Public Health in the New Millennium II: Social Exclusion

More than advances in medicine, it was improvements advocated by the public health movement of the early 1900s that led to a healthier US population. Our predecessors made enormous capital investments in systems for delivering clean, running water and disposing of waste and garbage. They fought the political battles necessary to pass laws protecting the safety of our food supply and the working conditions in our factories. They conducted major education campaigns. Classroom by classroom, civic gathering by civic gathering, at Ellis Island and in settlement houses, at grange halls and scout meetings, they educated the public about basic hygiene, disease prevention, home and occupational safety. We enjoy the benefits of their efforts in the form of lower infant and child mortality rates, longer lives for men and women, and reductions in contagious illness and disease.

Along with these achievements came another development: our consensus as a people that a public infrastructure for improving and maintaining health is fundamental to decent living. Water purification, responsible human waste disposal, regular garbage collection, government oversight of grocery stores and restaurants, and enforced occupational safety practices are all customary today. We take them for granted. Earlier in the 20th century, however, these were not a given. They required major investments of political as well as financial capital. Our country committed itself, in grand scale and wide scope, to improving the well-being of our people. The health we enjoy here as we enter the 21st century is directly traceable to the physical and legal public health infrastructure developed early in the 20th.

The question now, for this new century, this new millennium, is whether there is a new, equally important and equally challenging frontier for public health?

Visionaries from our past can provide answers for our future. Charles-Edward A. Winslow, once a dean of Yale's school of public health, gave us this vision of public health in 1920 in an address to new students:

> Public health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and *the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health* [emphasis added].

In other words, a goal of public health is to *produce the social conditions* that lead to good health. Beginning with this new millennium, we can extend our vision from what we (mostly) have achieved—systems for disease prevention and control, safety, and sanitation—to repairing our inequitable social system. We can look to addressing those socioeconomic realities, such as poverty, income and wealth disparities, ignorance, and unemployment, that weaken the public's health.

Historical traditions support the notion that public health demands a wider perspective. At the turn of the 20th century, we knew that outdoor privies could make people sick, but it was a leap from that knowledge to the philosophical, social, and political conclusion that the answer was to fund and build an interconnected system of mains, pipes, and water purification facilities so that clean, running water was available to all. We knew that rural folk, living isolated without electricity and telephones, suffered a poorer quality of life and health than their urban counterparts, but it took a major change in thinking during FDR's presidency to establish the Rural Electrification Administration and make the massive investments necessary to bring these services, which helped eliminate disease and premature death, to rural areas. Similarly, we know that people's socioeconomic status affects their health and longevity. The question is whether we are willing to make a similar leap and change the social and economic machinery for the sake of our people's health. The challenge for the public health professional in the new millennium is to develop the consensus that will make that happen.

A recent UNICEF report, *The State of the World's Children 2000,* documents that one in six children in the world's wealthiest countries live in poverty, with 47 million living in families so poor that their health and well-being is at risk. Indigent children, the report shows, are more likely to have learning difficulties, drop out of school, use drugs, commit crimes, be jobless, and have children too early. The most disgraceful finding in UNICEF's report is this: of the 29 countries in the Organization for Economic Cooperation and Development (OECD), next to Mexico, the United States has the highest percentage of children living in poverty. More than one in every five US children, or 22.4%, is poverty-stricken. (Twenty-six percent of Mexico's children live in poverty.)

We know that the consequences of childhood poverty cited by UNICEF—learning problems, school dropouts, substance abuse, crime, early parenthood, and joblessness—all translate into poor health outcomes over a lifetime and become causes of social exclusion even into the next generation. A five-year study by the Centers for Disease Control and Prevention found that higher-educated adults are healthier than adults without high school diplomas; college graduates get sick less often than high school graduates; unemployed adults get sick more often than employed adults; and people in poverty get sick the most often. Researchers elsewhere have found a correlation between physical and mental health and the extent to which people feel in control of the negative circumstances in their lives, such as poverty and joblessness. A study from Scotland showed that poor women who received the same quality of care for breast cancer as women who were not poor actually had poorer outcomes because their overall health was poorer. The authors of a Harvard School of Public Health study theorize that, at least in white men, chronic stress brought on by lower socioeconomic status triggers psychological factors, such as hostility, which in turn lead to negative physiological consequences such as higher blood pressure and higher blood sugar levels. The list goes on, and the specifics may vary, but the bottom line is this: people living in lower socioeconomic circumstances are excluded from partaking of the wealth of our social resources, and are consequently living in health-threatening conditions.

We can begin to address social exclusion in three ways: academically, through research; politically, by eliminating poverty; and socially, by addressing socioeconomic inequality, racism, sexism, and other forms of bias.

Research. Well-meaning public health practitioners and scholars must acknowledge the reality that, too often, bias creeps into their studies and models. It is understandable that this happens; the dominant paradigm, by virtue of its ubiquitousness, is often invisible. As researchers and academics, we have come far in ridding ourselves of this bias, but it still exists, and so we must continue to overcome it. How healthy we are has everything to do with our gender, race and ethnicity, income, education, employment status, disability, sexual orientation, and where we live. Yet we still envision a "generic person" who dominates our research, who too often has little or nothing to do with flesh-and-blood reality. Here are some examples:

- Car manufacturers designed airbags for their idea of the "generic person": a 5'9", 170-pound, un-seatbelted man. The result is that smaller people, especially women and children, have been killed or seriously injured by the excessive force of deployed airbags. And rather than redesign airbags, manufacturers tell us to deactivate them.

- Men are more likely than women to get emergency intervention during heart attacks because women present symptoms differently from men, and men's symptoms—the symptoms of the "generic person"—are considered the norm. Our emergency professionals should be equally trained in the classic heart attack symptoms of men and women. The "generic person" construct has left women at higher risk of premature death.

- African-American women are disproportionately victims of diabetic blindness, lower limb amputations, and other complications of diet-accelerated diabetes. One must wonder what the response would be if these burdens applied to the white male "generic person."

When researchers stop ascribing unrepresentative demographic characteristics to their study samples, their

research will begin to be targeted to those in our society who suffer the most from poor health.

In addition to weeding bias out of their models, researchers must do more comparative studies to help us isolate what holds for public health in the world, and what holds only—or disproportionately—in the US. Poor health is associated with lower socioeconomic status, but is it an inevitable outcome? The answer appears to be no. For example, there is a consensus in the US that a rise in single parent families implies a rise in childhood poverty. Yet, according to UNICEF, Sweden, the OECD country with the highest rate of single parenthood (20%), also has the lowest rate of childhood poverty (2.6%). There is a consensus in the US that high unemployment rates correlate with high child poverty rates, yet, according to UNICEF, Spain and Japan both have child poverty rates of 12%, while Spain's unemployment rate is 15% and Japan's is less than 5%. The same report noted that although Paris has as high a rate of poverty as Manhattan, Manhattan's infant mortality rate is nearly twice as high as Paris's. Manhattan's poor children are less healthy than their counterparts in Paris, largely because the French have a health system that makes it easy and affordable for parents to obtain health care and other services for their children. Comparative findings from other countries upend our assumptions and reveal that, in nations where programs exist to ensure the basic social and economic rights of all citizens—in other words, where social exclusion is not tolerated—the damaging effects of poverty can be minimized. Kawachi and Kennedy at the Harvard School of Public Health have argued that it is the gap in income, the differences in relative wealth and social inclusion in America, rather than absolute poverty, that contributes to disparities in health status.

Research needs to tell us, in greater depth and detail, what other industrialized nations are doing that is yielding better health outcomes than we enjoy. What can research teach us about remedies for the systemic causes of ill health for the poor in this country?

Poverty. Politically, we must resurrect eliminating poverty as a national priority. In 1967 and 1968, Senator Robert F. Kennedy toured several forgotten, poverty-stricken regions of the US to bring attention to the plight of the US poor. What he showed us was considered a national disgrace, and in his time, he helped to mobilize significant changes.

It is well past time to revisit this issue, to face it with the same degrees of shame at its existence and commitment to change. Because in our nation there are direct correlations between poverty and health status, poverty and educational attainment, poverty and housing, public health professionals must speak out clearly and consistently until the press and public begin to take notice. From grassroots on up to national levels, public health professionals must lead the antipoverty cause, educate local and national leaders about the social problems brought on by poor health derived from poverty, and then offer their knowledge, expertise, and clout to help enact political solutions.

One way to start informed discussion about poverty is to abandon the federal poverty line, which is widely acknowledged as not measuring the right factors, in favor of a more realistic standard. The Self-Sufficiency Standard used by the organization Wider Opportunities for Women, for example, measures how much income is needed for a family of a given composition in a given place to adequately meet its needs without public or private assistance. The standard assumes that all adults in the family are working, includes costs associated with employment (such as child care), takes into account the size of the family and the ages of the children, incorporates regional and local cost variations, and factors in the net effect of taxes and tax credits. In short, it looks at what a self-sufficient family would need to live adequately (not comfortably) in the real world. According to the Self-Sufficiency Standard, a family with two parents in Washington, DC, both working full time, with a preschooler and a school-age child, would have to earn at least $9.78 *per adult* per hour to cover costs with no public or private support. In the city of Boston, the same family would need to earn $10.08 per adult per hour. Bear in mind that the minimum wage is currently $5.15 an hour, which explains why, in this country, we have tens of millions of people in a category known as the "working poor."

This is not simply an argument for raising the minimum wage. It is instead a call for putting in place government programs to supply to the poor the basic necessities of a decent, healthy life. Every other industrialized nation has, for example, a national health care program so that none of its citizens are socially excluded from access to reliable, affordable, medical care. It is time for this and similar programs to be created or expanded here in the US.

Bias. While we must acknowledge that racism, sexism, and other forms of bias play a role in who winds up poor in this country, we need a new analysis of intermediate as well as long-term effects. When we focus exclusively on skin color, ethnicity, or gender, we miss information that could help make our remedial policies less divisive and more comprehensive. There are more poor whites than poor blacks in America, but the proportion of blacks who are poor is much higher than the proportion of whites who are poor; the obvious explanation for this disparity is racism. Martin Luther King, Jr., taught that racism not only keeps African Americans socially excluded, but also contributes to the social exclusion of poor whites by keeping them from joining their political interests with the political interests of African Americans. We need more of this universalist way of thinking in our policy discourse and development. For example, we now know that,

because of social exclusion, African Americans in general have not accumulated and transmitted wealth intergenerationally to the degree that most other groups of Americans have. The rise in social status in subsequent generations seen in other ethnic groups in the US has thus been slower for African Americans. This is a useful sociological finding because it implies that remedies are available through specific political solutions, and because it leads to a more inclusive understanding of poverty. Social exclusion is the result of multi-generational poverty. This is not a denial of racism; indeed, racism is the reason why African Americans disproportionately live in poverty. It is instead an acknowledgement that racism results in politically and economically remedial problems whose solution is in everyone's interest.

It makes sense to find common ground when we address bias. By the same token, however, we must see that different groups often do have different problems and that, even if a problem does not affect the majority, it is still worthy of our concern, our resources, and our commitment. The Human Genome Project offers a useful analogy. If the mapping of the human genome shows that we are 99.9% the same, the focus for researchers will still be on the way in which we are 0.1% different, or why those who appear to be 100% the same have different conditions or outcomes. Why do only some of us get breast cancer or diabetes? Why do some of us appear predisposed to chemical addiction, mental illness, or health-risky behaviors? Why are certain populations prone to coronary diseases? How much of what is called genetic is the interaction of behavior or the environment and the human body? So with social exclusion: we must address how and why gender, ancestry and ethnicity, socioeconomic status, disability, sexual orientation, and rural living affect health outcomes, but we must equally look at the interaction of institutions, law, policies, and programs on groups of people.

While research and analysis is essential, we cannot simply wait for the results of our investigations. The "social machinery" of which Winslow spoke is a human creation, not a force of nature, and therefore is subject to our intervention. We must demand the courage and leadership from ourselves as well as from elected leaders to create the means for all Americans to enjoy health, happiness, and prosperity. Our predecessors began this process. Now it is our turn.

—Judith Kurland

Truisms or Truth?

The verities of public health: are they fundamental truths or tired clichés? This issue of *Public Health Reports* allows us to look at some of these truths—and some from other fields—in practice and in policy.

"Everyone Understands the Importance of Schools"

Marion Nestle, whose last feature article for us was on obesity, makes another important contribution to public policy discussion in "Pouring Rights." What lies behind the situations she describes is the continued and even increasing abandonment of public functions and public institutions. Schools seek partners in the corporate world for many good and important reasons such as expertise, political support, and opportunities for students and faculty, but increasingly schools, underfunded and often under attack, need corporate partners for the funds that should be in basic budgets. Corporate partners that seek to improve education so an educated workforce and edu-

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