Literature Review:
Race and Health Inequity

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Phelan, Jo C., and Bruce G. Link. 2015. "Is Racism a Fundamental Cause of Inequalities in Health?" ***Annual Review of Sociology*** **41 (1): 311 – 30. https://doi.org/10.1146/annurev-soc-073014-112305.**

Columbia University sociologists Bruce Link and Jo Phelan have long been interested in the connections between socioeconomic status (SES) and health disparities. Their 1995 essay, "Social Conditions as Fundamental Causes of Disease," was a groundbreaking contribution to "fundamental-cause theory," often seen through the lens of social determinates of health. In their 1995 essay, Link and Phelan describe the effect of what they call "flexible resources" — money, knowledge, power, prestige, and beneficial social connections — on the health of lower SES groups, "If the problem is heart disease, a person with greater resources is better able to maintain a heart-healthy lifestyle and get the best medical treatment" (312). Differences in access to flexible resources, the authors argue, affects a multitude of disease outcomes because those without flexible resources aren't as able to address the root causes of their disease and comorbidities.

In their 2015 essay, "Is Racism a Fundamental Cause of Inequalities in Health?," Link and Phelan build on previous scholarship to explore whether and how race, like SES, is associated with health disparities. The authors make three major points. First, they note that racial minorities on average have a lower SES than their white counterparts. Several factors are indicative of SES status such as job prospects and promotions, education level and quality of education, as well as social and psychological factors. While both blacks and whites have gained proportionately in areas of income and education over the latter half of the past century, "racial gaps in median income (since 1948), wealth (since 1983), and percent with at least four years of college (since 1940) have remained relatively steady or grown" (316). Link and Phelan argue that these types of racial SES disparities are fundamentally linked to systemic racism.

The authors' second point builds directly on their 1995 essay to show that access to flexible resources has persisted as a causal link to inequalities in health and mortality. Finally, the authors turn to their third point arguing that racism has been a "fundamental cause of racial differences in health and mortality independent of SES" (316). While health disparities have declined in white communities over the last century due to the impact of public health policies dealing with communicable disease, the authors make the case that health outcomes within racial minority communities have worsened even when numbers are controlled for economic factors. In other words, differences in health outcomes are not simply linked to class

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or SES, but are informed by another factor: racism. Link and Phelan argue that lower than average SES is compounded by a lack of what they call "flexible race-related resources" such as prestige, power, beneficial social connections, and freedom. Possessing a lack of flexible race-related resources results in black families enduring multi-generational health disparities and, in turn, makes it more difficult for individuals to gain necessary flexible resources. The authors conclude their essay by examining the relationship to racism and "virtually all major disease outcomes" independent of SES (320). Of particular relevance, the authors point to previous studies indicating that, "black Americans receive lower-quality health services than white Americans do, and these inequalities are remarkably consistent across a range of illnesses and health care services" (321).

It is relatively uncontroversial to claim that a lower socioeconomic status (with all its effects on flexible resources) is indicative of negative health outcomes. This article adds nuance to this work, however, in the claim that, through the mechanisms of systemic racism, race is an independent variable for negative health outcomes. Link and Phelan's essay relies on the theoretical work of critical race theory to make their argument that subtle forms of prejudice and discrimination inform the ways in which employers, lenders, government organizations and the larger society interact with racial minorities. The subtleties of racism, for Link and Phelan, are often difficult to link directly to health outcomes; racism is often in the background and is a tertiary or quaternary cause of comorbidities, neighborhood segregation, or job prospects.

Karaye, Ibraheem M., and Jennifer A. Horney. 2020. "The Impact of Social Vulnerability on COVID-19 in the U.S.: An Analysis of Spatially Varying Relationships." ***American Journal of Preventive Medicine*** **59 (3): 317 – 25. https://doi.org/10.1016/j.amepre.2020.06.006.**

From early April, at the beginning of the COVID-19 pandemic, papers began to emerge that reported disproportionate cases, hospitalizations, and deaths of African Americans, Hispanics and Latinos, and Native Americans to the COVID-19 epidemic. All of these racial and ethnic groups rank high in terms of the Social Vulnerability Index (SVI) which measures access to medical care, income, transportation, level of education, and access to adequate nutrition, among other factors. Ibraheem Karaye and Jennifer Horney examined the trends of racial minority COVID-19 cases through the lens of social vulnerability to predict which U.S. counties are at greater risk of negative health outcomes because of the pandemic.

The SVI is a tool used by the Centers for Disease Control and Prevention to rank health outcomes after a disaster. The SVI uses 15 social vulnerability factors associated with four categories: socio-economic status, household composition and disability, minority status and language, housing type and transportation. These factors include a combination of things like crowded housing, poverty, lack of access to transportation, and lack of fluency in speaking English, which can predict, "a community's ability to prevent human suffering and financial loss in a disaster" (CDC SVI Fact Sheet).

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Karaye and Horney used previous SVI data which has shown patterns across all major U.S. cities indicating that a disproportionate number of racial minorities live in overcrowded apartment buildings as compared to their white counterparts. In fact, previous SVI geospatial mapping has revealed that high SVI populations are predominantly people of color. The authors of this paper overlaid existing SVI mapping with COVID-19 case counts to show not just *that* minority racial groups have been disproportionately affected by COVID-19, but also why that might be the case.

Karaye and Horney point out that many of the health problems endemic to racial minority populations which have made them more susceptible to the COVID-19 pandemic are due to inequalities related to social determinates of health. Living in polluted neighborhoods, multigenerational housing, unpaid sick leave, reliance on public transportation, and public interfacing jobs like those in the service industries (among several other factors) all lead to increased exposure to COVID-19. All of these factors are disproportionately experienced by racial minorities. The authors note that socially vulnerable populations like African-American communities are likely to experience disproportionately higher impacts from disasters of any type, including those of the pandemic. Karaye and Horney's model revealed that, "a percentile increase in overall SVI was associated with a 65% increase in COVID-19 case counts" (319). Their model further revealed that "a percentile increase in minority status and language was associated with a 6.69-fold increase in COVID-19 case counts" (319). In other words, the more socially vulnerable (lower socioeconomic status, lack of health insurance, or race), the higher the chance of contracting, being hospitalized, and dying of COVID-19.

The authors conclude that not only are people of color experiencing a disproportionate burden of this pandemic, but that these burdens will likely continue to disproportionately affect poor and racial minorities well into the future. They predict that COVID-19 will result in an increased risk of negative physical and mental health outcomes just as has been the case after any disaster. They conclude their report by making an appeal for the nation to address the social determinants of health, "such as housing, education, and environmental and economic justice…to reduce inequities in the health impacts of disasters" (323). Karaye and Horney provide evidence that the disproportionate negative health outcomes experienced by racial minorities correlates with indicators on the SVI, that COVID-19 is a disease affecting predominantly poor people of color. Their research doesn't definitively say that higher rates of COVID-19 cases, hospitalizations, and deaths are due to the effects of racism, but their work does suggest a high level of correlation and probability and it presents suggestions for how to care for the most vulnerable from a public health perspective.

Finn, Daniel K. 2016. "What Is a Sinful Social Structure?" ***Theological Studies*** **77 (1): 136 – 64. doi:10.1177/0040563915619981**.

Daniel Finn, professor of theological studies and economics at St. John's University in Collegeville, Minnesota, attempts to undergird the widely cited notion of "systemic racism" within Catholic Church teaching in his 2016

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essay, "What Is a Sinful Social Structure?" Finn begins his project by noting that the term "systemic racism" within magisterial documents is linked to the term "social sin" found in the writings of St. John Paul II and Pope Benedict XVI. The concept of social sin, however, isn't adequately developed within Church teaching where the notion of sin is personally mediated and where someone must be personally responsible for sin, but which fails to grasp how structures themselves can be sinful. Pope Benedict XVI described social structures as, "the sets of institutions and practices which people find already existing or which they create, on the national and international level, and which orientate or organize economic, social and political life" *(Second Instruction on Liberation Theology)*. And while social structures encourage members of society to adopt a set of beliefs and practices, they are not deterministic in the sense that we have no choice whether we will comply with their suggestions. Rather, as Finn insists, there is a, "reciprocal relation between structures and persons," which can both endorse and constrict the assumptions of the social structure (141).

In the second part of his essay, Finn utilizes the sociological method of critical realism to describe the mechanisms by which structures can cause, and not simply be a consequence of evil. A Thomistic moral approach takes into account the object, the intention, and the circumstances; this focuses solely on the free will of the moral agent. A traditional moral approach, however, has difficulty taking into account the social, interpersonal aspects of decision making. Social sin admits of the fact that decisions aren't made in a vacuum. Social structures can shape the context and deliberation a moral agent has before making a decision and, "have causal effect through the choices made by persons within them" (154). According to Finn, social structures are best understood as having moral valence, not that social structures are a moral agent, but that social structures are formed by moral agents and carry with them a certain way of taking up with the world. To make this point, Finn uses the social structures of a university. Despite differing professor and student personalities, the classroom assumes a social structure wherein certain "restrictions, enablements, and incentives" shape the manner in which the professor/student relationship is enacted. If a professor decides not to teach the department-required material or if a student decides not to read a text, even for a legitimate reason, the social structure of the university means that such resistance entails a price and it is easier to, "'go along' and sustain the existing social structure by their compliance" (153).

Finn concludes his essay with a reflection on original sin by quoting again Pope Emeritus Benedict XVI who pointed to "the presence of original sin in social conditions and in the structure of society" *(Caritas in veritate)*. Finn expresses that original sin has several dimensions, including both dispositions *and* environment and, "has long been understood as a sort of 'inclination to evil'" (156). Every person, in this understanding of sin, is affected by a proclivity to evil, to submitting in ways small and large to the influence of social sins like racism. It wouldn't be difficult to expand Finn's example of a university's social structure to that of, say, police interactions or those within a hospital. Both Finn and U.S. Catholic bishops point to injustice and inequitable

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burdens to guide reflections in identifying which social structures might be sinful (see, for example, the pastoral letter "Open Wide Our Hearts").

Synthesis: Discerning trends of racial health disparities in the United States is a notoriously complex and fraught endeavor. Interpreting race as having scientific and medical valence (as opposed race operating as a sort-of caste system based on melanomized skin) is widely debated (see: Jonathan Kahn's 2004 essay, "How a Drug Becomes Ethnic"). More empirical work is needed to determine its validity. Nevertheless, African Americans and other racial minorities experience higher rates of hypertension, kidney disease, and diabetes than their white counterparts. The debate, however, centers on the question: Why is it that people of color experience more comorbidities associated with COVID-19 than whites? And the ethical questions that follow: How might society understand and address this inequity? What is society's duty to address inequities in health outcomes? One possible insight to these questions already stated is that high COVID-19 cases are due to the biological predisposition of racial groups, for which there is little evidence. Another explanation is that these diseases are due to personal health and behavioral choices (diet, exercise, therapeutic noncompliance, for example). This approach, too, has been critically evaluated due to the fact that describing "blacks" or "African Americans" as having homogenous personal qualities can reflect (or be informed by) historical racial stereotypes. A third opinion, the one explored in this literature review, takes the line that intersecting social factors create the conditions for poor health disparities.

Karaye and Horney used CDC data to report that race and ethnicity (as understood through social vulnerability) has been shown to be associated with an increased risk for contracting, hospitalizations and death from COVID-19. Link and Phelan offered an explanation as to the mechanism by which the socially vulnerable experience poorer health outcomes by using their examination of flexible resources. Both essays express the phenomenon which has come to be known as systemic or institutional racism, defined as race-based differential access to the goods, services and opportunities of society. Finn offers an explanation regarding how Catholics might understand the popular notion of systemic racism as coinciding with magisterial reference to sinful social structures. Importantly, Finn suggests that the proclivity to racism and prejudice is one shared by every person affected by original sin. While we take steps to rid society of its sinful social structures, we must likewise come to an awareness of our own proclivity to sin. ✣

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