IMT; intima-media thickness) for black but not white women

-- chronic exposure to discrimination over 5 years was positively related to coronary artery calcification (CAC)

Troxel et al. 2003; Lewis et al. 2006

Arab American Birth Outcomes

- Well-documented increase in discrimination and harassment of Arab Americans after 9/11/2001
- Arab American women in California had an increased risk of low birthweight and preterm birth in the 6 months after Sept. 11 compared to pre-Sept. 11
- Other women in California had no change in birth outcome risk pre-and post-September 11

Lauderdale, 2006

Issue #8

We need to take more seriously the central role that place (and its related characteristics) can play in Health.

Understanding Elevated Health Risks

"Has anyone seen the SPIDER that is spinning this complex web of causation?"

Krieger, 1994

Racial Segregation Is …

1. Myrdal (1944): …"basic" to understanding racial inequality in America.
2. Kenneth Clark (1965): …key to understanding racial inequality.
3. Kerner Commission (1968): …the "linchpin" of U.S. race relations and the source of the large and growing racial inequality in SES.
4. John Cell (1982): …"one of the most successful political ideologies" of the last century and "the dominant system of racial regulation and control" in the U.S.
5. Massey and Denton (1993): …"the key structural factor for the perpetuation of Black poverty in the U.S." and the "missing link" in efforts to understand urban poverty.

How Segregation Can Affect Health

1. Segregation determines quality of education and employment opportunities.
2. Segregation can create pathogenic neighborhood and housing conditions.
3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
4. Segregation can adversely affect access to high-quality medical care.

Source: Williams & Collins , 2001

Race and Job Loss
Economic Downturn of 1990-1991

Racial Group	Net Gain or Loss
BLACKS	59,479 LOSS
WHITES	71,144 GAIN
ASIANS	55,104 GAIN
HISPANICS	60,040 GAIN

Source : *Wall Street Journal* analysis of EEOC reports of 35,242 companies

Race and Job Loss

	Percent Black		
Company	**Work Force**	**Losses**	**Reason**
Sears	16	54	Closed distribution centers in inner-cities; relocated to suburbs
Pet	14	35	Two Philadelphia plants shutdown
Coca-Cola	18	42	Reduced blue-collar workforce
American Cyanamid	11	25	Sold two facilities in the South
Safeway	9	16	Reduced part-time work; more suburban stores

***Source*: Sharpe, 1993: Wall Street Journal**

Racial Differences in Residential Environment

- "The sources of violent crime…are remarkably invariant across race and rooted instead in the structural differences among communities, cities, and states in economic and family organization,"p. 41
- In the 171 largest cities in the U.S., there is not even one city where whites live in ecological equality to blacks in terms of poverty rates or rates of single-parent households.
- "The worst urban context in which whites reside is considerably better than the average context of black communities." p.41

Source: Sampson & Wilson 1995

Segregation: Distinctive for Blacks

- Blacks are more segregated than any other racial/ethnic group.
- Segregation is inversely related to income for Latinos and Asians, but is high at all levels of income for blacks.
- The most affluent blacks (income over $50,000) are more highly segregated than the poorest Latinos and Asians (incomes under $15,000).
- Thus, middle class blacks live in poorer areas than whites of similar SES and poor whites live in much better neighborhoods than poor blacks.
- African Americans manifest a higher preference for residing in integrated areas than any other group.

Source: Massey 2004

Residential Segregation and SES

A study of the effects of segregation on young African American adults found that the elimination of segregation would erase black-white differences in

- Earnings
- High School Graduation Rate
- Unemployment

And reduce racial differences in single motherhood by two-thirds

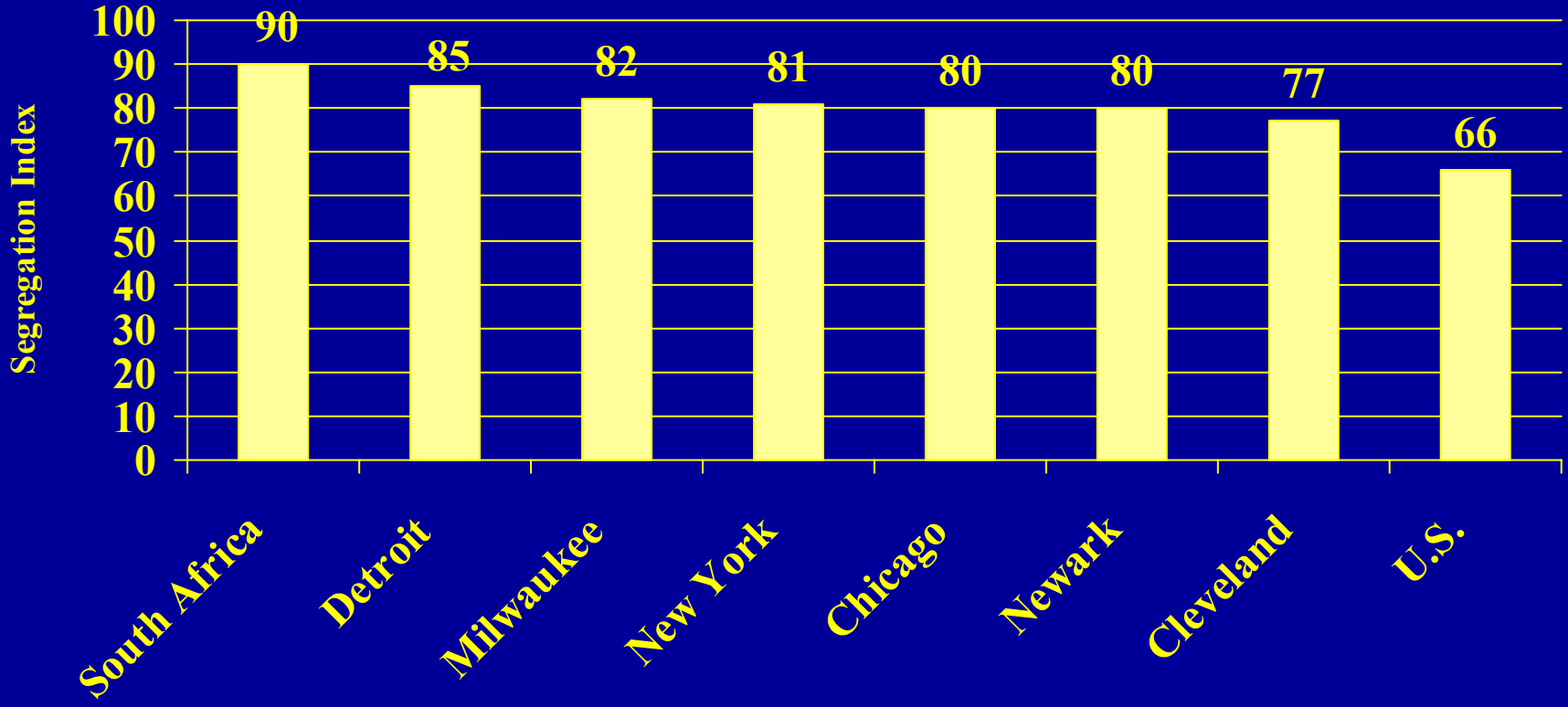
Cutler, Glaeser & Vigdor, 1997

President Bush

"America's long experience with the segregation we have put behind us and the racial discrimination we still struggle to overcome requires a special effort to make real the promise of equal opportunity for all."

Jan 15, 2003 before filing an amicus brief against the University of Michigan's race-conscious admissions policies

American Apartheid: South Africa (de jure) in 1991 & U.S. (de facto) in 2000



Source: Massey 2004; Iceland et al. 2002; Glaeser & Vigitor 2001

Improving Residential Circumstances

Policies to reduce racial disparities in SES and health should address the concentration of economic disadvantage and the lack of an infrastructure that promotes opportunity that co-occurs with segregation.

That is, eliminating the negative effects of segregation on SES and health is likely to require a major infusion of economic capital to improve the social, physical, and economic infrastructure of disadvantaged communities.

Source: Williams and Collins 2004

Issue #10

We need to better understand how resilience factors and processes can affect health

Religion & Health: Potential Mechanisms

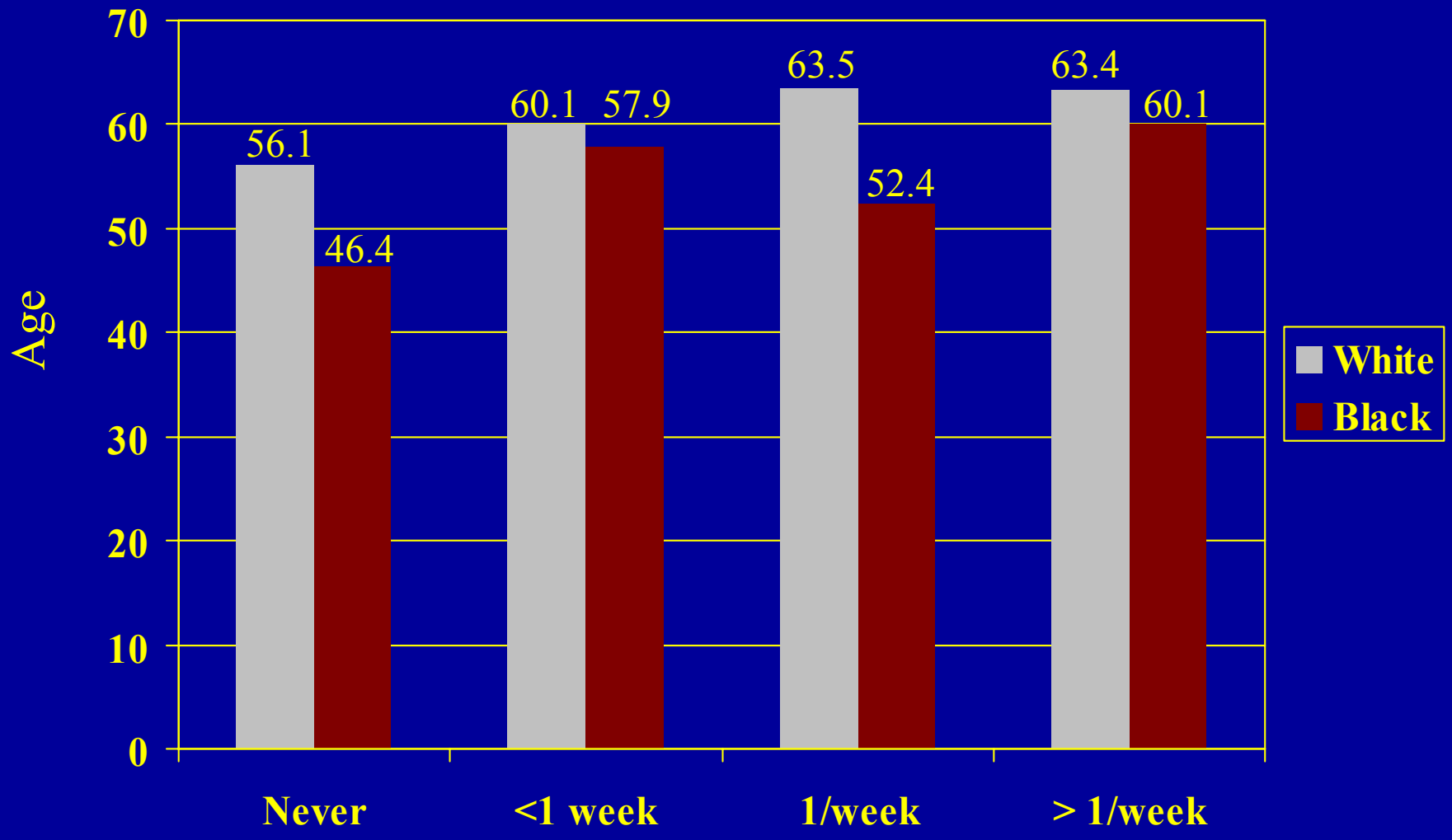
1. Religious institutions can provide support, intimacy, a sense of connectedness and belonging
2. Religious beliefs and values can provide systems of meaning to interpret and re-interpret stress
3. Religious beliefs can provide feelings of strength to cope with adversity
4. By encouraging moderation in all things and reducing risk taking behavior, religious involvement can reduce exposure to stress.
5. Religious participation can discourage negative health behaviors (tobacco, alcohol, drugs, risky sexual practices)
6. Religious institutions can generate stress: time demands, role conflicts, social conflicts, criticism

Religion and Adolescent Risk Behavior

- Religious high school seniors are less likely than their non-religious peers to
  - Carry a weapon (gun, knife, club) to school
  - Get into fights or hurt someone
  - Drive after drinking
  - Ride with driver who had been drinking
  - Smoke cigarettes
  - Engage in binge drinking (5 or more drinks in a row)
  - Use marijuana
- Religious seniors were more likely to
  - Wear seat belts
  - Eat breakfast, green vegetables and fruit
  - Get regular exercise
  - Sleep at least 7 hours per night

Wallace and Forman 1998; Monitoring the Future Study

U.S. Life Expectancy at Age 20 by Religious Attendance



Hummer et al. 1999

Issue #11

We need to better understand the contribution of racial/ethnic differences in access to care and the quality of care to observed disparities in health.

Race and Medical Care

- Across virtually every therapeutic intervention, ranging from high technology procedures to the most elementary forms of diagnostic and treatment interventions, minorities receive fewer procedures and poorer quality medical care than whites.
- These differences persist even after differences in health insurance, SES, stage and severity of disease, co-morbidity, and the type of medical facility are taken into account.
- Moreover, they persist in contexts such as Medicare and the VA Health System, where differences in economic status and insurance coverage are minimized.

Ethnicity and Analgesia

A chart review of 139 patients with isolated long-bone fracture at UCLA Emergency Department (ED):

- **All patients aged 15 to 55 years, had the injury within 6 hours of ER visit, had no alcohol intoxication.**
- **55% of Hispanics received no analgesic compared to 26% of non-Hispanic whites.**
- **With simultaneous adjustment for sex, primary language, insurance status, occupational injury, time of presentation, total time in ED, fracture reduction and hospital admission, Hispanic ethnicity was the strongest predictor of no analgesia.**
- **After adjustment for all factors, Hispanics were 7.5 times more likely than non-Hispanic whites to receive no analgesia.**

Todd, et al. 1993

Whites Stereotypes of Blacks (and Whites) %

1. Lazy		
Blacks are lazy	**44**	**(5)**
Neither	**34**	**(36)**
Blacks are hard working	**17**	**(55)**
2. Violent		
Blacks are prone to violence	**51**	**(16)**
Neither	**28**	**(42)**
Blacks are not prone to violence	**15**	**(37)**
3. Unintelligent		
Blacks are unintelligent	**29**	**(6)**
Neither	**45**	**(33)**
Blacks are intelligent	**20**	**(55)**
4. Welfare		
Blacks prefer to live off welfare	**56**	**(4)**
Neither	**27**	**(22)**
Blacks prefer to be self-supporting	**13**	**(71)**

Source: 1990 General Social Survey

Unconscious Discrimination

- **When one holds a negative stereotype about a group and meets someone who fits the stereotype s/he will discriminate against that individual**

- **Stereotype-linked bias is an**
  - **Automatic process**
  - **Unconscious process**
  - **It occurs even among persons who are not prejudiced**

Factors that Increase Stereotype Usage

- Time Pressure
- Need for Quick Judgments
- Cognitive Overload
- Tasks are Complex
- Tired
- Anxious

Medical Encounter: Time pressure, brief encounters, need to manage complex cognitive tasks.

Source: van Ryn 2002

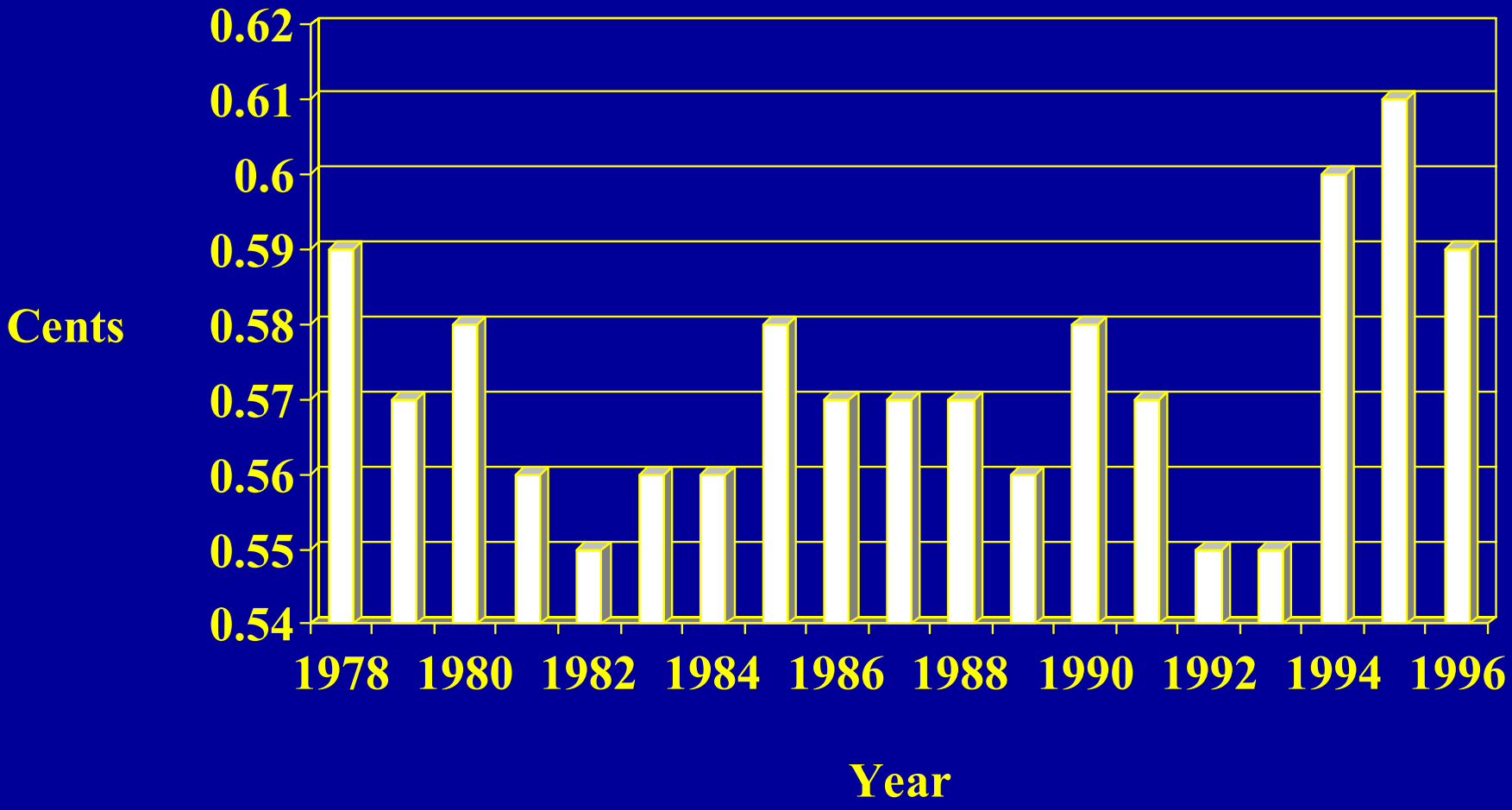
Issue #12

Economic Policy is Health Policy

Racial Inequality & Health

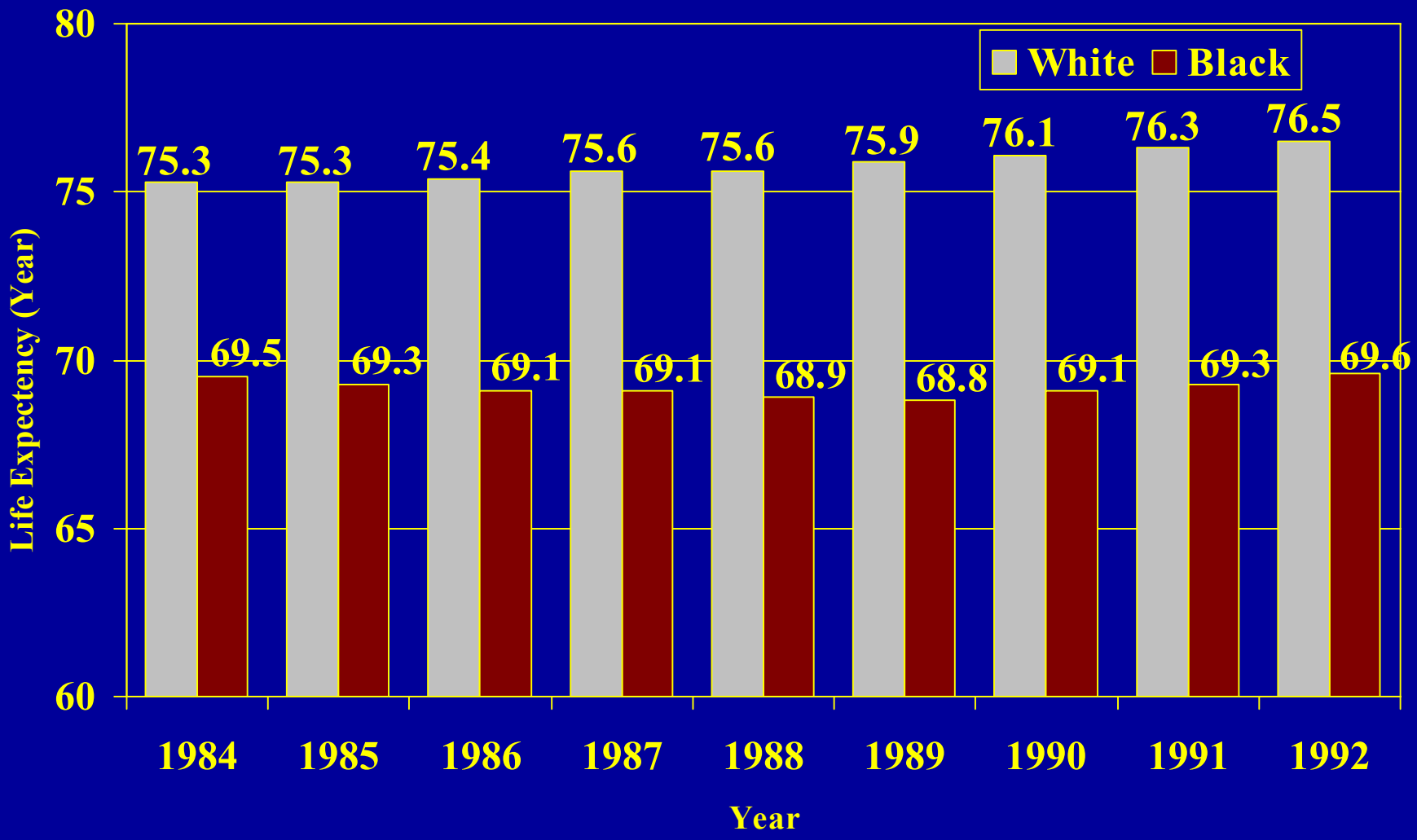
- In the past 50 years, changes in the black-white gap in income has been associated with parallel changes in the black-white gap in health.
- Between 1968 and 1978, in tandem with the narrowing of racial inequality due to the economic gains of the Civil Rights Movement, black men and women experienced a larger decline in mortality than whites, on both a percentage & absolute basis (Cooper et al. 1981).
- As black median household incomes fell from the 1978 level relative to those of whites throughout the 1980s, the black-white gap in adult and infant mortality widened between 1980 and 1991 (NCHS 1994).
- For 5 consecutive years after 1984, life expectancy for blacks declined from the 1984 level. Life expectancy for blacks began to increase in 1990 and was slightly higher than the 1984 level by 1992 (NCHS 1995).

Median Family Income of Blacks per $1 of Whites



Source: Economic Report of the President, 1998

U.S. Life Expectancy at Birth, 1984-1992



NCHS, 1995

Key Principles

- **Health Policy must be re-defined to include policies in all sectors of society that have health consequences.**
- **Policies which improve average health may have no impact on racial inequalities in health.**
- **We need policies that improve health overall and targeted interventions to address racial inequalities.**
- **Major gains can be achieved through strategies that tackle health problems that occur most frequently.**
- **Families with children should be a priority.**

Conclusions

1. **Racial disparities in health are large, pervasive and persistent over time.**
2. **Racial inequalities in health reflect larger social inequalities in society, of which SES is one component.**
3. **Accordingly, race still matters for health when SES is considered.**
4. **Research is needed that elucidates how risks and resources linked to living and working conditions combine, over time, to affect the health of socially disadvantaged populations.**
5. **We need to act NOW on current knowledge.**