



ELSEVIER

Contents lists available at ScienceDirect

SSM - Population Health

journal homepage: www.elsevier.com/locate/ssmph

Do rising tides lift all boats? Racial disparities in health across the lifecourse among middle-class African-Americans and Whites



Cynthia G. Colen^{a,*}, Patrick M. Krueger^b, Bethany L. Boettner^c

^a Department of Sociology, Ohio State University, 238 Townshend Hall, 1885 Neil Ave. Mall, Columbus, OH 43210, USA

^b Department of Health & Behavioral Sciences, University of Colorado, Denver, USA

^c Institute for Population Research, Ohio State University, USA

ARTICLE INFO

Keywords:

Health disparities
Life course processes
African Americans
Socioeconomic mobility
Self-rated health
Childhood disadvantage

ABSTRACT

Although racial inequalities in health are well documented, much less is known about the underlying mechanisms that create and sustain these population patterns, especially among nonpoor subgroups. Using 20 waves of data from the Panel Study of Income Dynamics (PSID), we estimate the magnitude of the Black/White gap in self-rated health among middle-income, working-age (18–65) adults and explore potential sources of this disparity. Findings from multilevel regression models suggest that intragenerational gains in family income result in significantly smaller improvements in self-rated health for middle-class African-Americans than similarly situated Whites. We also note that childhood disadvantage predicts subsequent health trajectories in adulthood, but does little to explain the Black/White gap in the association between family income and self-rated health. We conclude that middle-class status provides restricted health returns to upward mobility for African-Americans and this differential relationship cannot be accounted for by greater exposure to early life disadvantage.

Introduction

In the United States, the health of African-Americans lags well behind most other racial/ethnic groups. Compared to Whites, Black men and women face higher risks of chronic illnesses, infectious diseases, and injuries – all of which to serve to shorten their average life expectancy by as much as 6 years (Murphy, Xu, & Kockanek, 2013). However, Black/White disparities in wellbeing do not simply take root at advanced ages. Rather, they emerge at birth and fluctuate according to predictable patterns across the lifecourse (Williams, Mohammed, Leavell, & Collins, 2010). These divergent health trajectories translate into distinctly different life experiences for African-Americans and Whites.

Although the existence of stark racial disparities in health is well documented, much less is known about the underlying mechanisms that create and sustain these divergent trajectories. Socioeconomic status (SES) is known to be one of the most powerful predictors of subsequent morbidity and mortality (Pavalko, & Caputo, 2013), so much so that it is known as a fundamental cause of population health disparities (Phelan, Link, & Tehranifar, 2010). Individuals who occupy higher positions on the socioeconomic gradient can expect to live healthier and longer lives than those who occupy positions below (Adler et al., 1994;

Elo & Preston, 1996; Adler and Rehkopf, 2008). However, the evidence regarding the extent to which the Black/White gap in physical wellbeing is due to racial differences in SES has been mixed, with a majority of studies reporting that disparate levels of SES explain only a portion of racial inequalities in health (Franks, Gold, & Fiscella, 2003; Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010).

Moreover, the extent to which the health of African-Americans lags behind that of Whites is not consistent across levels of SES. Black/White disparities in morbidity and mortality tend to be more pronounced at higher levels of SES (Williams & Sternthal, 2010). For example, among adults with incomes below 100% of the federal poverty threshold, 11% more nonHispanic Blacks than Whites rate their health as fair/poor. Among adults whose family incomes are at or above 400% of poverty, 41% more non-Hispanic Blacks than Whites describe their overall health as being fair/poor (Centers for Disease Control and Prevention, 2012). This represents more than a two-fold increase in the Black/White gap in self-rated health at the upper versus lower end of the income distribution. These findings suggest that the ways in which race and SES interact to produce disparate health outcomes across the lifecourse are complex and deserve further study.

To this end, we examine the patterning of racial disparities in physical wellbeing among a subpopulation that has been vastly

* Corresponding author.

E-mail address: colen.3@osu.edu (C.G. Colen).

<https://doi.org/10.1016/j.ssmph.2018.07.004>

Received 15 March 2018; Received in revised form 30 May 2018; Accepted 17 July 2018

2352-8273/© 2018 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

understudied – middle-class African-Americans (Jackson & Stewart, 2003; Jackson, 2005; Landry & Marsh, 2011). Specifically, we seek to determine the extent to which the Black/White gap in self-rated health among middle-class Americans can be explained by two lifecourse mechanisms – early exposure to childhood disadvantage or the non-equivalence of socioeconomic status across race. The first suggests that middle-class Whites exhibit better health outcomes than their African-American counterparts because they are less likely to have spent their formative years with limited socioeconomic resources. Given what we know concerning the latent and long-lasting effects of childhood poverty (Duncan, Ziol-Guest, & Kalil, 2010; Case, Lubotsky, & Paxson, 2002) as well as the cumulative impact of negative social exposures on health throughout the lifecourse (Hayward, & Gorman 2004; Geronimus, Hicken, Keene, & Bound, 2006; Walsemann, Geronimus, & Gee, 2008), the consequences of this early life adversity might not be fully expressed until midlife or beyond. The second mechanism proposes a different pathway, whereby the impact of SES over the lifecourse (i.e. upward socioeconomic mobility) will have a muted impact on the health of middle-class African-Americans compared to middle-class Whites. For the purpose of this paper, we will be using the terms, health and wellbeing, interchangeably to capture the same underlying construct.

Background

Lifecourse SES and health: Theoretical perspectives

Researchers who examine the population patterning of health across the lifecourse typically invoke one of two explanatory mechanisms. The first emphasizes the role that early life exposures play in the production of wellbeing later in life, while the second highlights the cumulative impact of these health eroding insults over time. Existing lifecourse frameworks have emerged simultaneously from different disciplinary perspectives; however, there is much theoretical overlap. We will draw conceptual connections between subfields by discussing similar models in tandem.

Early origin frameworks

Early origin frameworks (EOFs) suggest that encountering socioeconomic hardship early in life, especially during developmentally sensitive (i.e. critical) periods, negatively impacts an individual's health as he/she ages. These critical periods might occur during fetal development, early childhood, or adolescence. What distinguishes early origins frameworks from other lifecourse approaches is their emphasis on specific, time-bound periods of maturation during early life in which exposures to disadvantage have outsized effects on subsequent health trajectories. Moreover, these approaches allow for the possibility that a substantial amount of time may pass between these exposures and the expression of adult disease or disability. This latency period is likely to be clinically unremarkable and offer few, if any, clues to the health deterioration that is about to occur.

Barker's Fetal Origins Hypothesis is the most well known EOH. Barker (2003) posits that individuals exposed to unfavorable intrauterine environments during specific stages of fetal development will undergo metabolic dysregulation and face increased rates of chronic illness, particularly cardiovascular disease, in adulthood. The most convincing evidence in support of the fetal origins hypothesis comes from natural experiments during which maternal nutritional intake during pregnancy was highly restricted (Almond, & Mazumder, 2011; Chen, & Zhou, 2007; Susser, & Stein, 1994; Stein, Zybert, van der Pal-de Bruin, & Lumey, 2006, 2007). These studies suggest that children exposed to limited caloric intake during gestation are significantly more likely to be obese, exhibit unhealthy fat distribution, have high blood pressure, and face a greater risk of schizophrenia as adults (Hoek, Brown, & Susser, 1998; St Clair et al., 2005; Stein et al., 2006, 2007; Chen, & Zhou, 2007).

Theoretical conceptualizations that emphasize the role of early life exposures, particularly those occurring after the perinatal period, in the subsequent development of health later in life are not without proponents in other fields. Researchers have noted that the years between birth and age 6 when most children begin formal schooling are particularly important for long-term outcomes, health and otherwise (Hayward, & Gorman, 2004; Case, Fertig, & Paxson, 2005; Palloni, 2006; Case, & Paxson, 2008, 2010; Currie, 2009; Conti, Heckman, & Urzua, 2010; Duncan et al., 2010; Heckman, Pinto, & Savelyev, 2013).

Critiques of EOFs are not without merit. One of the most striking shortcomings of these approaches is the tendency to downplay important changes in health that occur after the initial critical period. For example, subsequent studies have found that infants who experience an early adiposity rebound during childhood (2–6 years) have the highest risk of developing cardiovascular disease in adulthood (Koyama et al., 2014). Additionally, and perhaps more importantly, racial/ethnic disparities in health often become apparent well before midlife, with race-specific rates of several chronic diseases, such as diabetes, obesity, asthma, and even hypertension, diverging during childhood (Akinbami, Moorman, Simon, & Schoendorf, 2014; Akinbami, Simon, & Rossen, 2016; Caprio et al., 2012; Goren, 2008; Hardy et al., 2017; Ogden et al., 2016; Weiss, 2004). These empirical realities call for theoretical approaches that can capture exposure to disadvantage across the entirety of the lifecourse as well as the cumulative way these exposures erode health over time. It is to these frameworks that we now turn.

Cumulative disadvantage/advantage

The concept of cumulative (dis)advantage has a long tradition in sociology and can be traced back to the work of Merton (1968) and Blau and Duncan (1967). More recently, the concept of cumulative (dis)advantage has gained theoretical traction in the field of social epidemiology and led to the development of two distinct frameworks, each of which describes specific, time-dependent pathways through which health is produced over time. The first, the accumulation of risk model, predicts that the longer an individual is exposed to socioeconomic hardship, the worse her health will be. Thus, the relationship between SES and physical wellbeing across the lifecourse is thought to be relatively straightforward, with increases in SES over time resulting in concomitant improvements in health. The second framework, the chains of risk model, more directly draws upon the Mertonian concept of cumulative (dis)advantage in that it emphasizes the ways in which exposures to hardships earlier in the lifecourse can place an individual on a specific trajectory resulting in the expression of suboptimal health outcomes over time (Hertzman & Power, 2003; Pavalko & Caputo, 2013).

Both these cumulative (dis)advantage approaches have been criticized for not adequately incorporating the experiences of African-Americans (Schwartz & Meyer, 2010; Geronimus, 2013). Proponents of these frameworks often fail to consider how occupying another disadvantaged social status, such as being a member of a racial minority, might impact the seemingly straightforward association between SES and health (Schwartz & Meyer, 2010). Therefore, these approaches may have limited applicability when investigating why Black/White disparities in health are more pronounced among non-poor as opposed to poor subgroups.

Instead, we highlight the critical interplay between race and class to more fully explain (1) why the health returns to upward mobility might be muted among African-Americans compared to Whites and (2) how exposure to childhood disadvantage might influence the disparate association between lifetime SES and health across race. To this end, we rely upon the restricted returns hypothesis (RRH) put forth by Colen (2011). It suggests that the health returns to middle-class status are likely to be limited for African Americans compared to Whites due to racial barriers that operate at the structural (macro), interpersonal (mezzo), and intrapersonal (micro) level. Although it is beyond the scope of this paper to explain, in detail, all the possible pathways

Download English Version:

<https://daneshyari.com/en/article/11005549>

Download Persian Version:

<https://daneshyari.com/article/11005549>

[Daneshyari.com](https://daneshyari.com)