Eveline THEVENARD
Université Paris-Sorbonne (Paris IV)

HEALTH INEQUALITY AS A CLASS ISSUE

Introduction

The concept of class is an elusive one. In any case there is no agreed upon definition. The most frequent reference to class in American society, the term *middle class*, is just as vague, and its categorization often reflects political or ideological biases.[1] The word *class* is rarely used in political or academic discourse because the United States is supposed to be an egalitarian society, because class is associated with Marxism and the class struggle, and because references to class have generally been perceived as somewhat obsolete since the collapse of communism in the early 90s and the rise of the market as the dominant economic force.

Regardless of how it is defined, the concept of class is of particular relevance to the analysis of social welfare issues and social policy. After all, pioneering Germany under Bismarck created the first welfare state to avoid class conflict, while in Britain the rising political influence of the working class contributed to the passage of the first landmark social insurance measures between 1897 and 1911.[2] By contrast, in the U.S., the weakness of its welfare state has been attributed to, among other things, the weakness of its working class, the absence of class-based movements, a lack of class consciousness in a society where ethnic and religious loyalties prevailed over class identification,[3] and the conservatism of unions more focused on securing benefits for their own members than on attempting to establish an egalitarian society. Thus, during the Progressive Era, at a time when the medical lobby was not yet the conservative force it was to become in the 1920s, the

[1] A March 2007 report published by the Congressional Research Service indicated both a narrow view of the middle class (households earning between $36,000 and $57,600) and a broader definition (between $19,178 and $91,705). Brain W. Cashell. “Who are the ‘Middle Class’?” *CRS Report for Congress*. Surveys show that most Americans identify themselves as middle class and the economic policies of both parties are systematically promoted as benefiting the middle class, or "those who aspire at being part of the middle class" (cf. House Speaker Nancy Pelosi announcing the passage of a stimulus package based on tax cuts by Congress to restart the economy in January 2008).
[2] G. Rimlinger, *Welfare Policy and Industrialization in Europe, America and Russia*. Wiley & Sons, 1971, pp. 51-60 and 98-130.
[3] C. Noble. *Welfare as We Knew It: A Political History of the American Welfare State*. OUP, 1997, pp.22-24. S.M. Lipset. *American Exceptionalism*. Norton, 1996, pp.31-109.

American Federation of Labor and its leader, Samuel Gompers, sided with employers and insurers to defeat proposals aimed at creating a national health insurance system,[4] arguing that "governmental regulation tends to fix the citizens of the country into classes, and a long established insurance system would tend to make those classes rigid."[5] The New Deal saw the triumph of narrow class and professional interests over public health when, under pressure from the American Medical Association, Roosevelt decided to omit any reference to health insurance from the Social Security Act to preserve its chances of adoption by Congress.[6] After the war, unions opted for the collective bargaining process as the best channel for securing and expanding benefits for their members instead of trying to guide the broader policymaking process towards the creation of universal health care benefits as a right of citizenship.[7] And since the rise of identity politics in the 60s, discrimination by race, gender, or sexual orientation has become the primary focus of liberal activists, overshadowing class-based issues. So in many ways, the current absence of a universal health insurance system illustrates the way the fragmentation of social class has led to a fragmented welfare state, one characterized by public programs for the poor, generous health benefits for union members, government employees and some large private companies, and limited or nonexistent insurance for others.

The rise of inequality and economic insecurity since the 80s has been extensively documented by sociologists, economists, and welfare state historians,[8] and denounced by social workers and social activists, although the problem is rarely framed in terms of class. Upward mobility, which traditionally made inequality bearable and prevented the creation of rigid class boundaries, has become more difficult to achieve. International surveys such as the *Luxembourg*

---

[4] P. Starr, *The Social Transformation of American Medicine*, Basic Books, 1982, pp. 249-251. In addition, union officials didn't trust government, which had often backed the repression of the labor movement by business during the great strikes of the late 19th century, through police actions as well as court rulings favorable to employers; labor leaders also wanted to maintain unions' prerogatives and authority to negotiate benefits for their members with employers, which increased their legitimacy.

[5] A. Derickson, *Health Security for All*. J. Hopkins U. Press, 2006. pp. 12-15.

[6] P. Starr. Ibid., p. 269.

[7] M. Gottshalk, *The Shadow Welfare* State, Ithaca and London: ILR Press, 2000.

[8] M. Katz, *The Price of Citizenship*. Henry Holt, 2001. J. Hacker, *The Great Risk Shift*. OUP, 2006. B. Ehrenreich, *Nickel and Dimed*. Henry Holt, 2001. J. Morone, L. Jacobs, *Healthy Wealthy and Fair*. OUP, 2005. R. Frank. *Falling Behind. How Rising Inequality Harms the Middle Class*, University of California Press, 2007. K. Newman, V. Tan Chen, *The Missing Class: Portraits of the Near Poor in America*. Beacon, 2007. Also of interest are three series on class inequalities, published in the *L.A Times* (Oct 2004), the *Wall Street Journal* (May 2005) and the *New York Times* (2005).

Income Study, comparing income distribution across nations, show that the United States ranks first among industrialized countries in inequalities of wealth and income. It also has the highest child poverty rate. Political scientist Lawrence Jacobs notes that "from the late 70s to the mid 90s, inequality in the distribution of income increased by 24% in the United States" against "7% in Canada, Germany, Finland and Norway."[9] This increasing inequality is partly due to economic changes – the shift from manufacturing to services and from industrial to knowledge jobs – and the pressure of global competition, which have affected not only incomes but also benefits, in particular health insurance, the most valued of workers' benefits. Thus over the past 10 years there has been a sharp decline in employer-based health insurance: health care premiums have skyrocketed as companies are determined to cut costs in order to remain competitive. Because health benefits are not mandated by federal law but are rather left to employers to grant, a lot depends on the bargaining position of employees, leaving low skilled, low income, lower class workers the most vulnerable.[10] But economics cannot be separated from politics: at the same time as the safety net has shrunk since the 80s, the policies originating in the New Deal and the post-war period, such as the Treaty of Detroit, have given way to market-oriented policies that have benefited corporate interests and high income earners at the expense of the middle and working classes.[11]

However, the question of whether health can be seen as a reflection of class is a very complex one that includes but also goes beyond the issue of access to care. Is health in fact a marker of class in the United States? This is a question that I will attempt to address in this paper. I will first show that the issue has attracted a great deal of interest in recent years, from both government officials and private researchers. I will then argue that the convergence of multiple factors has created a society with tremendous health inequalities. Finally, I will conclude with a look at the kinds of responses or lack of response which the problem has generated, and on prospects for the future.

---

[9] *Healthy, Wealthy, & Fair: Health Care and the Good Society*. N.Y., OUP, 2005, p. 41.

[10] *Kaiser Commission on Medicaid and the Uninsured*, March 2006. http://www.kff.org/uninsured/upload/7553.pdf.

[11] Paul Krugman demonstrates that the economic hardships suffered by many Americans over the past few decades must be ascribed not only to the globalisation factor, but also to the departure from the norms and institutions created by the political environment which prevailed between the New Deal and the late 70s, and which brought about a sharp decline in inequalities. *The Conscience of a Liberal*, Norton, 2007, ch.1.

1. A Growing Concern

The link between class and health is not new. Since the 19th century, disease has been correlated with poverty and environmental conditions associated with the lower classes, such as overcrowded housing and lack of sanitation, as well as with lifestyle habits such as alcoholism that are associated with the lower classes.[12] Engels, in *The Condition of the Working Class* (1844), wondered, "How is it possible … for the lower class to be healthy and long lived?"[13]. Edwin Chadwick, in his 1842 *Report on the Sanitary Condition of the Laboring Population of Great Britain*, found that the mortality of the residents in London's poorest districts was much higher than in wealthy areas. Historically, general improvement in population health has been due to rising living standards at least as much as to medical advances.

Over the past two decades, the issue of health disparities, not only between countries but also within countries, has generated a huge body of research worldwide.[14] The issue has risen to prominence in the U.S. too, probably because it is perceived as particularly unfair, even in a society where tolerance of inequality is higher than in other developed countries. Americans appear to be more sensitive to disparities in health than to other inequalities, and more accepting of government intervention: Medicaid has never been targeted as viciously as welfare, even if abuse and overspending are regularly denounced, and if program cuts periodically penalize recipients in a number of states. Whether *class* can be equated with *inequality* is up for discussion,[15] but it should be noted that in the existing literature on class and health, the term *socioeconomic status* is most of the time used as a proxy for social class. In fact, when it comes to differences in health conditions within a population, two issues should be considered. One is concerned with health status and the persistence of a social gradient: British social scientists and epidemiologists such as Michael

[12] A. Deaton, "Policy Implications of the Gradient of Health and Wealth," *Health Affairs*, March/April 2002: p. 13.
[13] B. Starfield, "State of the Art Research on Equity in Health," *Journal of Health Policy Politics and Law,* v. 31, no. 1, Feb. 2006.
[14] H. Graham, "Social Determinants and their Unequal Distribution: Clarifying Policy Understandings," *The Milbank Quarterly*, v. 82, no. 1, 2004: pp. 101-24.
[15] P. Kingston acknowledges the existence of inequalities, but denies the reality of classes, because the groups of people that share similar socio-economic status do not necessarily share the common cultural characteristics that create classes and class consciousness/identity. In addition, he notes that boundaries between those groups are blurred as well as temporary. Stratification is not rigid. *The Classless Society,* Stanford: Stanford University Press, 2000.

Marmot have pioneered the research on the social determinants of health. The other has to do with differences (usually expressed in terms of access to insurance) in the use of health services and in outcomes of care. In the U.S., in both areas, race or ethnicity must be taken into account, as well as the main dimensions of socioeconomic status, i.e. income, wealth, education and occupation.[16]

The issue of equity or distributive justice in health is also receiving a great deal of interest from policymakers. A number of official government-commissioned reports on health disparities have been released over the past decade. The Institute of Medicine issued six on the problems of the uninsured between 2001 and 2004, and one on ethnic and racial disparities in 2003. *Healthy People 2010* explicitly aims not only to improve the health of the overall population (the initial focus of the initiative when it was launched in 1979), or to *reduce* health disparities (one of the goals of *HP 2000*), but also to *eliminate* them.[17] It acknowledges the importance of non-medical determinants of health and of income inequality as underlying causes of health disparities. Another major federal initiative since 2003 has been the annual *National Health Care Disparities Report*, which measures disparities in quality and access to care based on race or ethnicity and socio-economic status (income and education). But a major difference between British and American approaches to research on health disparities is that the British reports (there were three between 1980 and 1998) include policy prescriptions and recommend specific measures, specific strategies aimed at income redistribution to tackle the problem.[18] They have led to policy changes, whereas the American reports set goals without prescribing the means to reach them. Most of these reports (and most public health campaigns) don't address the root causes of health inequalities. Their primary focus tends to be on health care access and individual behavioral changes as the pathways to reduce differences, without references to the broader economic and social environment.

There is also a reluctance to use the word *class* in American reports. Various terms are used to define differences in health status or access to care – *disparities, inequalities, inequities* (the last

---

[16] N. Adler, K. Newman. "Socio-economic Disparities in Health. Pathways and Policies." *Health Affairs*, March-April 2002.

[17] The *Healthy People* report is a national ten-year plan published by the Department of Health and Human Services which sets health objectives for the Nation to achieve over a ten-year period.

[18] The 1998 Acheson report made 39 recommendations targeting vulnerable sections of the population and policy areas such as employment, taxation and education.

referring to disparities considered inherently unfair and avoidable through appropriate social and economic policies). We have already noted that the term *socioeconomic status* has generally replaced the more ideologically charged *class*.[19] It is also interesting that there are far more officially commissioned reports on *health disparities* than there are on *socioeconomic inequality*, the former condition most likely being perceived as more unfair, more focused on race, and more likely to be reduced without a major redefinition of fundamental economic choices.

2. Socioeconomic Disparities and Health in the U.S.

The American population has on the average never been healthier. Nevertheless, OECD and World Health Organizations surveys regularly show that by a number of health indicators such as life expectancy and infant mortality,[20] the U.S. doesn't compare well with other developed countries and has been slipping further behind since the 1970s.[21] A recent study showed that white Americans had on average a lower life expectancy than the average Canadian regardless of race, due to Canada's universal health insurance and lesser income inequality.[22] Within the U.S. there are shocking disparities. While the existence of a social gradient in health has been documented even in countries that are more egalitarian than the U.S. and which have a generous welfare state with universal health insurance,[23] it is in the U.S. that economic inequalities translate most glaringly into health disparities and differences in mortality and morbidity, due to very limited redistributive policies.[24] Individuals in the lowest income categories and with the lowest education level die

---

[19] SES is a convenient measure but there is a lack of consensus over its appropriateness to define class, and over the respective influence of income, profession, education and wealth. T. Wolhfarth. "Socioeconomic Equality and Psychopathology: Are Socio-economic Status and Social Class Interchangeable?" *Social Science and Medicine*, v. 45, no. 3, 1997.

[20] In 2006, the annual *State of the World's Mothers* report found that the U.S. had the second worst infant mortality rate of all developed countries.

[21] In 2000, in its evaluation of health systems worldwide,WHO ranked the US 37th, based on five performance indicators, including health disparities within the population.

[22] S.Kunitz. "Mortality of White Americans, African Americans, and Canadians: the Causes and Consequences for Health of Welfare State Institutions and Policies". *The Milbank Quarterly*, v. 83, no. 1, 2005.

[23] British epidemiologist Marmot conducted two landmark studies, Whitehall and Whitehall 2 (in 1967 and 1985), on the health of British civil servants, and demonstrated that health declined with each decrease in job grade. Thus, workers at the lowest levels of the hierarchy were four times as likely to suffer from heart disease and other conditions as those at the top, although all workers had access to the National Health Service and none of them were poor.

[24] John Lynch, et al. "Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review." *Milbank Quarterly*. v. 82, no. 1, 2004.

earlier than those at the upper income and education levels, and they are also in worse health.[25] Several studies have shown that for some health indicators, the gap has widened over the years. Some of these disparities are directly linked to access to health care, but non-medical factors are also to be taken into account, and they call for different policy responses.

Class, Access to Care, and Quality of Care

Because health care is viewed as a consumer good and not a social good, because it is market-based, access to care is a function of the ability to pay for it. It is thus easy to infer that access to care is a reflection of class in America, and to a large extent this is the case. In such a system, the disadvantaged classes suffer from the 'inverse care law': those who most need health care have the most difficulty getting it.

While underfunded, understaffed public clinics serve the poor, 'boutique' practices attract high-paying patients by offering 24-hour service and premium care. Although insurance status doesn't fit neatly into a class categorization, the higher one's income, the more likely one is to have coverage. A *New York Times* story on health care, part of a series on class, shows clearly that the wealthy, educated, and well-connected have the greatest chance of surviving a heart attack. Having insurance, one has timely access to a provider. Lack of insurance is not the only cause of ill health, but a percentage of deaths could be avoided simply by increasing access to care, in particular primary care. According to the Institute of Medicine, 18,000 deaths a year can be directly traced to inadequate access to care.[26] Because the U.S. system for those under 65 is employment-based, the lower their occupational status, the less likely workers are to have insurance. Managerial and professional classes, meanwhile, have better access to care. With companies competing to attract the best workers, in a knowledge economy, the better-educated are the least likely to lose their insurance. In non-unionized sectors, the power to bargain for benefits belongs to those with skills valued by employers. In addition to the fact that higher-income jobs are more likely to carry

[25] S. Woolf, R.Johnson, H.Geiger."The Rising Prevalence of Severe Poverty in America: a Growing Threat to Public Health." *American Journal of Preventive Medicine*. v. 31, no. 4.
[26] *Insuring America's Health: Principles and Recommendations*. IOM, Jan 2004.

insurance, the education level of those who hold them equips them to navigate the system's pitfalls, make smart choices (selecting a health plan, for example) and fight for their rights (i.e. coverage: the move from fee-for-service to managed care plans in the 90s has made the system more complex; it’s not always easy to know which procedures are covered).

The dwindling portion of industrial workers belonging to a union has also affected access to insurance, and in recent years most industrial disputes or strikes have been over the issue of health insurance, the benefit which, just as much as wages, puts the beneficiaries within the middle class. Fewer and fewer workers are organized, even in traditional industries: carmakers increasingly outsource operations to non-union contractors. The division between unionized and non-unionized workers within the same firm prevents the formation of class consciousness and class solidarity. The 2007 contract negotiations at General Motors in which management won huge concessions from the United Auto Workers, shifting responsibility for retirees’ health insurance to a union-managed fund, signals another move away from the post-war consensus on employer-sponsored benefits.

Uninsurance or underinsurance is therefore often a reflection of diminished class status for workers. According to the Census Bureau, 47 million Americans were uninsured in 2006, most of the time because they couldn't afford the premium. Statistically, two-thirds of all uninsured persons are members of families earning less than 200% of poverty, and 25% don't have a high school diploma (IOM). In the case of unskilled workers, the employer calls the shots and may decide (Wal-Mart has offered the most notorious example of such practices) to unilaterally reduce the number of weekly hours an employee can work, in order to suppress their eligibility for insurance benefits. Dependents are rarely covered, and families may then have to rely on public programs. Having no insurance doesn’t mean having no access to health services, but care is more limited, more expensive, and often inferior. The lack of preventive care often means treatment is not sought until a patient's condition has severely deteriorated. Insurance status can also be correlated with race: 20% of blacks and 35% of Hispanics don't have insurance, as they are more likely to be in a low income, service sector, or non-union job.

Among young adults, a growing category of the uninsured, class also impacts their health status. Those from higher income families are usually healthier and can rely on parental financial support in case of illness, while the health status of those from a lower-class background may be affected by material deprivation or illness in early childhood.

It is true that the very poor have Medicaid – but this targeted, means-tested program is in itself a marker of class. Its bureaucratic, sometimes humiliating application process deters many potential applicants. Also, many doctors don't accept Medicaid patients, and while the program has been growing over the years, it is constantly threatened by funding cuts. The same goes for S-CHIP, the federal-state program for low-income children. In addition, although most of the 8 million currently uninsured children are eligible for S-CHIP or Medicaid, because of the perception of those programs as "public assistance," many parents who see themselves as middle-class are reluctant to enroll.

The fragmented structure of American health care perpetuates a class system even for those entitled to Medicare, since that near-universal public program fails to provide full coverage, and premiums and out-of-pocket payments can be a heavy burden for retirees on modest pensions. However, the health gradient after age 65 is less pronounced, offering evidence of the equalizing effect of such programs.

The quality of care can also be measured in terms of class and race. Low income patients often get inferior care. The type of preventive care, the number and frequency of screenings (pap tests and mammograms, childhood immunization, enrolment in prenatal care), and the treatment that patients are offered all depend on class and race.[27]

Class and Health Status: Social Determinants of Health[28]

---

[27] Fiscella et al. "Inequality in Quality: Addressing Socio-Economic, Racial, and Ethnic Disparities in Health Care." *JAMA*, v. 283, no. 19, May 17, 2000.
[28] According to Graham, the social determinants of health are the non clinical factors that shape the health of individuals and populations. ibid., p. 107.

It must be said, however, that health status can only be partly linked to access to care and insurance coverage. It is also due to factors unrelated to medical care – to poor environmental conditions, poverty, lifestyle, lack of social support, lack of access to social networks (social capital theory), and to the social gradient (relative inequality), which can also be traced to socio-economic disparities.

Lower income populations are more likely to live in areas characterized by high crime, unsafe housing, and exposure to toxic substances like lead and carbon monoxide, where lack of public transportation hinders access to health services.

Surveys have also shown that hazardous industrial sites tend to be located in ethnic or low-income neighborhoods. Poor eating habits, linked to conditions like diabetes or cardiovascular disease, are more common in neighborhoods where healthy food choices (fruits and vegetables, etc.) are too expensive or not widely available. New York City, with its poverty rate of 20%, also has a high percentage of diabetics (1 in 8). Education influences lifestyle and health behaviors, and together with the problems induced by economic hardship, contributes to class differences in dietary choices and consumption of tobacco and alcohol. Differences in the work environment also account for the longer, healthier lives of those in higher income categories. Socially disadvantaged workers, meanwhile, are disproportionately represented in dangerous occupations (such as meat-packing, where the rate of work-related injuries is highest). They are more likely to work in stressful environments over which they have no control, and research has shown that the degree of workplace control and autonomy one has defines one's class relations as well as health status.[29]

It can therefore be argued that improving the social and economic circumstances of populations would be just as and possibly more effective in reducing health disparities than improving access to health care. But since the 90s, housing programs, occupational health programs, and early childhood education programs (such as Head Start, which also includes a health component) have all taken sharp cuts. The minimum wage remained stuck at the same level between 1997 and 2007, unions are in decline, and tax and fiscal policies have favored the wealthy

[29] M. Marmot. *The Status Syndrome*, Henry Holt, 2004, ch.4.

at the expense of low income earners and the poor. The takeover of OSHA, the federal agency in charge of safety regulations, by former industry officials, has led to a dismantling of workplace protections and increased exposure to health hazards for workers in various industries,[30] such as food processing and construction.

Class, Race, and Health

Belonging to a racial minority of course amplifies the effect of class. Traditionally the U.S. has collected statistics on the health of its population by race. The various reports published by the National Center for Health Statistics highlight race-based disparities for vital statistics and health status. It is well known that the infant mortality rate for African Americans is more than double that for whites,[31] and this difference has not been reduced over the years although the overall newborn mortality rate has decreased. Blacks also have a lower life expectancy (7 years less) than whites,[32] and a worse health status. African Americans are two to three times as likely as whites to suffer from hypertension and diabetes.[33] The prevalence of HIV infection and cardiovascular disease is higher among blacks, and they are also more likely to be victims of homicide. In 2001, the age-adjusted death rate for cancer was 25.4 percent higher for African Americans (243.1 per 100,000 population) than for white Americans (193.9).

In many cases, because minorities have a much higher poverty rate than whites, health disparities by race simply reflect class disparities. In some studies, when health differences are adjusted for socioeconomic status, racial disparities disappear. On a number of health measures, disparities are wider between income categories than between racial categories. So class matters more than race. However, other studies tend to show that even after controlling for socio-economic

---

[30] Steven Labaton. “OSHA Leaves Worker Safety in Hands of Industry.” *The New York Times*, April 25, 2007.
[31] 13.3 %° against 5.7%° for whites. *Healthy People 2010*.

[32] In 1998 the mortality rate for the black population was 1.5 times that of whites, identical to what it was in 1950. J.S. House, D.R. Williams, “Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health.” In B.D. Smedly and S.L. Syme, eds., *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, D.C. : National Academy of Sciences Press, 2000: pp. 81-124.

[33] I. Kawachi, N. Daniels, D. Robinson. "Health Disparities by Race and Class: Why Both Matter." *Health Affairs*, v. 24, no. 2: p. 344.

status, blacks still have worse health indicators than whites. Thus college educated black women are more likely than their white counterparts to have low-birthweight babies. Various explanations have been proposed, including the impact of racial discrimination on health, in particular, stress.[34] Also, SES indicators usually reflect only income, not wealth, and for a similar income, a black household will have far less wealth than a white one, and therefore less security in case of major health problem.

Race and class are intertwined, so it is very difficult to disentangle the effects of racial discrimination from those of socioeconomic status. One reason is that the collection of U.S. data correlating income and health is problematic. For example, on death registries, income doesn't appear and education only sometimes appears, while race always does. A major problem is that in the U.S., the health statistics routinely collected by public health agencies at federal and state levels historically have included few socioeconomic data, whereas they have systematically been stratified by race.[35] For example, in 2003, of the 58 tables on the determinants of health in *Health, United States*, the annual federal report on the health of the nation, only eight contained information on socioeconomic status, but 57 contained information on race.[36] In fact, because of the interactions between race and class, both measures should be used when collecting and analyzing health disparities, and a number of researchers have criticized the focus on race over SES in the collection of health data and have called for a systematic recording of income and education levels in vital statistics and national health surveys.[37]

In addition to the problem of the traditional 'racialization' of health data, over the past three decades, official policy has tended to focus on race and gender over class.[38] This is pernicious for

[34] D.R. Williams, C.Collins. "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." *Annual Review of Sociology*. v. 21, 1995: pp. 349-86.

[35] Due to limited administrative resources, only essential data are collected; there are also confidentiality concerns, especially when it comes to linking data across different agencies.

[36] Stephen L. Isaacs, et al. "Class: the Ignored Determinant of the Nation's Health." *New England Journal of Medicine* v. 351,no. 11: pp. 1137-1142.

[37] N Krieger, D.R. Williams, N.E. Moss. "Measuring Social Class in U.S. Public Health Research." *Annual Review of Public Health*. v. 18, 1997: p. 341.

[38] Thus, a Minority Health Agency was created in 1985. Most states have an office of minority heath; research on race-based disparities, whether publicly or privately funded, has been far more encouraged than research on class-based disparities. Reports and conferences on racial disparities far outnumber those on class. M. Schlesinger. *Journal of Health Politics Policy and Law*, v. 31, no. 1: pp. 1-10.

several reasons. How is race objectively defined? People sometimes identify themselves differently from one survey to another. What about individuals of mixed heritage? There is also the risk that these data can be used to explain health disparities in terms of biological differences and to perpetuate racist stereotypes. Just as important, the focus on racial disparities can be used to hide, or at least downplay class differences and to divide the poor along racial lines, in the same way that divisions based on race and ethnicity have historically prevented the emergence of class solidarity.[39]

3. The Political Response

What kind of political response has the issue of health disparities elicited? How is the political debate on health and class framed? In public discourse (political, media) when the term *class* is used in association with health care it is most often associated with the *middle class* (health insurance being traditionally a marker of middle-class status, and losing insurance a testimony to a fraying of that status, with increased insecurity). It is associated with laments on the 'declining middle class' or the 'middle-class squeeze,' in an outpouring of studies on the travails of a mythical category emblematic of the American Dream.... In a way, the problem of health insurance now blurs the contours of class, since anyone can lose their job and their health insurance. Indeed, what does it mean to be middle-class if you are burdened with medical bills you cannot pay? It is because rising health costs are a threat to the social category most Americans are supposed to belong to, that it has become a national issue that figures prominently in campaign speeches and political discourse in general. However, because the term *middle class* is so vague, the huge differences in social status, income, power, bargaining position within it are erased. References to the middle class by both parties and attacks on Medicaid and other public programs from conservatives are also employed to justify maintaining the existing system of private insurance in the name of freedom of choice and individual rights. Thus, references abound, from both Democrats and Republicans, to the growing number of "hard-working" Americans without coverage, showing that the debate on health and

[39] Kawachi, op. cit., pp. 348-349.

welfare is still framed in moral as well as in economic terms, in accordance with America's historic approach to social problems.

Indeed, the current health care system bears the legacy of America's ambivalence on class issues and of the influence of race in preventing the formation of class-based movements and the creation of a universalist welfare state. The public-private pattern that emerged from New Deal and Great Society initiatives has become firmly entrenched as deeply symbolic of American values, despite the fact that it has established a two-tier welfare state that denies Americans the social citizenship which would be created by universalist policies while it maintains class divisions.

The controversy over the reauthorization of S-CHIP, twice vetoed by George W. Bush in late 2007, shows that class (income) is still the cornerstone of the bifurcated American health care system. Although fiscal considerations were used by the Administration and its allies in Congress to justify the veto, the President made it clear that his main objection was ideological: the proposed bill would have betrayed the purpose of the 1997 legislation by covering more middle-class children and diverting them from private insurance, instead of focusing on the poor. There was also the fear, voiced explicitly by one of the president's advisers, that extending the program to middle-class children would pave the way for a public, universal heath care system. Although the level of bipartisan support for the bill was unusually high, it twice failed to gather enough votes to override the veto, squarely placing S-CHIP, within the bounds of a class-based system that contradicts the conservative mantra about the obsolescence of class.

Health insurance is a class issue to a large extent, but it has not been able to trigger a class-based response. In addition to the reasons mentioned earlier (the myth of a classless society, the historical absence of strong class identification), the uninsured are a diverse group who find themselves in very different situations: the middle-class class executive who is between two jobs, the illegal immigrant, the Wal-Mart worker. They may all have problems getting access to care, but they differ in health status and may be in and out of health insurance, and therefore cannot form a lobby to influence public policy. As for the permanently uninsured, so many don't vote, either

because they are very poor and are alienated from the voting process, or because they don't have citizenship.

The issue of equal access to care ('health care for all') is bound to be a central theme of the 2008 presidential election campaign. Recent state initiatives to cover the uninsured have generated a great deal of interest.[40] However, contenders for the Democratic nomination have been treading cautiously on the topic, anxious to avoid messages that could translate as 'class warfare' and antagonize powerful interest groups. And although the advocates of market mechanisms in the provision of health care can no longer tap into the fear of communism to criticize anything that smacks of class struggle, the rhetoric of 'socialized medicine' is still unashamedly used, along with accusations of 'class-based campaigns,' against any proposal aimed at expanding public programs or mandating employer participation in workers' coverage. Given the structure of the American political system and absent a party truly representative of labor interests, progressives have to promote legislation through fragile and divided coalitions that are unable to compete with well-financed corporate interests. The 2003 Medicare drug legislation and the victory it conceded to pharmaceutical companies is testimony to the enduring imbalance of power relations that makes it so difficult for class-based inequities to be redressed through the political process.

What will ultimately drive the government to act won't be a concern about class or equality, but rather a recognition of the tremendous burden that the current system places on the economy. At this point no one knows whether the system is at last on the verge of a radical overhaul. If the past is any gauge, one might be skeptical. Although it would take considerable political will, and wouldn't be an easy task, establishing universal health insurance as a social right would no doubt be a first step towards reducing health inequalities. But disparities in health status would require an even more fundamental change: the adoption of more redistributive policies, a 'war on health inequalities' initiative that would echo Johnson's War on Poverty in the 60s – and it would need to start with the official recognition that class matters.

---

[40] In April 2006, Massachusetts adopted legislation which combines an employer mandate with obligatory health insurance for all individuals. Low-income families will get subsidies. Companies with over 10 workers which do not offer insurance will have to pay a tax. The then Governor who signed the legislation into law, Mitt Romney, during his subsequent campaign for the Republican nomination, downplayed the use of public programs to extend coverage to the low-income, instead emphasizing expanded access to private insurance.

The reluctance to refer to *class* in relation to health inequalities reflects the nation's deep-rooted aversion to anything that smacks of potential social conflict, as well as its persistent belief in the dream of an egalitarian society. In a country which above all values equality of opportunity, analyzing health inequities through the lens of class and acknowledging their relationship would inevitably highlight the need for programs aimed at an equality of outcomes, covering not only insurance access and improved public health infrastructure, but other elements conducive to healthier living conditions, such as better housing, decent wages, affordable quality childcare, and adequate sick leave. It would involve broadening the definition of health policy, recognizing that it cannot be designed in isolation from economic and social policy.