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Article *in* Health Affairs · March 2005

DOI: 10.1377/hlthaff.24.2.343 · Source: PubMed

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Health Disparities By Race And Class: Why Both Matter

We must link efforts to address the injuries of race and class simultaneously if we are to reduce health disparities.

by **Ichiro Kawachi, Norman Daniels, and Dean E. Robinson**

ABSTRACT: In this essay we examine three competing causal interpretations of racial disparities in health. The first approach views race as a biologically meaningful category and racial disparities in health as reflecting inherited susceptibility to disease. The second approach treats race as a proxy for class and views socioeconomic stratification as the real culprit behind racial disparities. The third approach treats race as neither a biological category nor a proxy for class, but as a distinct construct, akin to caste. We point to historical, political, and ideological obstacles that have hindered the analysis of race and class as codeterminants of disparities in health.

MORE THAN A DECADE AGO Vicente Navarro drew attention to the apparent tension between a race-based account of health disparities versus the class-based view.¹ Although (as Navarro wryly noted) the United States has classes as well as races, data on health disparities are seldom presented along both axes of stratification. The U.S. government is one of the few developed Western nations that does not routinely report health statistics by class.² For example, whereas long-term time series are readily available on the U.S. black-white life expectancy gap, there is a dearth of corresponding data on trends in class disparities, whether measured by income, occupation, or educational attainment.

In this paper we critically dissect the public and academic discourses on health disparities. We aim to show how hidden tensions between a race-based as opposed to a class-based account of health disparities closely parallel the long-standing tensions within other policy arenas (for example, affirmative action in hiring and college admissions). We first lay out the three prevailing interpretations of race-based health disparities within U.S. society. Next we present an argument about how the race-based account of disparities has been historically manipulated to suppress class-based discourse in the United States. We then sketch

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out the policy implications of adopting the view that emphasizes both class and race as codeterminants of disparities in health.

Three Interpretations Of Racial Disparities In Health

Racial disparities in health have been interpreted in three distinct ways, which may be characterized (in a somewhat stylized fashion) as follows: (1) racial disparities reflect biological (that is, inherited) differences in susceptibility to disease; (2) race is a proxy for class, or racial disparities are confounded by class; and (3) racial and class disparities exist independently within the United States, and both matter.

■ **Race as biology.** The attribution of racial disparities in health to inherited biological differences in susceptibility to disease is rooted in a long-standing U.S. tradition that continues to the present day. Within medicine, Nancy Krieger has traced the origins of this tradition to the pre-Civil War debate about slavery.³ For scientists on both sides of the debate, the future of the institution of slavery rested at one point on a question that only medical science was deemed capable of answering: Are blacks innately inferior to whites and therefore fit only to be slaves? The "science" underpinning this debate (for instance, involving supposed racial differences in cranial sizes or oxygen-carrying capacity) has long been discredited, yet the tradition of ascribing racial disparities in health to fixed biological traits persists. Biologized notions of racial disparities have even risen to prominence in recent years in the wake of the human genome project and the search for race-based genetic susceptibility to diseases such as hypertension and diabetes mellitus.⁴

The prevalence of hypertension and diabetes is two to three times as high among African Americans as among whites, which partly explains the higher burden of heart disease among African Americans.⁵ But it is a gross oversimplification to assume that differences in genetic susceptibility could explain the observed racial disparities. For instance, representative surveys of populations in West Africa and African-origin populations in the Caribbean have revealed prevalence rates of hypertension and diabetes that are two to five times lower than those of black Americans or black Britons.⁶ Such observations alone should give pause to molecular enthusiasts who have advocated for a vast expansion of research efforts to search for the genetic explanation of racial disparities in these diseases.

The molecular paradigm may yet prove useful for advancing our knowledge of the mechanisms underlying the etiology of diseases in susceptible people. But since "racial" groups are socially constructed, the categories we use are not useful as markers of disease susceptibility among discrete genetic populations. The search for genetic markers of disease is often advocated on the grounds that identifying gene-environment interactions may prove useful for prevention. Yet even in this case, the environmental conditions that interact with putative polymorphic variations to trigger the onset of disease, not those variations themselves, would likely be the targets of intervention (or the cause of disease per se). To wit, a good

deal of skepticism seems warranted in pinning our hopes on the biological account of racial disparities in health. According to Richard Cooper:

It is now well documented that African populations are of greater internal genetic diversity than are populations outside Africa. This heterogeneity is further increased in the western hemisphere by the admixture of European genes, currently estimated at 25% among U.S. blacks.

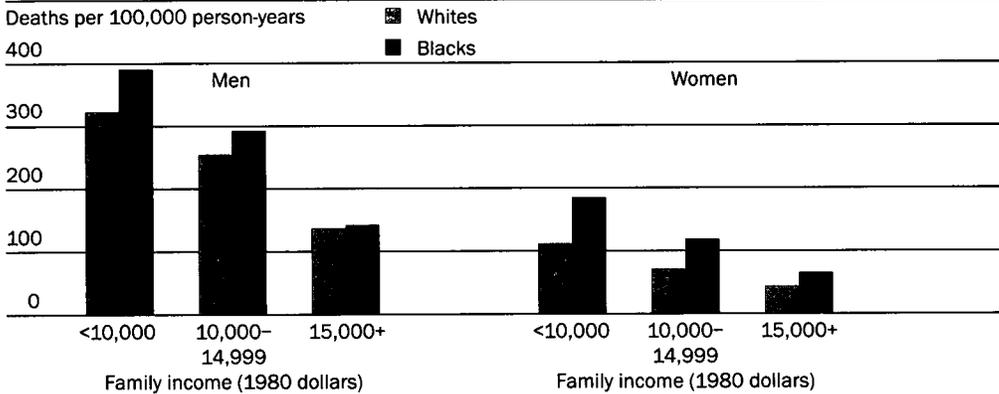
Although candidate genes for diabetes have been identified...estimating the average genetic risk of specific populations will be a difficult task. These considerations highlight the need for caution in declaring "genetic predisposition" as the explanation for increased risk of non-insulin dependent diabetes mellitus in U.S. minority groups.⁷

■ **Race as a proxy for class.** A different view of racial disparities is one that treats race as a proxy for class. This common but unwarranted practice seems to be grounded on two sets of observations: (1) Black Americans are overrepresented among socioeconomically disadvantaged groups (for example, they have 2.5 times the poverty rate of white Americans); and (2) adjusting racial disparities in health for indicators of class greatly reduces (and in some instances, entirely eliminates) the racial differences. Given the paucity of class data in many routine sources of health statistics, race tends to be used instead.

The problem with using race as a proxy for class is that it is a very rough proxy.⁸ The majority of the poor in the United States (68 percent) are white, for instance.⁹ It is sometimes suggested that racial disparities in health are somehow "confounded" by class, because the magnitude of health disparities across income groups (or other indicators of class) is much bigger than the size of the difference between blacks and whites. For example, as shown in Exhibit 1, the differentials in heart disease mortality are much bigger across family income categories (a two- to fourfold disparity comparing top to bottom) for both men and women, as con-

EXHIBIT 1

Heart Disease Death Rates Among Men And Women Ages 25-64, By Race And Family Income, 1998



SOURCE: National Center for Health Statistics, *Health, United States, 1998, with Socioeconomic Status and Health Chartbook* (Hyattsville, Md.: NCHS, 1998).

“It is politically acceptable to promote racial equality so long as we do not draw explicit connections between race and class.”

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trusted with the mortality differentials by race (black versus white) that exist within any given income level. Stated differently, low-income black Americans have more in common—as far as their risk of heart disease is concerned—with low-income white Americans than with middle-class or affluent black Americans. These patterns have led to recommendations that racial differences in health ought to be routinely controlled for class or socioeconomic status.

However, the potential drawback of doing so is that it may encourage the illusion that class is a “confounder” of racial differences. This notion is erroneous because race, as an ascriptive characteristic, is antecedent to class—that is, it is race that influences class position in U.S. society, not the other way around. Accordingly, any analysis of racial differences that adjusts for class could be viewed as statistically “overcontrolling” for a large portion of the causal effect of race on health. After all, as noted by Cooper, “The ‘unadjusted’ difference is the disease burden actually borne by blacks, and it is the ‘raw’ facts that must be explained.”¹⁰

■ **Race and class as separate constructs.** The third and (we argue) defensible view of racial disparities is one that simultaneously accounts for the independent and interactive effects of both class and race in producing health disparities. According to this view, race is neither a biologically meaningful category nor a proxy for class, but is a separate construct from class, more akin to caste.¹¹ The distinction between this view and the second view (race as a proxy for class) is often subtle but nonetheless important. Three sets of propositions follow as a consequence of adopting the third approach. First, race should not be conceptualized as a proxy for class. For example, within each level of family income in Exhibit 1, being black is associated with an additional excess risk of heart disease over being white.

Second, racial disparities should not be analyzed without simultaneously considering the contribution of class disparities. That is, whenever possible, class-based differences in health status ought to be examined within racial groups. As Navarro pointed out, even if racial disparities in health outcomes could be eliminated, most blacks would still have worse health than the U.S. average because of their class position.¹² The major difference between this position and the second perspective is that instead of treating race as a proxy for class, class is viewed as partly mediating the association between race and differential health outcomes. Moreover, this approach suggests that class-based health disparities should never be analyzed without simultaneously considering the contribution of race.

Third, potential interactions should be considered between race- and class-based disparities. For example, it is not uniformly the case that racial disparities are largest among the most socioeconomically disadvantaged groups (as would be suggested if class position were the major mediating factor between race and

health). For notable health outcomes, such as low birthweight (a major contributor to infant mortality), the black-white disparity in the prevalence of this condition actually increases with higher levels of educational attainment.¹³ Although this finding remains incompletely understood, it seems unlikely to be explained by biological differences between races, unless one is prepared to argue that genetic susceptibility to having low-birthweight babies is more frequent among college-educated black women than among their white counterparts.

We contend that the foregoing set of principles would lead to more lasting and effective approaches to reducing and ultimately eliminating health disparities in this country than concentrating on racial inequalities alone. Treating race as a codeterminant of health disparities along with class still leaves open the possibility that race independently influences health through pathways such as personal experiences of discrimination or cultural differences in lifestyles.¹⁴

So why has it proved so difficult to achieve this more integrative view of health disparities—that is, why do research and policy initiatives so often tackle either race or class disparities, but not both together?

Race And Class: Why Can't We Talk About Them Together?

We are not the first to note that class has been the “ignored determinant of the nation's health.”¹⁵ Much of the history of thinking about inequality in the United States, including health inequality, has usually been framed in terms of race or class, but seldom both. In this section we offer some thoughts that aim to explain, at least partially, the features of the public discourse.

Our argument is based upon two propositions: (1) One of the main functions of racism in the United States has been to divide people with common class interests so that they are less able to struggle politically in their common interest; and (2) an aspect of that function is to make race a highly visible feature of public policy while hiding or disguising anything that resembles class. The common accusation that any mention of inequality is tantamount to waging “class warfare” is but a culmination of a long-standing ideological effort to suppress any consciousness of class. The roots of this rejection of making class inequality a public issue are deep, and they branch out into many features of our social science.

In keeping with the second proposition, there is room in our public discourse to address racial health disparities while in general downplaying class disparities. In other words, it is politically acceptable to promote racial equality so long as we do not draw explicit connections between race and class. A case in point is the launch of Healthy People 2010 in January 2000, whose Goal 2 signaled the commitment of the U.S. government to eliminating health disparities not only by race, but also by education and income (besides a few other dimensions).¹⁶ Despite the inclusive vision of Healthy People 2010, one interpretation of the legislative and policy actions that followed in its wake is that they have primarily concentrated on reducing racial disparities. For example, Congress in 2000 passed the Minority

Health and Health Disparities Research and Education Act (P.L. 106-525), which, as the title suggests, focuses primarily on “improving minority health and reducing health disparities” through the National Institutes of Health (NIH).

In this context, those who promote class as a key focus of work on health disparities may be seen by those who focus on race as missing the importance of this opportunity to address racial inequality, and even as distracting from it. Indeed, it may be portrayed as a form of racism not to concentrate on race disparities as a primary focus, given the salience of this form of inequality in U.S. history.

The value of our thesis, however, is to suggest that we cannot separate these two issues: Racial and class identities are mutually constitutive.¹⁷ Over the course of U.S. history, elites and white workers have often defined “class” in relation to subordinate, black identity—that is, class has had a white face. This has occurred in spite of the fact that blacks and other racial minorities have been disproportionately represented among the working class. More often than not, “racial” identity appears to trump class identity.

Long before W.E.B. DuBois suggested that poor whites in the Old South supported regimes that rendered them politically and economically powerless by appealing to their “whiteness,” numerous observers have wondered about the tendency of many whites to support politicians who work against their economic interests.¹⁸ Three interrelated historical developments go some way in explaining this pattern. First, whites historically enjoyed obvious advantages so long as racial identity was tied to civic rights, educational, housing, and employment opportunities.¹⁹ Second, the federal government built the welfare state without fundamentally challenging the advantages that whites had over blacks (and other non-whites) in the South and North. For instance, New Deal legislation gave working-class whites the right to bargain collectively and to maintain segregated local unions. Federal housing policy, as another example, was complicit in perpetuating residential segregation and contributed to the sorts of housing patterns we see even today.²⁰ Third, when in the 1960s the federal government passed civil rights laws, advanced antipoverty policies under the Great Society, and instituted affirmative action, many whites turned against the idea of government intervention for minorities and for an expansion of social welfare provision.²¹ Thus, the appeal of “whiteness” (persisting in coded form since the 1960s) and the corresponding stereotypes of “blackness” as the absence of proper biological or cultural attributes have historically undermined class solidarity. This, in turn, has tended to weaken support for more redistributive policies and more generous social welfare provision.

One of the less studied elements of our view is the harm done to white working-class Americans by the use of racism. It is possible to trace accounts of how racism was used to weaken unionization efforts in the United States or to mislead white Americans about social policy in building a conservative political bloc in the South and elsewhere.²² For example, the issue of race has a long history of be-

“Opposing racial inequalities in health has the appeal of ridding all of us of a vestige of an unjust past.”

ing used in the United States to divide poor whites and blacks so that they fail to see their common interests. As President Lyndon Johnson, the architect of the War on Poverty, explained to an aide in 1960: “I’ll tell you what’s at the bottom of it. If you can convince the lowest white man that he’s better off than the best colored man, he won’t notice you picking his pocket. Hell, give him somebody to look down on, and he’ll empty his pockets for you.”²³

That said, there is wide social acceptance of the injustice of racial disparities in health. Part of the reason for this is that overt racism (for example, differential treatment by medical providers) is viewed as a violation of basic human rights as well as the moral and legal framework of equal opportunity that many associate with U.S. culture. Unless some “victim blaming” ideology has a grip on us, or unless there is credible evidence of some unavoidable biological difference, it is easy to point to racial disparities as unjust because the only explanation for them is unjust social policy.

By contrast, class inequalities either are not seen or understood, or are obscured by rationales that provide some apparent justification for them. We have a long strand of social science that has whittled away at the idea of class. To the extent that U.S. inequalities came to be viewed as not rigid and that class mobility was common, class lost its sting. The notion that people can rise (or fall) to what they deserve became an entrenched feature of the belief system that characterized U.S. society as meritocratic, especially over the second half of the twentieth century. As noted by Philip Klinker and Rogers Smith: “The fifty years that followed World War II saw a decline in the strength of organized labor, and a corresponding decline in class consciousness. During the last 35 years, coded appeals to racism have been a consistent part of the strategy many conservative politicians have used to make the case for more limited government intervention on behalf of racial minorities and the economically disadvantaged more generally.”²⁴ So it goes until (and unless) we notice the huge price paid in terms of health inequalities for growing class inequalities.

We note an additional barrier to seeing the importance of class and not just race. Although race has often been used to divide “us” from “them,” this division has lost much of its appeal, at least at the conscious level. Therefore, opposing racial inequalities in health has the appeal of ridding all of us of a historical anomaly, a vestige of an unjust past. Especially if we can address this through improvements in insurance, access to medical care, and improved medical treatments, victory over race-based health inequalities will seem part of the struggle of people against nature. By contrast, class inequalities are intrinsically divisive: It is not us against them, but some of us against some of us. Political struggle is unavoidable, and the

contest involves questions of equity and reallocation, if not redistribution, of vital resources. So there are formidable obstacles to making class inequalities in health a focus of policy reform. Our thesis is that major progress against either form of health inequalities (by race or class) requires linking efforts to address them, not separating such efforts.

Policy Implications

On a practical level, opening a second front in the push to eliminate disparities—by addressing class in addition to race—will require strengthening the nation's information infrastructure to measure and monitor both kinds of disparities. This proposal would redress the situation noted by the 2004 Institute of Medicine report *Eliminating Health Disparities*: namely, that the U.S. infrastructure for measuring disparities remains inadequate at both the federal and state levels.²⁵ For example, although Medicare claims and enrollment files have been widely used for analysis of racial disparities, the race/ethnicity data in these files are of limited accuracy, completeness, and detail. State-based data, such as vital records, Medicaid administrative data, and registry data, often do not collect information on race and ethnicity in standardized ways. As for measures of class or socioeconomic status, many sources of data simply record insurance coverage status. Even when limited measures of socioeconomic status are gathered (such as educational attainment on death certificates), they often are not coded by the states or reported. One result (as noted by Stephen Isaacs and Steve Schroeder) is that of the fifty-eight trend tables on "health status and determinants" published in *Health, United States, 2003*, only eight contain information on socioeconomic status (usually educational level), whereas fifty-seven contain information on race.²⁶

The payoff of strengthening the U.S. data infrastructure to improve the measurement of race/ethnicity as well as class/socioeconomic status is that these steps will enable policymakers to monitor the effects of their policies on health disparities. But in addition to retrospective evaluation, we propose instituting prospective "health equity impact assessments," analogous to the Health Impact Assessments put forward by the British *Independent Inquiry into Inequalities in Health* (the "Acheson report").²⁷ Such assessments would provide the basis for projecting how well legislative efforts are targeted to address both the racial/ethnic and class dimensions of disparities.

For example, a program that is primarily targeted toward reducing racial disparities—whether it is targeting the location of health facilities in highly segregated neighborhoods or correcting biases in response to patients on the basis of skin color—would not by itself go very far to eliminate the health status gaps between average African Americans and average white Americans. As we noted before, the reason is that disproportionately more black Americans are in low-income or -education groups, and those class effects would not be addressed by policies that are primarily targeted to race-based inequalities. In this instance, a

health equity impact assessment would show that the most that can be achieved is to correct the additional disparity that race adds, while we leave minority groups that are poor at a disadvantage created by class membership. That is still a gain, and an important one, but modest in magnitude compared with the class disparities that remain. Similarly, a program targeting geographic pockets of class disparities (such as poor whites in rural Appalachia, who have been the focus of recent NIH efforts) would have limited impact relative to the class and racial disparities that exist in U.S. society at large.

IT IS NOT FAR-FETCHED TO EXPECT that health equity impact assessments might eventually be applied not only to health-sector policy proposals (such as health savings accounts or consumer-driven health plans) but also to other social-sector policies (such as Social Security reform) that have potentially important implications for class- and race-based health disparities. The first step toward such a goal would be to gather standardized information on both class and race on official health data.

Many historical, ideological, and political obstacles stand in the way of understanding that both race and class must be seen as determinants of disparities. Our proposals to strengthen the information infrastructure and to use the new data to conduct health equity impact assessments for policy initiatives both inside and outside the health sector aim to improve that understanding. There is no shortcut to addressing health disparities, and we must link efforts to address the injuries of race and class simultaneously if we are to succeed here or anywhere.

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Ichiro Kawachi's work is supported in part by the MacArthur Foundation Network on Socioeconomic Status and Health.

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