

# Explaining US racial/ethnic disparities in health declines and mortality in late middle age: The roles of socioeconomic status, health behaviors, and health insurance

Joseph J. Sudano<sup>a,b,\*</sup>, David W. Baker<sup>c</sup>

<sup>a</sup>*Center for Health Care Research and Policy, Case Western Reserve University at The MetroHealth System, Rammelkamp 236, 2500 MetroHealth Drive, Cleveland, OH 44109-1998, USA*

<sup>b</sup>*Departments of Medicine and Epidemiology and Biostatistics, Case School of Medicine, Case Western Reserve University, Cleveland, OH, USA*

<sup>c</sup>*Division of General Internal Medicine, Feinberg School of Medicine, Northwestern University, 676 N. St. Clair Street, Rm. 255, Chicago, IL 60611, USA*

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## Abstract

Pervasive health disparities continue to exist among racial/ethnic minority groups, but the factors related to these disparities have not been fully elucidated. We undertook this prospective cohort study to determine the independent contributions of socioeconomic status (SES), health behaviors, and health insurance in explaining racial/ethnic disparities in mortality and health declines. Our study period was 1992–1998, and our study population consists of a US nationally representative sample of 6286 non-Hispanic whites (W), 1391 non-Hispanic blacks (B), 405 Hispanics interviewed in English (H/E), and 318 Hispanics interviewed in Spanish (H/S), ages 51–61 in 1992 in the Health and Retirement Study. The main outcome measures were death; major decline in self-reported overall health (SROH); and combined outcome of death or major decline in SROH.

Crude mortality rates over the 6-year study period for W, B, H/E and H/S were 5.8%, 10.6%, 5.8%, and 4.4%, respectively. Rates of major decline in SROH were 14.6%, 23.2%, 22.1% and 39.4%, for W, B, H/E and H/S, respectively. Higher mortality rates for B versus W were mostly explained by worse baseline health. For major decline in SROH, education, income, and net worth independently explained more of the disparities for all three minority groups as compared to health behaviors and insurance, reducing the effect for B and H/E to non-significance, while leaving a significant elevated odds ratio for H/S. Without addressing the as-yet undetermined and pernicious effects of lower SES, public health initiatives that promote changing individual health behaviors and increasing rates of insurance coverage among blacks and Hispanics will not eliminate racial/ethnic health disparities.

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\*Corresponding author. Center for Health Care Research and Policy, The MetroHealth System, Rammelkamp 236, 2500 MetroHealth Drive, Cleveland, OH 44109-1998, USA. Tel.: +1 216 778 1399; fax: +1 216 778 3945.

*E-mail addresses:* jsudano@metrohealth.org (J.J. Sudano), dwbaker@northwestern.edu (D.W. Baker).

## Introduction

Over the past several decades, studies have accumulated overwhelming evidence of mortality and health status disparities between racial and ethnic groups (Bassett & Krieger, 1986; Feldman & Fulwood, 1999; Geronimus, Bound, Waidmann, Hillemeier, & Burns, 1996; Schulz et al., 2000; Smith & Kington, 1997). Conceptual models have emerged in the literature that attempt to explain these differences (Mendes de Leon & Glass, 2004; Schulz, Williams, Israel, & Lempert, 2002). Generally, these explanatory models focus on how “upstream” macrosocial factors (e.g., racism and racial discrimination, racial residential segregation, social stratification) structure and limit the personal resources (e.g., educational, occupational, financial) available to racial and ethnic minority group members, and how in turn various “downstream” social and individual level mechanisms (e.g., stress exposure, lack of medical care, unhealthy lifestyles) impact health outcomes over time.

Several key factors have emerged and been identified as the primary social pathways and processes that affect health. These include low socioeconomic status (SES) (Lantz et al., 1998; Schulz et al., 2002; Williams & Collins, 1995), adverse health behaviors (Black, Ray, & Markides, 1999; Lantz et al., 2001), and lack of health insurance (Baker, Sudano, Albert, Borawski, & Dor, 2001; Monheit & Vistnes, 2000). To the extent that these adverse health factors tend to cluster together and are more prevalent among racial/ethnic groups (Lynch, Kaplan, & Salonen, 1997), they may explain the observed disparities in health outcomes between minority group members when compared to majority group members, i.e., typically non-Hispanic whites in the United States (Mendes de Leon & Glass, 2004). However, several limitations in the studies listed above have prevented a more complete understanding and elucidation of the causal relationships between these factors and the observed racial/ethnic disparities. These include: variations in study design (e.g., cross-sectional vs. longitudinal); focus on only one particular health outcome (typically mortality); the coarse or inadequate measurement of key factors (usually SES but also baseline health status); aggregating very distinct racial/ethnic sub-groups (e.g., more or less acculturated Hispanic groups); or the omission of key factors from the analysis (e.g., insurance status). In the background section that follows, we first elaborate on several of these issues, and then finish with the research questions we investigate in this study.

## Background

Any examination of racial/ethnic disparities in health outcomes must necessarily include an investigation of socioeconomic (SES) determinants because of the strong

correlations between SES and health, and SES and race/ethnicity. For example, because African Americans are disproportionately poorer and have less education compared to non-Hispanic whites in the United States, SES differentials confound the relationship between race and health outcomes. Therefore, if inadequate or “coarse” controls for SES are employed, researchers will underestimate the effect of SES. This results in a “residual race effect”, leaving the causes of health disparities only partly explained, and often implicitly attributing the unexplained portion to some underlying “genetic” difference (Kaufman, Cooper, & McGee, 1997).

Among the variables available to measure SES, education and income are the most used. Education is relatively easy to measure and stable over time; and it is positively related to a variety of health outcomes, both perceived and objectively measured (Ross & Mirowsky, 1999). Education contributes to an array of resources that are salutary to health, including cognitive and problem solving skills; self-directedness, self-efficacy and personal sense of control; healthy lifestyles; and more lucrative and health-sustaining occupations (Mirowsky & Ross, 1998; Ross & Wu, 1996). Moreover, these salutary relationships persist notwithstanding some salient racial and gender variations in financial returns from educational attainment (Williams & Collins, 1995).

Regarding financial resources, income is the most commonly used—whether measured at the individual or household level. There is a longstanding positive relationship between income and health in the literature (Lynch, Kaplan, & Salonen, 1997; Lynch, Kaplan, & Shema, 1997; Lynch & Kaplan, 2000), but the use of “contemporaneous income” (i.e., typically income measured in the year prior to a survey) does pose several measurement challenges when studying health outcomes over time. First, it is highly volatile over the lifecourse, particularly for those persons in the service and labor sectors of the economy, who are also disproportionately members of racial/ethnic minority groups. Second, current income may be susceptible to “reverse causation” in its relationship to health, where declines in health may produce lower income. Hence, some authors suggest measures of accumulated *wealth* may be better indicators of financial resources available for health and health-related decisions across the lifecourse, particularly for aging adults (Duncan, Daly, McDonough, & Williams, 2002).

There are several pathways by which wealth may affect health. First, it may be a marker for an intergenerational transfer of advantage—including health stock and life-chances—during the developmental years, through childhood and adolescence, and into early adulthood (Lynch & Kaplan, 2000). Alternatively, the lack of wealth when measured in adulthood may be a marker for past economic hardship, and poorer health stock and fewer

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