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Racial health inequalities in the USA: the role of social class

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African Americans die at a younger age and are sicker than Whites in the USA due to a number of diseases. Eliminating these racial health inequalities has become a stated goal of federal health agencies.¹ In 2000, the US Congress established the National Center for Minority Health and Health Disparities at the National Institutes of Health (NIH) to help spearhead NIH efforts to study the causes of these health inequalities, and it also requested an Institute of Medicine study to assess the extent of racial and ethnic health disparities, evaluate the causes of these disparities, and recommend interventions to eliminate them.²

As noted by Krieger,³ research on racial inequalities in health is in its infancy. Untangling and explaining the relationship between social class and racism and their respective roles in creating and maintaining racial and ethnic health inequalities remains a largely unanswered challenge in this research.

Unfortunately, answering this challenge is hampered by a liberal, classless approach to the study of health inequalities. In the period between 1960 and 1990 (as noted by Navarro⁴), a substantial body of work was undertaken to assess the effect of social class on population health. This earlier research on health inequalities explained issues of class exploitation and class power. However, this radical perspective lost ground as funding agencies funnelled support to other, less critical views. These subsequent studies 'focused not on class or even on power relations (terms seen as too ideological) but rather on income and status, referring to income and status differentials, rather than class differentials'.⁴ Due to this shift in political and economic (funding) focus, the socioeconomic status (SES) construct became the mainstream framework for discussing population health, and it is the dominant theoretical framework for the study of racial and ethnic health disparities today.

A theoretical framework that accounts for social class is needed in order to better understand how racial health inequalities are established and maintained. This article will take the specific example of African Americans in the USA to see how one should integrate an understanding of racial discrimination and social class in evaluating health inequalities.

Racial discrimination against African Americans is historically rooted in slavery. Smedley⁵ explains the complex history of the development of race and racism in the USA, arguing cogently that the ideology of race arose in England concurrently with the development of slavery. Williams⁶ explains how the English cotton and textile industries and the shipping

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industry in the north-eastern American colonies grew on the backs of African slaves, through the British slave trade and slave labour in the Americas. African slave labour produced the capital that drove England's industrial revolution. After the defeat of the slave-holding south in the US Civil War, racist ideology was promulgated by the non-slaveholding property owners as a means of dividing the workers and weakening their opposition.⁷

Denied land tenure following the US Civil War, African Americans were driven primarily into the working class.⁷ Wright⁸ provides empirical evidence that such a concentration exists. Racial discrimination drives the disproportionate location of African Americans into non-managerial, non-credentialed and non-property-owning class positions. This process of the differential disposition of social layers within classes helps to explain within-class differences in health status, such as those seen in the Whitehall studies in the UK.⁹

As noted by Williams,¹⁰ racism restricts the socio-economic attainment of African Americans. He argues that SES is not just a confounder of racial differences in health, but part of the causal pathway by which race affects health. Moreover, Williams explains that race is an antecedent to and determinant of SES, and racial differences in SES reflect, in part, the successful implementation of discriminatory policies premised on the inferiority of certain racial groups.

Racialized class relations concentrate African Americans in the working class and constitute part of the causal pathway by which race affects health. However, the processes of racial and social class formation in the USA are inter-related with one another. The dominant social classes of the 17th and 18th Centuries racialized labour through slavery, and today's capitalist class, which politically, economically and ideologically dominates our world,⁸ racialized the development of the US working class through incorporating the inequalities of slavery into modern class relations and maintaining those inequalities through racial discrimination.⁷ Therefore, a proper understanding of the health status of African Americans requires that one take into account both racial and class stratification. The key argument here is that class exploitation and racial discrimination are distinct social processes that, nevertheless, reinforce and reproduce one another in contemporary societies.

The SES construct glosses over the structural nature of one class exploiting others through dissolving social class divisions into occupational categories, educational attainment and income. Although SES indicators (income, occupational stratification, education) are powerful predictors of morbidity and mortality, an analysis of social inequalities in health needs to include an explanation of the social mechanisms that generate SES in the first place. Occupational categories (and the division of labour upon which they are based), the educational needs of individuals performing these functions within the division of labour, and the income received by them are all related to and the result of particular social relations between bosses, workers, managers and other people in the production process.⁸ These social relations of production are the social structure of power differentials in the economy. By glossing over this relationship, the SES construct can lead one to conclude that racial and ethnic inequalities in health can be eliminated without structural changes in economic relations, shifting the focus of public health interventions to limited, targeted interventions.

The point is not that targeted interventions have no value in the effort to eliminate racial health inequalities. Rather, the point is that to achieve this goal in any lasting way for the entire African American population will require a restructuring of social relationships.

This explanation of social inequality, which bases itself on an analysis of social relations of production, sheds light on the social mechanisms of exploitation in a way that analyses limited to SES and racial discrimination do not. Social inequalities in health care, as in other aspects of social life, are structurally inherent to the capitalist economy. These social inequalities,

therefore, can only be eliminated through a fundamental transformation of social relations of production.

Although those who argue that social inequalities are rooted in SES and racism may believe that major social changes are needed to eliminate inequalities, such a perspective is not essential to their theoretical outlook. From this viewpoint, it is possible to argue that income redistribution and educational efforts aimed at dispelling racist ideology can eliminate racial and ethnic health inequalities.

Income redistribution and antiracist education are laudable goals. However, if proposed in isolation from a call for deeper social transformation, such a programme implies that there is nothing inherently wrong with the social relations that produce the inequalities in the first place. Unless one is willing to criticize the mechanisms that produce inequality and sets the ground for most forms of racial stratification to occur, major advance is unlikely. Social epidemiologists need to explain the mechanisms for social inequalities in health and draw the necessary public health implications.

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