

Bay Area Health Inequities

By Bob Prentice

The generation of Americans born at the beginning of the 21st century can expect to live, on average, 30 years longer than those born at the beginning of the 20th century. And at least 25 of those years are attributable, not to antibiotics, vaccines, and other medical advances, but to improvements in our physical and social environments, such as food and water sanitation, workplace and traffic safety, restrictions on the use of tobacco products, and housing conditions.¹

In fact, the odds of being healthy can depend very much on the community in which you live. In the San Francisco Bay Area, for example, people who live in West Oakland can expect to live on average 10 years less than those who live in the Berkeley Hills. Similarly, people in Bayview/Hunters Point can expect to live on average 14 years less than their counterparts on Russian Hill, and residents of Bay Point can expect to live on average 11 years less than people in Orinda.²

Life expectancy in the Bay Area—and around the nation—conforms to a pattern called the “social gradient.”³ The more income and wealth people have, the more likely they are to live longer. This pattern can be seen in the graph “Bay Area Life Expectancy by Race/Ethnicity: Data from 1999-2001” (on page 85), which correlates life expectancy to the extent of poverty in specific areas (census tracts). People who live in places where there is the least poverty can expect to live, on average, 10 years longer than people in places with the most poverty.

An Old and Systemic Problem

If everyone in the Bay Area lived as long as people in areas with the lowest poverty, death rates in the poorest areas would be reduced by nearly half, and in the “middle class” neighborhoods, by 20 percent.⁴

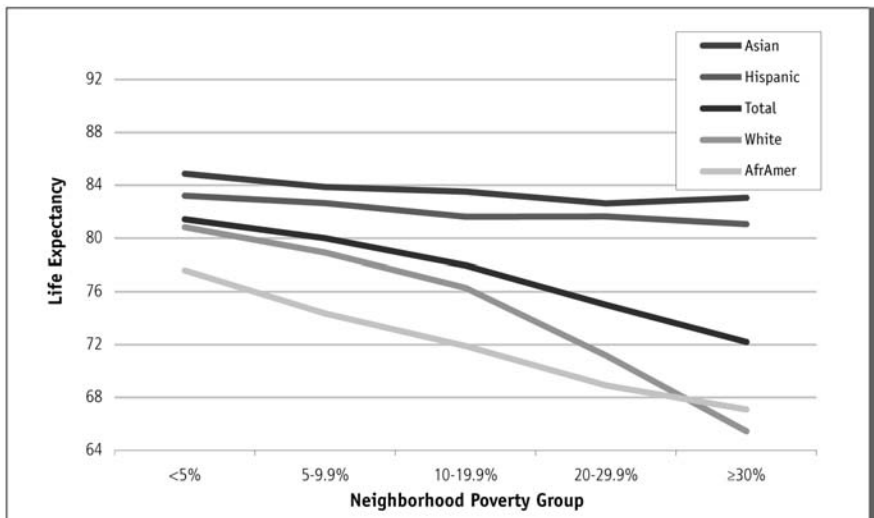
Residential segregation into affluent, middle income, and poor communities contributes to the reasons why where we live can have a significant

influence on how long we can expect to live. But beyond the effects of income distribution, there is growing evidence that racism itself is a factor in health, translating into persistent stress and associated illnesses.

Over the centuries, racism has taken its greatest toll on Native Americans and African Americans, who have the poorest health status. (See graph on page 85.) African Americans have the lowest life expectancy in general.⁵ And although whites have lower life expectancy in the highest poverty areas, fewer than one half of one percent of whites live in those areas.

Asians and Latinos have overall longer life expectancies than both African Americans and whites, and are less likely to show the influences of poverty. While the issues are complex, a probable contributing factor is, in part, significant immigrant populations. Many studies have shown that, while the health of immigrants overall is comparatively good, their health status deteriorates the longer they live in the United States, with subsequent generations showing poorer health along a number of public health indicators.⁶

The influence of neighborhood on health is not only a matter of poverty and physical environment, but also of cultural factors, such as family, community, and diet, which can help or hinder people’s abilities to withstand the effects of poverty and environmental risks. Unfortunately, many of the cultural supports and practices that help immigrant popula-



Bay Area Life Expectancy by Race/Ethnicity: Data from 1999-2001.

tions maintain better health initially are subject to erosion over time as subsequent generations adopt new ways of life and environmental factors, both social and physical, take their toll.

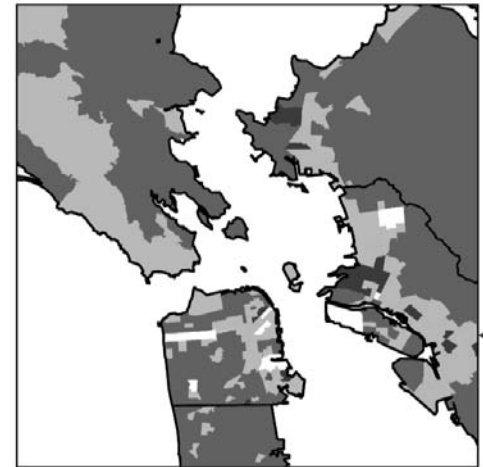
Improvements in neighborhood living conditions can benefit those who are most vulnerable as well as those who are most resilient.

Bridging the Chasm Between Rich and Poor

The United States today has a degree of income and wealth inequality not seen since the 1920s, thanks to the changes in the way income, estates, and capital gains have been taxed over the past few decades. In order to close the health gap between the ultra rich and the middle and lower income groups, we have to take some steps to level the economic playing field.

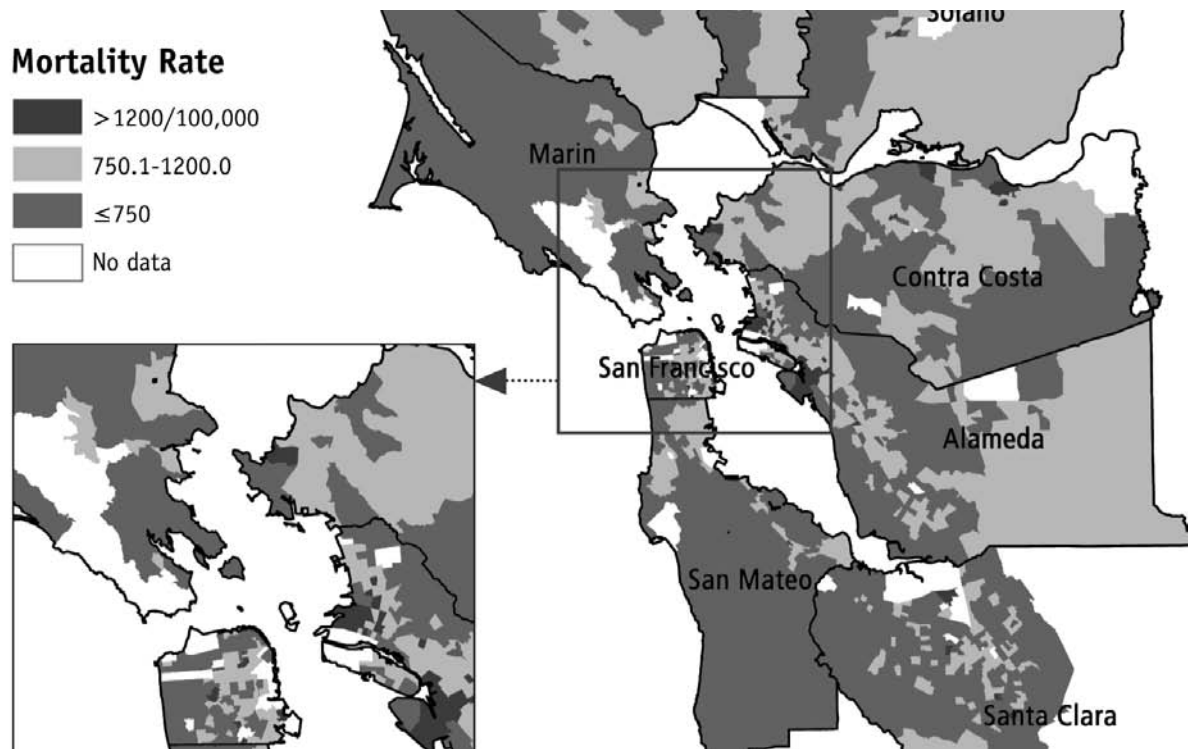
1. Create a more equitable tax structure through policies that shift some of the tax burden from the middle and working class to the wealthy.
2. Tie minimum wage policies to cost of living. The first minimum wage increase passed by Congress in this decade has not kept close to the rise in cost of living. Living wage campaigns, such as the one passed in San Francisco, provide additional financial and health benefits.
3. Introduce education policies—from early childhood development through college—that mitigate, rather than exacerbate, levels of inequality in society. Educational priorities, such as those recently announced by the California Superintendent of Public Instruction to reduce high school dropout rates among African Americans

Poverty Rate



Geographic distribution of poverty rates in Bay Area counties.

- and Latinos, will be important for creating avenues out of poverty.
4. Create housing policies that enable more people to make secure investments, which can contribute to improvements in overall health. Improvement of living conditions in increasingly multi-ethnic, low-income communities will have to become a priority for public agencies and private business investment if we want to contribute to improving health. Building new alliances within communities to assure that neighborhood improvements do not mean displacement and gentrification will be an important corollary.
5. Revise land use, transportation, economic development, and redevelopment policies with an eye to creating equity and improving health. There is a growing recognition that the built environment has consequences for health, and public health departments and planning agencies are gradually beginning to work together to make health a consideration in land use and transportation decisions.
6. Encourage neighborhood living conditions that



combine mixed income and mixed use facilities, public transportation, affordable housing, open space, and removal of blight without causing displacement.

Public Health in the 21st Century

After decades of urban sprawl resulting from bad development decisions that did not consider the needs or necessities of affected communities, there are, finally, new currents in land use planning. Smart growth and the new urbanism are consistent with many planning principles that support good health. However, we are still a long way from making the relationship between public health and planning a priority for achieving greater health equity. That, calls for wider political support.

One avenue for widening political support is through renewed national dialogues about race and racism. We certainly hope that the openings for such a dialogue emerging from the 2008 presidential election might yield new strategies for reducing the toll taken by racism on the health of poor and immigrant populations and contribute to improving the health of future generations.

Endnotes

- 1 See, for example, Kawachi I, Kennedy B.P, Wilkinson R.G., *The Society and Population Health Reader: Income Inequality and Health*, The New Press, New York, 1999; Sieguistr J., Marmot M., *Social Inequalities and Health: New Evidence and Policy Implications*, Oxford University Press USA, 2006; Hofrichter R, *Health and Social Justice: Politics, Ideology and Inequity in the Distribution of Disease*, Jossey-Bass, San Francisco, 2003; Adler N, et al, *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the United States*, The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health, 2008, www.macses.ucsf.edu
2. Life expectancy is calculated using deaths for census tracts aggregated by poverty level and/or race/ethnicity. While the census tracts do not conform precisely to the city or neighborhood boundaries cited, they are within those boundaries.
3. Life expectancy is the number of years someone born today can expect to live if exposed to current death rates throughout their life.
4. Death rates refer to the number of deaths per 100,000 population. They are adjusted to allow comparisons among populations with different age distributions. Death rates are used when groupings cause the numbers to be too small to calculate life expectancy reliably.
5. See Adler N., et al, op. cit. *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the United States*, 2008,
6. See, e.g., Koya, K.L. and Egede, L.E. "Association Between Length of Residence and Cardiovascular Disease Risk Factors Among an Ethnically Diverse Group of United States Immigrants," *Journal of General Internal Medicine*, 22(6):841-6, June, 2007.

Bob Prentice is the director of the Bay Area Regional Health Inequities Initiative (BARHII). Matt Beyers, an epidemiologist with the Alameda County Public Health Department, produced the data in this article, including the graphs and maps. A copy of the full report, as well as related information, can be found at: www.barhii.org

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