

UNNATURAL CAUSES ...is inequality making us sick?

A four-hour series airing on PBS and a national public impact campaign

EDITED INTERVIEW TRANSCRIPT DAVID R. WILLIAMS

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How do socio-economic status and race interact to influence health outcomes?

We know that, across the world, socioeconomic status is a powerful predictor of health. In fact, it's a more powerful predictor of health than genetics or medical care or cigarette smoking. Now, why is that important to our discussion of race? It's very important because, on average, in our society, socioeconomic status differs by race. So, on average, Blacks have lower levels of income, lower levels of wealth, and lower levels of education than whites do. And for other minority populations, a similar pattern is evident.

So, many of the racial differences we see are not due to skin color, but to the fact that disadvantaged minority populations have fewer economic resources than whites do. But that certainly does not account for all of them.

What we find across multiple measures, or multiple indicators of health status, is that at every level of economic status, Blacks are *still* doing more poorly than whites. For example, as a woman's education level increases, the birth outcomes for her children get better, and that is the expected pattern. However, a pattern of excess deaths or higher infant mortality rates exists for Black women, such that a Black woman with a college degree has a higher rate of infant mortality than a white woman who hasn't finished high school. And what that illustrates is that, in addition to socioeconomic status, there are other factors linked to race that we need to understand in order to appreciate what's driving racial disparities in health.

Might genetics play a role in these inequities?

We have been studying racial differences in health in the United States for a long time: for centuries, literally. We have observed that these differences exist, and the early explanation of these differences was, of course, that there are differences in health across the races because the races actually reflect very different biological and genetic makeup.

Physical anthropologists have taught us for a long time, and the human-genome project reinforces this same notion, that the fact that you and I know exactly what race we belong to tells

us a lot more about our society than about our biological makeup. There are genetic differences that exist in human populations, but they don't map across our artificially created racial categories.

There's more genetic variation within each race than between races. In other words, some Black people are more similar genetically to some white people than they are to other Black people. So, genetic differences are not plausible from a scientific point of view to account for this really striking pattern of racial disparities that we see across the fifteen leading causes of death. We need to understand what it is within the social environment that produces these patterns of ill health that exist for multiple health conditions and that have been so stable and consistent over time.

I am not saying we shouldn't study genetics at all. Genetics plays a role, but it plays a role in interaction with the environment and is most likely a minor contributor to the pattern of health disparities that we see.

What are some of these other factors that contribute to race-based health disparities?

There are at least three reasons why we think that we see this persistent effect of race even when we look at individuals with comparable economic status.

Reason number one requires that we think of economic status not just in terms of the current economic status of an individual, but of the exposure of that person to economic adversity over the life course. So, let's think of the college-educated African-American woman compared to a college-educated white woman. The African-American woman is more likely to be a first-generation college graduate, is more likely to have grown up poor, is more likely to have experienced economic adversity and problems of access to medical care in childhood. So research is now telling us that some of the childhood deficits experienced actually follow an individual over the life course and adversely affect their health—and maybe even the health of their children—many years after they are experienced. So, one important point, then, is we need to pay attention to an individual's life course exposure to economic and social adversity.

A second reason is what researchers call the “non-equivalence of economic status” across race. That's a fancy term, and what it means is that an indicator of economic status does not mean the same thing for one racial group as another.

So for example, let's think of education. National data [from the U.S. Census] reveals that a given level of education in a Black person provides less income than the same level of education for a white person. In other words, a Black person in America with a college degree, on average, earns less income than a white person with that same level of education.

If we think of income, economists talk about the purchasing power of a level of income. And that is, given a dollar, how much can you buy with a dollar? That's what we mean by purchasing power. Research has shown that, given residential segregation and the areas where Blacks live,

the cost of goods and services are higher. By goods and services, I mean the cost of rent, the cost of housing, the cost of groceries, the cost of home insurance, the cost of auto insurance are all higher in the places where Blacks live. So, a dollar doesn't stretch as far for Blacks as it does for whites.

Probably one of the most dramatic examples of the non-equivalence of economic status has to do with the difference between income and wealth. Income tells me something about the flow of resources into the household; wealth tells me something about the economic reserves that the household has to cushion shortfalls of income. When we look at national data, there is a huge racial gap in wealth at every level of income. Even if we look at the poorest 20% of the population, whites at that level have average wealth of about \$10,000; Blacks have, on average, only \$1.00. It's important to realize that there is not a racial difference in savings behavior when you look at individuals at the same level of income. The differences in wealth really reflect differences in housing equity and home ownership, and also differences in the transfer of wealth across generations. That is, whites are more likely to inherit money from relatives than Blacks are because their relatives are much less likely to have been poor. This non-equivalence of economic status is a big factor.

The third factor is the *R-word*: racism. Racism and the legacy of racism in our society continue to affect health in many powerful ways. We normally think about three different types of racism. We think first of institutional racism. That exists in the policies and practices of institutions and can operate even if the persons working within those institutions are not racist or aren't prejudiced. Another type of racism is at the interpersonal level. That has to do with experiences of discrimination as individuals interact personally. A third type of racism we think of is internalized racism. One of the ways to think about that is, within a society where some groups are regarded as dominant and some are subordinate and some groups, based on race, are viewed negatively, some proportion of persons who are viewed negatively will actually buy into and believe society's negative characterization of them. When individuals do that, it is an example of internalized racism—they have accepted as true the society's negative characterization of their group. And there's research that suggest that all of those dimensions of racism have a negative impact on health.

Some people might say that discrimination is a subjective thing, that it's all a matter of perception.

There is a lot of research that indicates in a very objective manner that discrimination exists. I can give you two quick examples. Some of the classic studies are the audit studies, many of them done by the United States government. They would send testers—let's say a Black person and white person who have identical resumes—to apply for jobs or try to rent an apartment or purchase a home, and look to see if the white applicants were preferred. In the employment arena, the research finds that 20% of the time, one in every five audits, a Black person is disadvantaged in terms of getting a job. So, there's very good research out of these fairly independent audit studies that documents discrimination in the housing market and in employment.

There was a fairly dramatic study done in Milwaukee, Wisconsin about two years ago, where they sent Black and white testers, men, all with identical resumes, to apply for 350 entry level jobs. What this study found was that a Black male with a clean record, no criminal record, was less likely to be offered a job than a white male with a felony conviction. And remember, their resumes were identical. So it was a dramatic example in the year 2004 of the persistence of discrimination in American society, and some of these experiences of discrimination individuals are aware of and can subjectively experience as stressful.

So how does job instability or unemployment affect health?

When someone loses their job, they experience a broad range of psychological effects. Certainly, there's uncertainty around financial responsibilities and obligations, the stress that is associated with that uncertainty about "how am I going to do this?" and clearly the sense of responsibility. Take an individual who has others dependent on them for resources to survive. That becomes very stressful. But then there's also that psychological component; many people lose a sense of value and of worth because their job gave them a sense of identity and made them feel that they were making a worthwhile contribution to society. So, it's really complex and there are multiple factors involved.

There is research, for example, that shows that just the anticipation of losing one's job can lead to increases in blood pressure levels. What we're looking at is the disregulation of underlying biological systems in the body. As that becomes chronic, that level of stress and the level of multiple systems of the body not functioning right can lead to a broad range of chronic diseases.

Now, when there are many persons in a community that are negatively affected by unemployment or job insecurity, you can see effects not just at the level of the individual and family, but also on the level of the community. So, if there are lots of people unemployed in a particular community, lots of people who are very insecure in their employment and are not sure that their jobs will be there for them in the future, all of the negative effects that we've talked about at the individual level could be seen at the community level.

For example, you can have increases in blood pressure levels within the community, which can lead to increase in the levels of stroke, increasing levels of heart disease. Many people try to sooth this chronic stress they're facing by eating more, and eating more high fat foods than they normally would. Many people are somewhat depressed by it and are less likely to be active and exercise and take care of themselves in the way they had done in the past. Many people could become very depressed and hopeless about what the future has to offer them.

So you can quickly see at the community level increases in mental health problems, increases in poor health behaviors, increases in substance use and alcohol abuse that can lead to increases in chronic illnesses like cancer or heart disease or diabetes or stroke. And clearly can, in the long run, lead to increases in mortality and just poor health for the community generally.

Why do we see the clustering of negative health outcomes in certain communities?

I think it's important to realize that health does not occur in a vacuum, and the conditions in which we live—the neighborhood, the places where we work, the homes in which we live—can either support the good health behaviors that we want, or can make it much more difficult to practice those good health behaviors.

I think, sometimes, we naively think of improving health by simply changing behaviors, or simply targeting the individual to improve their behavior. It's certainly important for every individual to have full knowledge and full information so that they can make the right choices for their health. But we also have to recognize that the choices of individuals are constrained and are often limited by the environments in which they live, and frequently people are in environments that promote bad health.

For example, 80% of billboards in the United States are targeted to the Black and Hispanic communities, who are less than 30% of the U.S. population. And the number one and two products sold on billboards are alcohol and tobacco. What that means is alcohol and tobacco advertising makes those products appear more normative for those populations. There's also research that indicates that there is a higher concentration of retail outlets for the sale of alcohol in poor neighborhoods and in minority neighborhoods. Again, greater availability of these substances increases the use.

On the other hand, if we think of good health habits such as eating more fruits and vegetables, the research reveals that in poor neighborhoods, especially poor minority neighborhoods, there are fewer supermarkets, fewer places that sell fresh fruits and vegetables. And the availability of fresh fruits and vegetables in your neighborhood is a powerful predictor of how much fresh fruit and vegetables you eat. If it's not available for purchase, hard for you to get, you are less likely to consume fresh fruits and vegetables.

Similarly, we can take exercise as another example. Of course everyone knows there's an obesity epidemic in the country. It's really important for us to get exercise. But persons who live in areas where they don't feel safe walking outside, where there aren't safe playgrounds, where there aren't sidewalks where they can walk, are much less likely to go outside and take a walk. So, we have to support individuals in making good choices, and we can do that by creating environments that encourage and make it possible for them to engage in the good health behaviors that we would like them to have.

Now, in the United States, because of the history of race and segregation, we have different racial groups living in very different environmental circumstances. Researchers have studied the 171 largest cities in the United States, and they concluded that the worst urban context in which whites reside is better than the average context of Black communities. That's in terms of poverty rates, in terms of rates of female heads of household, in terms of unemployment rates.

What that says is that the racial groups are living in very, very different economic circumstances. So, for example, it's very important to remember that there are more poor white people in the United States than poor Black people. But most poor whites are spread through the population

and live in reasonable neighborhood circumstances. Most poor Blacks, and increasingly most poor Hispanics, are living in areas where most of the people are poor.

You can imagine it makes a big difference for a poor kid going to a school if there are 20 students in that class and 18 of the 20 are poor, than if a poor kid goes to a school where there are 20 kids and just two or three of them are poor. And that's the difference: Most poor white kids go to schools where the majority of kids are middle class, and most poor Black and Latino kids go to school where the majority of the kids are poor.

What we're talking about in the area of education is also what's happening in the area of health. Adversities, negative housing and residential conditions—those things go together and they come in families. So when you have one bad thing, you have multiple bad things occurring. The concentration of these negative neighborhood conditions produces this very bad environment that is detrimental to health, detrimental to educational success, detrimental to being able to really live and experience the American dream.

Could you explain the term *learned helplessness* and how it relates to all this?

There is research that suggests that learned helplessness could be a powerful force shaping the psychological orientation of individuals, and it could actually shape racial depression. [This idea] comes from early research done with animals, where they were exposed to electric shock and the researcher would look to see if the animals would try to escape. Those animals who [initially] found some ways of being able to escape would try to escape even if the door of escape was closed later. However, those animals who from the first attempt to escape always found the door closed, after some time, even when the door was opened and they were shocked, they would not take advantage of that open door to escape. They had learned from their early experiences to be helpless.

We think that there is a human parallel here. When individuals in their early lives have always experienced failure, have always experienced blocked opportunity, sometimes even when the door of opportunity opens they have learned to be helpless. So, one of our challenges is to make real to individuals that there are opportunities, and also to create opportunities that provide a ladder out of their difficult situation so that they do not fall into this trap of learned helplessness.

There is also recent research looking at the effects of hopelessness on health. Following individuals over time, research has found that those who are hopeless, who don't have a future to believe in, have more rapid development of heart disease as measured in their blood vessels. It's common sense that at some level it would affect us psychologically, but what that research suggests is that hopelessness—not being able to believe in a future—is actually killing us. It's having negative physiological consequences for how we are able to function.

Now, certainly optimism and positive expectations are good for health. When someone is in a good social situation and isn't burdened down by all the negative chronic stressors, they have the freedom to focus on the higher level order of needs: doing what they can to develop themselves,

to improve themselves, and believing they can accomplish anything. So, whatever we can do that gives people hope and gives them a sense that there is something to look forward to is a good thing in terms of their health.

Have we made any progress in closing the racial health gap?

If we look at the health of Blacks and whites in the United States over the last 50 years, what we see is that the racial gap in health today is very similar to what it was 50 years ago. In fact, for some measures of health, it's even worse than it was 50 years ago. That might lead one to conclude that there has been no change in health over time. Actually, if we look at the data a little more closely, we can find periods of time where we made progress as a society in narrowing the gap in health and periods of time when we move backwards as a society in worsening the gap in health.

The best example I'll give you is about two periods. One is between 1968 and 1978. Research has documented that during this period of time, the health of African Americans improved more rapidly than that of whites, both on a relative and an absolute basis. Blacks had more rapid declines in overall mortality rates and more rapid increases in life expectancy. So, health improved absolutely. And there are two reasons contributing to that. Number one were the economic gains of the civil rights movement. During the 1960s to early '70s, the Black-white gap in income narrowed, and the Black-white gap on multiple indicators of health also narrowed. So, that was a period of progress due to economic improvement. In addition to that, during the '60s we had the implementation of Medicare and Medicaid, and one of the things that Medicare and Medicaid did was foster the desegregation of hospitals in the South and enhance African Americans' access to medical care. So the twin benefits of better access to medical care as well as improved economic circumstances had a positive effect on health.

However, during the following decade, the decade of the '80s, where there was a widening of the economic gap between blacks and whites, we had a worsening health of the African-American population on multiple measures. The infant mortality gap got wider during the '80s, the life expectancy of Blacks declined for five years in a row from the 1984 level. What this says very eloquently is that economic policy is health policy, and when we improve economic circumstances and narrow the economic gap between the races, we improve health. When the economic gap between the races widens, health worsens. So, good economic policy is good health policy.

How can we bring more health-promoting resources to impacted communities?

We have to stop and think about how these negative conditions came into being. They are not accidents and they are not acts of God. They really reflect the implementation of specific policies. Deliberate policies made in the past created the segregation that we have and the concentration of poor people in public housing that we have. The good news is, because they

were humanly made and they reflect the implementation of specific policies, they can also be reversed if we have the will and the commitment to make changes and develop a different model of giving individuals opportunity.

One of the things we witness in society is that communities that lack political clout, that lack economic power, are less able to get resources directed to them. So, one thing that has happened in many poor communities is that as the middle class has moved out, the community no longer has economic clout and its residents suffer. They suffer in terms of the quality of municipal services they get. They suffer in the quality of police service they get and quality of garbage collection they get. The poor really get the worst in virtually every domain, and partly that is driven by the nature of political organization—the poor are less an organized voting block—and frequently, politicians can fail to act in ways to benefit the poor and there are no consequences.

One example we can point to in public policy in the United States is how the fortunes of Medicaid and Medicare have been very different over the last several decades. Medicare is a universal program that benefits all persons over age 65. Persons over age 65, as a group, are a powerful voting block in this country and have multiple organizations that represent them. Politicians listen to what the elderly say and what the elderly are concerned about. Medicaid, on the other hand, is a joint program between the federal government and the state. It's means-tested: It's only for poor people. Politicians can cut Medicaid at will. There are no consequences because the poor are not mobilized, are not organized to fight and to make politicians pay for any action that adversely affect them.

So, this general pattern then carries through to so many other domains of life. The more political and economic power you have—the more influence you have in society—the more say you have over outcomes that affect you.

Research by Thomas LaVeist from John Hopkins University found that the greater the political power of Blacks in a particular community [measured by the proportion of Black elected officials], the better their health in terms of infant mortality. This was a study of various counties across the United States suggesting that having increased political power, which means you have persons who can represent and advocate for your interests, can lead to better health. Health then is embedded in the larger social and economic environment in which individuals live, and the better we can create that environment, the better we can help individuals achieve good health.

What does America's health future look like?

There are two patterns that are quite disturbing in terms of health. One is the growing concentration of income and wealth among the few, and the fact that the poor are getting poorer and the middle class is getting squeezed. With what we know in terms of health, that suggests that we will have even more health problems in our society in the future.

There is a second trend linked to the first that is equally disturbing, and it is the high level of poverty among American children. When children grow up poor, when children grow up

materially, socially, and economically deprived, they are put on a trajectory like they're taking the first step on an escalator that leads to bad health.

The problem of poverty among children is even more dramatic among poor children who come from disadvantaged minority backgrounds. The levels of poverty among African-American children, among Latino children, are really very high. Then, if we look not only at those who are actually poor but those who are economically vulnerable—just above the poverty line—we are looking at almost seven out of ten Black and Hispanic kids in the United States growing up in a home that is either currently poor or at risk of becoming poor at some point in their childhood. That's just unacceptable in a society like ours, which wants to guarantee good health and success for these children in their future.

Isn't one of the biggest risk factors for child poverty being raised by a single mother?

I think that reflects the choices we are making in our society. Many individuals are aware that one of the strongest predictors of a child growing up poor in the United States is a child being raised by a single parent. Now, Sweden, for example, has a higher rate of single parent households than the U.S. does. But in Sweden, they have broken the link between being raised by a single parent and growing up in poverty. Society has come in and has provided an economic cushion and economic resources, so that even being raised by a single parent, that child is still doing well economically. They have built a social safety net for the most vulnerable to protect them from the negative effects of growing up poor.

We are a more wealthy society; we can do it. The question is: What do we spend our resources on? I think it's really important for us to invest in the next generation and invest in our children.

Why should healthy, affluent white people care about health inequities?

Health disparities in the United States affect us all. We are all connected to each other. When some groups are hurt, and when some groups suffer, it has cost implications for the entire society. When we ensure that every American can grow up to be productive and be successful, we are ensuring the future of the one America to which we belong. We're ensuring higher payment into the Social Security system to benefit us all. We're ensuring better success in terms of lower rates of crime and lower rates of delinquency. So, everything we do to improve the quality of life among the most vulnerable in society has wonderful economic and social and moral payoffs for the rest of our society.