who can buy a $1 million home in an affluent suburb will also be able to provide their children with superior schools." The U.S. public school system is still rigged in favor of students from richer, whiter districts; and as Rebell remarks, the United States remains "the only major developed country in the world that exhibits this shameful pattern of educational inequity."

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CAUSE OF DEATH: INEQUALITY

Alejandro Reuss

Inequality Kills

You won't see inequality on a medical chart or a coroner's report under "cause of death." You won't see it listed among the top killers in the United States each year. All too often, however, it is social inequality that lurks behind a more immediate cause of death, be it heart disease or diabetes, accidental injury or homicide. Few of the top causes of death are "equal opportunity killers." Instead, they tend to strike poor people more than rich people, the less educated more than the highly educated, people lower on the occupational ladder more than those higher up, or people of color more than white people.

Statistics on mortality and life expectancy do not provide a perfect map of social inequality. For example, in 2002, the life expectancy for women in the United States was about five years longer than the life expectancy for men, despite the many ways in which women are subordinated to men. Take most indicators of socioeconomic status, however, and most causes of death, and it's a strong bet that you'll find illness and injury (or "morbidity") and mortality increasing as status decreases.

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Among people between the ages of 25 and 64, those with less than a high school diploma (or equivalent) had an age-adjusted mortality rate more than three times that of people with at least some college, as of 2003. Those without a high school diploma had more than triple the death rate from chronic noncommunicable diseases (e.g., heart disease), more than 3½ times the death rate from injury, and nearly six times the death rate from HIV/AIDS, compared to those with at least some college. People with incomes below the poverty line were nearly twice as likely to have had an asthma attack in the previous year (among those previously diagnosed with asthma) as people with incomes at least twice the poverty line. Poor people were over 2½ times as likely to suffer from a chronic condition that limited their activity and over three times as likely to characterize their own health as "fair" or "poor" (rather than "good" or "very good"), compared to those with incomes over double the poverty line. African Americans have higher death rates than whites from cancer (¼ higher), heart disease (⅓ higher), stroke (½ higher), diabetes (twice as high), homicide (more than 5 times as high), and AIDS (more than 8 times as high). The infant mortality rate for African Americans was, in 2002–2003, over twice as high as for whites. In all, the lower you are in a social hierarchy, the worse your health and the shorter your life are likely to be.

The Worse off in the United States Are Not Well off by World Standards

You often hear it said that even poor people in rich countries like the United States are rich compared to ordinary people in poor countries. While that may be true when it comes to consumer goods like televisions or telephones, which are widely available even to poor people in the United States, it's completely wrong when it comes to health.

In a 1996 study published in the *New England Journal of Medicine*, University of Michigan researchers found that African-American females living to age 15 in Harlem had a 65% chance of surviving to age 65. That is less than the probability at birth of surviving to age 65 for women in India, according to 2000–2005 data. Meanwhile, Harlem's African-American males reaching age 15 had only a 37% chance of surviving to age 65. That is less than the probability at birth of surviving to age 65 for men in Haiti. Among both African-American men and women, diseases of the circulatory system and cancers were the leading causes of death.

It takes more income to achieve a given life expectancy in a rich country like the United States than it does to achieve the same life expectancy in a less affluent country. So the higher money income of a low-income person in the United States, compared to a middle-income person in a poor country, does not necessarily translate into a longer life span. The average income per person in African-

American households ($15,200), for example, is about three times the per capita income of Peru. As of 2002, however, the life expectancy for African-American men in the United States was about 69 years, less than as the average life expectancy in Peru. The infant mortality rate for African Americans, 13.5 per 1000 live births, is between that of Uruguay and Bulgaria, both of which have per capita incomes around $8,000.

Health Inequalities in the United States Are Not Just About Access to Health Care

Nearly one sixth of the U.S. population below age 65 lacks health insurance of any kind, private or Medicaid. Among those with incomes below 1½ times the poverty line, over 30% lack health coverage of any kind, compared to 10% for those with incomes more than twice the poverty line. African Americans under age 65 were about 1½ times as likely as whites to lack health insurance; Latinos, nearly three times as likely. Among those aged 55 to 64, uninsured people were about ⅔ as likely as insured people to have seen a primary-care doctor in the last year, and less than half as likely to have seen a specialist, as of 2002–2003. Among women over 40, about 55% of those with incomes below the poverty line had gotten a mammogram in the last two years, compared to 75% of those with incomes over twice the poverty line, as of 2003. Obviously, disparities in access to health care are a major health problem.

But so are environmental hazards; communicable diseases; homicide and accidental death; and smoking, lack of exercise, and other risk factors. These dangers all tend to affect lower-income people more than higher-income, less-educated people more than more-educated, and people of color more than whites. African-American children between the ages of 3 and 10 were nearly twice as likely to have had an asthma attack in the last year as white children, among those previously diagnosed with asthma. The frequency of attacks is linked to air pollution. Among people between ages 25 and 64, those without a high school diploma had over five times the death rate from communicable diseases, compared to those with at least some college. African-American men were, as of 2003, more than seven times as likely to fall victim to homicide as white men; African-American women, more than four times as likely as white women. People without a high school diploma (or equivalent) were nearly three times as likely to smoke as those with at least a bachelor's degree, as of 2003. People with incomes below the poverty line were nearly twice as likely to get no exercise as people with incomes over double the poverty line.

Michael Marmot, a pioneer in the study of social inequality and health, notes that so-called diseases of affluence—disorders, like heart disease or diabetes, associated with high-calorie and high-fat diets, lack of physical activity, etc. increasingly typical in rich societies—are most prevalent among the *least* affluent people in these societies. While recognizing the role of such "behavioral" risk factors as smoking in producing poor health, he argues, "It is not sufficient . . . to ask what contribution smoking makes to generating the social gradient in ill health, but we must ask, why is there a social gradient in smoking?" What appear to be individual "lifestyle" decisions often reflect a broader social epidemiology.

Greater Income Inequality Goes Hand in Hand with Poorer Health

Numerous studies suggest that the more unequal the income distribution in a country, state, or city, the lower the life expectancies for people at all income levels. A 1996 study published in the *American Journal of Public Health*, for example, shows that U.S. metropolitan areas with low per capita incomes and low levels of income inequality have lower mortality rates than areas with high median incomes and high levels of income inequality. Meanwhile, for a given per capita income range, mortality rates always decline as inequality declines.

R.G. Wilkinson, perhaps the researcher most responsible for relating health outcomes to overall levels of inequality (rather than individual income levels), argues that greater income inequality causes worse health outcomes independent of its effects on poverty. Wilkinson and his associates suggest several explanations for this relationship. First, the bigger the income gap between rich and poor, the less inclined the well-off are to pay taxes for public services they either do not use or use in low proportion to the taxes they pay. Lower spending on public hospitals, schools, and other basic services does not affect wealthy people's life expectancies very much, but it affects poor people's life expectancies a great deal. Second, the bigger the income gap between rich and poor, the lower the overall level of social cohesion. High levels of social cohesion are associated with good health outcomes for several reasons. For example, people in highly cohesive societies are more likely to be active in their communities, reducing social isolation, a known health risk factor.

Numerous researchers have criticized Wilkinson's conclusions, arguing that the real reason income inequality tends to be associated with worse health outcomes is that it is associated with higher rates of poverty. But even if they are right and income inequality causes worse health simply by bringing about greater poverty, that hardly makes for a defense of inequality. Poverty and inequality are like partners in crime. "Whether public policy focuses primarily on the elimination of poverty or on reduction in income disparity," argue Wilkinson critics Kevin Fiscella and Peter Franks, "neither goal is likely to be achieved in the absence of the other."

Differences in Status May Be Just as Important as Income Levels

Even after accounting for differences in income, education, and other factors, the life expectancy for African Americans is less than that for whites, U.S. researchers are beginning to explore the relationship between high blood pressure among

African Americans and the racism of the surrounding society. African Americans tend to suffer from high blood pressure, a risk factor for circulatory disease, more often than whites. Moreover, studies have found that, when confronted with racism, African Americans suffer larger and longer-lasting increases in blood pressure than when faced with other stressful situations. Broader surveys relating blood pressure in African Americans to perceived instances of racial discrimination have yielded complex results, depending on social class, gender, and other factors.

Stresses cascade down social hierarchies and accumulate among the least empowered. Even researchers focusing on social inequality and health, however, have been surprised by the large effects on mortality. Over 30 years ago, Michael Marmot and his associates undertook a landmark study, known as Whitehall I, of health among British civil servants. Since the civil servants shared many characteristics regardless of job classification—an office work environment, a high degree of job security, etc.—the researchers expected to find only modest health differences among them. To their surprise, the study revealed a sharp increase in mortality with each step down the job hierarchy—even from the highest grade to the second highest. Over ten years, employees in the lowest grade were three times as likely to die as those in the highest grade. One factor was that people in lower grades showed a higher incidence of many "lifestyle" risk factors, like smoking, poor diet, and lack of exercise. Even when the researchers controlled for such factors, however, more than half the mortality gap remained.

Marmot noted that people in the lower job grades were less likely to describe themselves as having "control over their working lives" or being "satisfied with their work situation," compared to those higher up. While people in higher job grades were more likely to report "having to work at a fast pace," lower-level civil servants were more likely to report feelings of hostility, the main stress-related risk factor for heart disease. Marmot concluded that "psycho-social" factors—the psychological costs of being lower in the hierarchy—played an important role in the unexplained mortality gap. Many of us have probably said to ourselves, after a trying day on the job, "They're killing me." Turns out it's not just a figure of speech. Inequality kills—and it starts at the bottom.

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IMMIGRATION'S AFTERMATH

Alejandro Portes

It is well known by now that immigration is changing the face of America. The U.S. Census Bureau reports that the number of foreign-born persons in the United States surged to 28 million in 2000 and now represents 12 percent of the total population, the highest figures in a century. In New York City, 54 percent of the population is of foreign stock—that is, immigrants and children of immigrants. The figure increases to 62 percent in the Los Angeles metropolitan area and to an amazing 72 percent in Miami. All around us, in these cities and elsewhere, the sounds of foreign languages and the sights of a kaleidoscope of cultures are readily apparent. But the long-term consequences are much less well known.

A driving force behind today's immigrant wave is the labor needs of the American economy. While those needs encompass a substantial demand for immigrant engineers and computer programmers in high-tech industries, the vast majority of today's immigrants are employed in menial, low-paying jobs. The reasons why employers in agribusiness, construction, landscaping, restaurants, hotels, and many other sectors want this foreign labor are quite understandable. Immigrants provide an abundant, diligent, docile, vulnerable, and low-cost labor pool where native

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