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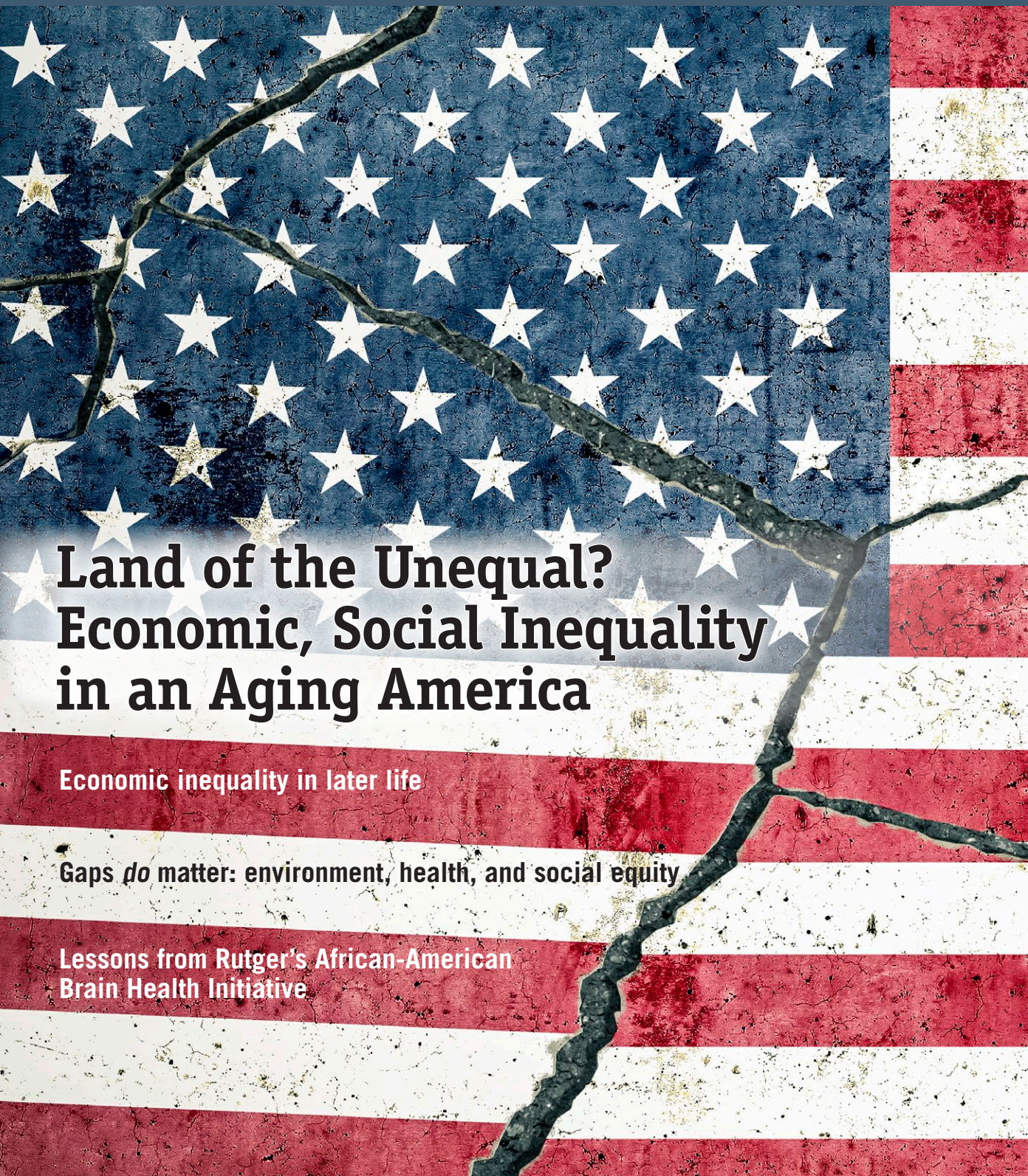

Land of the Unequal? Economic, Social Inequality in an Aging America

Economic inequality in later life

Gaps *do* matter: environment, health, and social equity

Lessons from Rutger's African-American Brain Health Initiative

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GENERATIONS STAFF

Publisher
Robert G. Stein

Editor
Alison Hood

Senior Editor
Alison Biggar

Typography & Production
Michael Zipkin | Lucid Design, Berkeley

Generations cover and book design by Lisa Rosowsky, Blue Studio.

inside **generations**

Land of the Unequal? Economic, Social Inequality in an Aging America

Our Guest Editor

Solving America's "wicked problems" through social innovation and action

Despite the surging stock market and wealth evident in America's big cities, especially those with thriving technology sectors, homelessness and poverty are equally on display, often on the same block. In the current atmosphere of liberal versus conservative teeth-gnashing, it was refreshing to engage with **Guest Editor Karen D. Lincoln** on this issue of *Generations*, which focuses on economic and social inequality in America as it pertains to older adults. Lincoln takes a levelheaded and persistent approach in her efforts to work through the often overwhelming landscape of American inequality.

'We need to find ways to close the distance between "us" and "them." '

KAREN D. LINCOLN

She cites a highlight to her career as founding Advocates for African American Elders (AAAE; see her article on page 73), which began in 2011 with her desire to end social, economic, and health disparities among older African Americans in South Los Angeles. The group now "is a dynamic academic–community partnership with a history of service and participatory research that is making an impact on the lives of their neighbors."

As associate professor in the Suzanne Dworak-Peck School of Social Work at the University of Southern California (USC), director of the USC Hartford Center of Excellence in Geriatric Social Work, co-director of the Southern California Clinical and Translational Science Institute, and senior scientist at the Edward R. Roybal Institute on Aging, we are thankful that she could spend the considerable time necessary to guest-edit this issue of *Generations*. Though pulled in many directions, Lincoln seems to identify most as a teacher and mentor to her students at USC.

"It is rewarding to see how a small (and sometimes large) investment of time, advice, support, and a few kind words, can significantly impact the experience and careers of young scholars," she says, in the same breath crediting mentors for her own successes.

Lincoln is a fellow of the Gerontological Society of America and a Hartford Faculty Scholar. In 2014, she was ranked third among the most influential African American social work scholars in the United States and, in 2015, was ranked 12th among all female social work scholars in the United States. She has testified before the Senate Select Committee on Aging and Long-Term Care and was appointed to the California Task force on Family Caregiving by Sen. Kevin De León (D-Los Angeles).

She has published more than 60 articles and book chapters, and received more than $2.8 million in grant funding to support her research on improving clinical and community-based treatment of African Americans with mental health disorders and chronic health conditions.

For this issue of *Generations*, Lincoln turned her sights on social and economic disparities in America, especially as they relate to older adults. Reflecting on the turbulence around America's economic and social inequalities, she says, "I am not sure we have seen all of the challenges around economic and social inequality ahead. We continue to witness widening gaps in income and social distance between different groups of people."

Lincoln places her hope in younger people. "It is this generation of disruptors that will likely be the change agent we need to redefine the way we think about and solve the problem of economic and social inequality," she says.

It is the job of the older generations, she believes, to instill in the young a sense of civic and public engagement "that encourages their thinking around inequality of any kind and how it impacts them, personally. It's not about ideology."

Lincoln believes it also is the job of teachers and other thought leaders to engage politically and civically—to teach via example. "We need to find ways to close the distance between 'us' and 'them,' " she says, referring to economically and socially diverse populations, "[and] sometimes that distance is just a few blocks."

She lauds efforts like that of Harvard University, which through their admissions policy now considers socioeconomic diversity. This has resulted, Lincoln says, in an increase in the number of students attending the school who are from low-income families. "Next is the necessary culture shift so that the campus is more welcoming to these students."

Lincoln's most recent work is both personal and professional: she has designed an intervention to increase Alzheimer's disease literacy among African Americans. "My mother is currently suffering from severe dementia, and I have also seen firsthand how low knowledge of Alzheimer's disease impacts families," through her work at the AAAE.

The pilot intervention showed such promise that Lincoln is working to fund it on a much wider scale through the Patient-Centered Outcomes Research Institute (PCORI).

Lincoln hopes solutions launched in university settings can work for lower-income communities.

Acting locally is one of Lincoln's ongoing priorities. Circling back to social and economic disparities, she says it is critical to "foster ties between community-based organizations and those in other disciplines to create 'transformative science' to better understand the factors that interact over the life course to create conditions that put older adults at risk of being poor or homeless in late life."

Lincoln is hopeful that some solutions launched in university settings can also work in lower-income communities. "Universities such as USC and the University of Michigan have programs for graduate students that foster innovation and social entrepreneurship. These programs allow students to be socially engaged and to create solutions to some of our most 'wicked problems.' Similar programs should be available in underserved communities, so that those most impacted by social and economic inequality can be part of the solution."

—Alison Biggar and Alison Hood

Economic Inequality in Later Life

By Karen D. Lincoln

A reflection of cumulative advantages and disadvantages across the life course.

Levels of economic inequality—encompassing inequality in the distribution of income and wealth—have hit unprecedented heights and appear to be rising. In 2014, the average income for adults in the United States was $64,600. However, this average obscures a great deal of heterogeneity (Piketty, Saez, and Zucman, 2018). The bottom 50 percent of adults earned on average $16,200 per year, while the middle 40 percent earned roughly the same income as the U.S. average. In stark contrast, the top 10 percent received 47 percent of all U.S. income—$304,000, which is 4.7 times the national average, while the top 1 percent of adults earned $1,300,000—twenty times the national average income. Today, the top 1 percent takes home more than 20 percent of all income in the United States.

The extreme disparity in income and wealth distribution has a real and distinct impact on older adults. According to the latest data, more than 7 million older adults are living below the Federal Poverty Line, per the Supplemental Poverty Measure (Cubanski et al., 2018). This number will increase to 72 million by 2030. A 2016 study by the Kaiser Family Foundation found that half of all Medicare beneficiaries have incomes below $26,200 per year; while 25 percent have incomes below $15,250. Only 5 percent have incomes above $103,450 (Jacobson et al., 2017).

Studies also show that economic insecurity is particularly concentrated among older women of color. In 2013, African American single women between ages 65 and 84 had a median wealth of $55,700, compared to $187,000 for non-Hispanic white single women in the same age category (Sullivan and Meschede, 2016). Among educated women, older, single African American women with a college degree have a mere $11,000 in wealth, which is the lowest of any women in that age range and is in stark contrast to the $384,400 in median wealth among single white women with a bachelor's degree (Zaw et al., 2017). This wealth gap is present across all age categories and begins much earlier in the life course (Sullivan and Meschede, 2016).

Aging is a stratified process that reflects the inequalities that structure our life chances from birth onward. Barriers to accessing wealth-building opportunities, wages, and workplace benefits, as well as experiencing household responsibilities that restrict labor force participation by race and by gender are circumstances

→ABSTRACT The rapid increase of economic inequality in the past few decades is one of the most disturbing social and economic issues of our time. Economic opportunities are not randomly distributed, but determined by people's positions within the social structure. Multiple social identities—race, class, gender, and sexual orientation—shape economic and social experiences that accumulate over the life course and determine economic status in late life. This article provides an overview of economic inequality across race, class, and gender, and introduces the articles in the Summer 2018 issue of *Generations*. | **key words:** *inequality, inequity, socioeconomic status, race, class, gender, sexual orientation*

that converge, accumulate, and lead to astonishingly high rates of poverty and economic inequality in later life. While some of these wealth-building opportunities are based upon economic factors, such as income and wages, others are based upon social factors.

Social inequality has economic implications. For example, racial segregation in the United States has been slowly declining over the past four decades, yet it remains very high. At the same time, residential segregation by income, which was very low in 1970, has risen sharply (Logan, 2011; Reardon and Bischoff, 2011; Watson, 2009). One study reported that poor whites tend to live

The top 1 percent of U.S. adults earned $1,300,000—twenty times the national average income.

in more affluent neighborhoods than do middle-class African Americans and Latinos, which means that these groups are more likely to contend with lower-quality schools, higher crime, less access to resources, and greater social problems, all of which structure economic opportunities for children in the future. The gap separating African Americans and Latino neighborhoods from white neighborhoods persists up and down the income ladder (Reardon, Fox, and Townsend, 2015).

Consequently, racial economic inequality continues to be strikingly high. A recent Pew research analysis of the Current Population Survey found that racial gaps in income and earnings, with white households earning more than their black counterparts, remained largely constant or even widened between 1967 and 2015 (Bialik and Cilluffo, 2017; Gittleman and Wolff, 2004). For example, in 2014, the median African American and Latino household incomes were about $43,300, while non-Hispanic white household income was about $71,300 (Pew Research Center, 2016).

The return on income and education also differs by race. On average, household heads with higher levels of formal education tend to have higher household incomes. However, the black–white gap in income occurs across all educational levels. For example, the median adjusted household income among African American householders with at least a bachelor's degree was $82,300 in 2014, while the income of college-educated non-Hispanic white householders was $106,600.

Clearly, more studies are needed to understand the causes and consequences of inequality. However, there is growing recognition that economic inequality is due to the convergence of a multitude of factors—political, social, and economic—that intersect to contribute to the problem. Both past and present racism and sexism, lack of healthcare access and educational opportunities, environmental risks and hazards, and more all contribute to inequality—particularly among those who are affected, negatively or positively, by more than one of these interconnected issues. For older adults, how they experience inequality as they age is really the result of a lifetime of experiences.

To understand the persistence of economic inequality, the individual determinants of unequal treatment of social groups must be examined. For example, studies that focus on social determinants of inequality highlight the unequal distribution of resources that promote economic stability, such as access to education, employment, and housing. These social determinants, however, are determined by a broader set of factors that structure and shape the contexts in which people live, work, and age. It is in the broader societal factors—e.g., capitalism, racism, and patriarchy—whereby income disparities take root, inequalities grow, and inequities reproduce.

In this Summer 2018 issue of *Generations*, the twelve articles that follow explore societal and social factors that create and maintain economic inequality among older adults. The authors represent the disciplines of social work, gerontology, environmental science, economics, neuropsychology, and sociology. Various forms of inequal-

ities are investigated based upon race, ethnicity, gender, sexual orientation, and migratory status. Reflecting the interdisciplinary nature of these contributing authors, a broad range of societal and social factors are considered as potential determinants of economic inequality across the life course.

Introduction of Feature Articles

Is the distribution of resources fair? This is a question of *equity* in income and wealth. Is the distribution of the population within economic categories the same regardless of social position? This is a question of *equality*, and the metric we use to measure progress toward achieving economic equity and eradicating inequities. Equity is the means. Equality is the outcome. Inequity, inequality, and disparities often are used interchangeably. However, these concepts are not the same, and the difference between them is crucial for understanding and addressing economic inequality in the United States.

The first feature article by Takeuchi and colleagues highlights the distinction between equity and equality and reveals the complexity of these two constructs. The authors argue that most research on equity and equality focuses on outcomes that demonstrate group differences in valued resources, such as pay, wealth, and education. But these studies are limited to the extent that they explain why inequalities persist over time. Accordingly, Takeuchi and colleagues spotlight mechanisms that constrain opportunities for some social groups, and offer approaches for advancing research, policy, and practice to address inequity and inequality in our society.

A growing body of literature posits that more unequal societies have more polluted and degraded environments, perhaps helping to explain why more unequal societies are often less healthy. The relationship between environmental quality and social inequality along the axes of income, wealth, political power, race, and ethnicity suggests that more attention should be paid to the interplay between inequality, the environment, and health, including initiating more studies that elucidate causal pathways and points of intervention.

The next set of feature articles highlights the mechanisms linking unequal environments to economic inequality and the well-being of individuals, communities, and society. Ailshire and García document the link between race, ethnicity, socioeconomic position, and disadvantaged environments. They argue that unequal environments limit the opportunities for older adults to lead healthy, active, and engaged lives. Pastor and Morello-Frosch raise the argument that reducing economic and social inequality may not only help those who are most exposed to health-damaging pollutants in their neighborhoods, but also may improve environmental conditions for all.

Multiple identities such as race, ethnicity, class, and gender intersect and have multiple effects on one's ability to participate in the labor market, to achieve economic security, and to plan for old age. The next set of feature articles highlights the causes and consequences of economic insecurity for older women and older adults of color.

Moore and Ghilarducci describe the economic status of older women within the context of societal inequity, stratification, and intersectionality; they highlight the importance of understanding economic inequality within a framework that takes into account the intersections of various social identities and the societal determinants of inequity (e.g., capitalism, racism, patriarchy), as it is the societal determinants that determine the laws, norms, and policies that create and maintain inequality over time. Angel and Angel continue this conversation by discussing the implications of lifelong income inequality for individuals, families, and society. Poor older

'More attention should be paid to the interplay between inequality, the environment, and health.'

adults are expensive. The Angels argue that a lifetime of low earnings, combined with demographic shifts and the changing role of families, has a social cost that results in an increased burden to states for Medicaid support and an increased need for innovative solutions to long-term care for poor elders.

The economy of the United States becomes more robust as the health and well-being of its citizens improve. Improving the health of all Americans can directly result in economic growth, partly because more people are more productive in the labor force. However, racism and discrimination hamper access to opportunity. Studies consistently show that racism has deleterious consequences for health. However, bias based upon race results in an income gap that costs the United States $1.9 trillion per year, significantly slashing the country's wealth. Addressing factors such as healthcare inequities, unjustified incarceration disparities, and fewer employment and education opportunities would generate 12 percent more annual U.S. earnings. America's changing demographics highlight the urgency of addressing bias based upon race, gender, and sexual orientation and its impact on people's health, wealth, and our nation's economic growth.

The next set of articles explores the unequal impact of mass incarceration, and the implications of racial discrimination and economic inequality upon health and aging among racial, ethnic, and sexual minorities. Cox encourages us to think about racial health disparities and aging within the context of mass incarceration. Criminal justice policies and practices result in the unequal impact of mass incarceration that disadvantages individuals based on race, ethnicity, and class. African American men make up 40 percent of the prison population compared to 6 percent of the population of the United States. Thus, health, aging, and wealth in this population and others disproportionately represented among those incarcerated cannot be fully understood without considering the causes and consequences of incarceration, and how these impact individuals, families, and communities.

Gorman and Oyarvide highlight the diversity among older adults in the United States in an article focused on bisexual older adults. Their piece reveals heterogeneity among LGBT older adults and identifies a socioeconomic profile among older bisexual men and women that is less positive than those of gay, lesbian, or heterosexual older adults. In doing so, the authors encourage us to consider how socioeconomic status differences shape the health and aging trajectories of sexual minority older adults and the implications for their financial security and long-term care.

Finally, Nguyen highlights the historically important role of the African American church for filling the gap left by limited access to formal mental health services by socially and economically marginalized groups. Empirical evidence shows that individuals with higher socioeconomic positions have lower prevalence of mental health disorders due to the protective nature of income, education (Gaines, 2007), and employment (Lincoln and Chae, 2010; Lincoln et al., 2011). If the causal order is reversed, studies show that mental health disorders predict educational attainment, labor force participation, income, and earnings.

For example, persons with psychiatric disorders are more likely to have difficulty finding a job, retaining a job, and have reduced earnings while employed (Kessler et al., 2008). Thus, social resources that can mitigate the relationship between mental health and financial insecurity are crucial for individuals who might otherwise be disadvantaged due to their social position. Nguyen's article highlights the exposure of African Americans to racial discrimination and the toll this exposure can take on older adults' well-being. In lieu of access to formal mental health services among older African Americans, the author demonstrates the role of the church for providing informal sources of support that can protect congregants from seri-

ous mental illness associated with exposure to social stressors like racial discrimination.

Introduction of Program Spots

Economic inequality is tied to societal and social determinants indexed by inequalities in economic stability, neighborhood resources, hazardous toxic exposures, and opportunity structures. Thus, efforts to end economic inequality require disruptive, life-course interventions at the individual, community, and policy levels. The final set of articles follows a "program spot" format that serves to highlight four initiatives designed to address economic, social, and environmental inequity in ways that can affect outcomes across the life course, while also generating knowledge and policy ideas of local and national importance. These shorter pieces provide examples of how to address social and economic inequality with programs that build economic assets during childhood, increase health literacy and community engagement among African Americans in urban neighborhoods, and increase our knowledge about the intersection between race, place, and income to identify important points of policy interventions at local and national levels.

The persistent difference in wealth has consequences for child outcomes in the United States, particularly for the large and growing population of non-white children. Without the potential buffer that wealth provides in times of unemployment and emergency expenses, family well-being can suffer. When children grow up in households that have no wealth and face economic insecurity, they may experience significant stress and have limited opportunities for upward mobility.

In the first program spot, Shanks describes different approaches to help low-income, low-wealth households build assets that could improve near-term economic security, and help children succeed academically and achieve future economic success. The programs and policies described by Shanks have the potential to increase financial capability and promote pathways toward economic mobility, which can lessen economic disparities across the life course and reduce economic inequality in later life.

Low health literacy is linked to a wide range of poor health-related outcomes, including low use of preventive medical services, uncontrolled chronic health conditions, delays in accessing or foregoing needed care, difficulty finding a provider, lack of a usual source of care, and mortality (Berkman et al., 2011). Thus, health literacy—an individual's ability to access, process, and understand basic health information and services needed to make appropriate health decisions—is an important determinant of health inequities across groups.

Programs that increase health literacy can help close the gap between economic insecurity and health disparities.

Health literacy is determined by individual and community-level socioeconomic status, and connections with others through work, civic engagement, and social networks (Rikard et al., 2016). There is a social and economic gradient in health literacy such that low health literacy is more prevalent among older adults, racial and ethnic minorities, and groups of low socioeconomic status (Rikard et al., 2016). However, the benefits of health literacy interventions appear greater for racial and ethnic minorities and individuals with low incomes than for those with higher incomes (Miller, 2016).

Given the link between economic inequality, health literacy, and poorer health outcomes, programs that increase health literacy among racial and ethnic minority and low-income populations can help close the gap between economic insecurity and heath disparities. The next two program spots feature academic–community initiatives designed to help close the health gap.

In my program spot article, I share key successes from an outreach and engagement program that I founded at the University of Southern

California. Advocates for African American Elders (AAAE) was created to increase access to health information and resources to older residents in South Los Angeles, a community that is underserved, under-resourced, and economically disadvantaged relative to other communities in Los Angeles County. AAAE increases health literacy for older African Americans and their families by partnering with community stakeholders, including organizations, advocates, and residents, to conduct community-partnered participatory research, to raise awareness, and to increase knowledge about chronic health conditions, mental health disorders, and the available health-promoting resources in the community.

Gluck, Shaw, and Hill describe their unique university–community partnership that promotes brain health among African American older adults in the greater Newark, New Jersey, area. The African-American Brain Health Initiative combines research, education, and community engagement to increase brain health literacy. African Americans have a disproportionate risk for Alzheimer's disease, memory loss, and other age-related brain health problems. However, less than 5 percent of this population is included in Alzheimer's disease prevention studies or clinical trials. Gluck and colleagues offer outreach and engagement strategies that have contributed to the success of their educational and outreach programs, and their engagement of African Americans in research for more than a decade.

The fourth program spot by Dearing, McRoy, and Mulrean features a young, dynamic initiative that brings together researchers from Boston College and beyond with practitioners and policy makers to better address the root causes of social, economic, and environmental inequity. To do this, Research in Social, Economic and Environmental Equity (RISE) faculty use research strategies to understand how race, place, and poverty intersect to impact the daily lives of individuals living in disadvantaged neighborhoods.

RISE explores the "basic tools of opportunity," such as use of and access to transportation and childcare and associated costs to families in time and money, to demonstrate how race, ethnicity, and income affect vulnerable families in practical ways. The goal of RISE is to use the tools of research to impact policies, to support the efforts of community-based organizations to change public assistance policies, and to help families and neighborhoods improve their own lives.

Conclusion

The inequalities that shape our opportunities from birth structure our final years. Advantages and disadvantages accumulate over the life course. In developing policies to address economic inequality and senior poverty, policy makers, researchers, analysts, and advocates should better understand the conditions experienced by our country's most vulnerable older adults throughout their lives. Age, race, gender, and place influence economic and social experiences and risks leading up to and in later life.

The contexts in which we live powerfully affect our opportunities—regardless of compositional differences in individual resources.

Addressing inequity in aging requires a life-course approach that includes targeted interventions and policies at various points within the life course. The contexts in which we live powerfully affect our opportunities—regardless of compositional differences in individual resources. Thus, policies targeting vulnerable elders should consider the role that inequality in neighborhoods, social networks, and opportunities plays in creating, maintaining, and perpetuating economic inequality across the life span. Meeting the challenge of eliminating economic inequity requires examining the "root causes"; focusing on what can be seen as upstream inter-

ventions and primary prevention; and addressing unequal distribution of power, income, goods, and services.

As the Race Matters Institute (2014) says, "The route to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone equitably, or justly, according to their circumstances."

Karen D. Lincoln, Ph.D., M.S.W., M.A., is associate professor in the Suzanne Dworak-Peck School of Social Work at the University of Southern California.

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Equality and Equity: Expanding Opportunities to Remedy Disadvantage

By David T. Takeuchi, Tiziana C. Dearing, Melissa W. Bartholomew, and Ruth G. McRoy

Of social inequality and inequity in American society—and a model program that might foster social change.

We have been watching a competition between two runners—one race per day over the past week. It is the eighth day as we wait for the next contest. One runner always dresses in a purple jersey and the second in orange. Purple wins each race by at least ten yards. We decide to go to the start to see how Purple manages to triumph so consistently over Orange. Does Purple have an initial burst of speed, a late surge, or is it a steady pace over the entire course? Or is Orange a slow and ineffective runner? We arrive a few moments before the next race takes place. We notice that these races are unusual because there is no official starting line—only a finish line. Orange is prepping for the race ten yards behind Purple. We notify the race official who then moves Orange ten yards forward. The official decides to provide the same treatment to both runners and advances Purple ten yards. The race begins. Purple wins another race.

The foregoing example is exaggerated to illustrate equality versus equity. This article considers these two constructs, focuses on equity as compatible with fairness and social justice, argues how equity can shape our understanding of available opportunities, and provides an example of a program that intends to change inequities in some situations.

Defining Equality

The two terms, especially equality, frequently take on the prescriptive quality of an ideal and are used as a rhetorical device to show unity when there is disagreement (Westen, 1990). A classic example appears in the Declaration of Independence, "We hold these truths to be self-evident: That all men are created equal; that they are endowed by their creator with certain unalienable rights; that among these are life, liberty and the pursuit of happiness . . . " It is dif-

→ABSTRACT Over time, equality has changed in meaning to refer to the similarity of treatment of individuals and groups. Equity has emerged as an alternative construct linked to social justice, especially in the fields of health and education. Equity invokes a search for the social, economic, and political causes of inequality and for remedies that consider context and circumstances of disparate outcomes. This article discusses how a focus on opportunities could advance research, policy, and practice to enhance the quality of life of people disadvantaged by their position in society. | **key words:** *equality, equity, opportunity hoarding, exploitation*

ficult to disagree with these assertions because they prescribe an ideal, equality, in which we should all believe. However, at the time of its writing, women, Native Americans, blacks, and people who owned no property were excluded from opportunities and privileges open to property-owning white men. While debate persists over whether Jefferson intentionally excluded groups from this statement, or if he offered the statement as an aspirational goal, the reference to equality masks the debate and the reality that groups were excluded from the parameters of the document at the founding of the United States (Curry, Riley, and Battisoni, 2003).

Equality, however, is more than a rhetorical device and has substantive roots in philosophical writings and arguments. There is much debate on what people are advocating for, or critiquing, when they discuss equality (Dworkin, 2000). At a minimum, the concept of equality involves responses to two related questions: Equal to, and on, what? Equality involves a reference to some object that may be a normative standard, a person, a group, or another unit by which something is described. It infers a comparison of one of those groups on a topic such as health, wealth, income, or other forms of social status. The concept has gone through different iterations and has led some to conclude that it has no unified meaning. Accordingly, it may be best to see equality as a multifaceted construct that provides a moral compass for addressing disparate positions and outcomes in society (Rae et al., 1982; Rawls, 1971; Williams, 1973).

'Equality became associated with assimilation into the dominant male, white, or middle-class norms.'

The nuances and multifaceted dimensions of equality have morphed over time into a shorthand for similarity or sameness of treatment. The concept has been critiqued for its inability to convey the reality that not all people begin at the same starting point. Equality became associated with assimilation into the dominant male, white, or middle-class norms (Gosepath, 2011).

Defining Equity

Equity emerged as an alternative and prominent construct linked to social justice, especially in the fields of health and education. Equity invokes a search for the social, economic, and political causes of an inequality, and for remedies that consider the context and circumstances of disparate outcomes. In the example given at the beginning of the article, equal treatment advances both runners the same distance regardless of their starting point. Equity, on the other hand, moves only the disadvantaged runner, Orange, to the same starting point as the second runner. The second runner, Purple, is not moved from the original spot.

In a more concrete example, equality would give families a $5,000 tax credit for college tuition, while equity would give the credit only to families earning below a certain income threshold. While the concept of equity has its critics, especially around providing certain groups with special treatment, it is aligned with research evidence that points to the social and structural causes of social, economic, education, and health problems such as poverty and racism (Burton and Welsh, 2015; Link and Phelan, 1995). The evidence supports solutions that advance the runner who is structurally disadvantaged by a poor starting position.

The scholarship on equity (and equality) has tended to focus on outcomes that assess group differences in some valued resources such as gender disparities in pay, racial differences in wealth, and nativity gaps in access to health insurance. While this emphasis has documented the scope and magnitude of inequalities, the research in this area has been less successful about why inequalities persist over time.

Exploitation and opportunity hoarding

The persistence of unequal outcomes has led to calls to examine the opportunities that pro-

duce dissimilar ends (Burton and Welsh, 2015). Exploitation and opportunity hoarding are two mechanisms that constrain opportunities for some social groups (Tilly, 1998). Exploitation or discrimination occurs when the dominant group restricts other groups from achieving full value for their efforts.

One concrete example is the wage gap between blacks and whites. This wage gap is larger today than it was in 1979. While this discrepancy has not been linear and has fluctuated over time, it has increased since 2000. By 2015, controlling for different correlates of wages, black men made 22 percent less than white men on average hourly wages; black women made 34 percent less than white men and 12 percent less than white women (Wilson and Rogers, 2016). Even at the same education levels, black men and women are paid less than their white counterparts.

The wage gap between whites and blacks is larger today than it was in 1979.

Fryer, Pager, and Spenkuch (2011), in their analysis of the wage gap, found that one-third of the discrepancies in wages can be attributed to discrimination against blacks. Blacks may experience a lower return on their education in the marketplace, and, consequently, may not receive the same wages for their accomplishments. The consequences of the wage gap go far beyond income. Less pay can mean fewer and restricted opportunities for living in a safe neighborhood, sending children to good schools, purchasing health insurance and quality healthcare, and accumulating wealth.

Opportunity hoarding occurs when powerful groups directly or indirectly limit access to valuable or scarce resources. An innovative study illustrates how opportunity hoarding works. Pager, Western, and Sugie (2009) conducted a field experiment in New York City to study how race and a prison record influences job prospects. Matched teams of black men and white men applied for low-wage jobs, using identical resumes except for their race and criminal background (the treatment conditions). Applicants were less likely to have positive employment outcomes, with the effect much larger for blacks. Black men with the same history of incarceration were less likely than white men to be invited for job interviews.

A recent meta-analysis of twenty-eight similar field experiments shows that the basic findings about hiring discrimination in the U.S. labor market endure (Quillian et al., 2017). In the review of twenty-four studies since 1989, whites received 36 percent and 24 percent more callbacks than did blacks and Latinos, respectively. Since 1989, discrimination in the labor market did not change for blacks; for Latinos, there was a slight decrease in discrimination (Quillian et al., 2017).

Othering and boundary maintenance

While exploitation and opportunity hoarding are two mechanisms that help explain inequities in opportunity, two social-psychological processes exemplify their power and effects over long periods of time. Othering occurs when status groups create or reproduce inequities by casting members of certain groups (e.g., by race, ethnicity, nativity, gender, sexual orientation) as intellectually, morally, socially, or culturally inferior (Prus, 1987). Groups defined as inferior become distinct from the "in" group, or from "us." They instead become and maintain the status as the "out" group, or the "other." Once a group is defined as inferior in some dimension, it is difficult to break out of the label and it becomes ingrained into common images and stereotypes.

Negative perceptions can lead to biased and unfair treatment. Immigrants often come from countries where the social norms, cultural practices, and languages may differ from those in the United States. These differences can be defined as deficits. At its worst, differences are defined as so far apart from the U.S. mainstream as to be

considered deviant or even criminal. A prevailing stereotype, for example, is that a large proportion of Mexican immigrants are criminal offenders (Bender, 2003). Evidence shows that immigrants are less likely to commit crimes than U.S.-born individuals (National Academy of Sciences, Engineering, and Medicine, 2015). However, it is easy to see how these stereotypes can shape interactions, especially in meaningful activities such as finding a job or getting paid the same wage as other groups.

Boundary maintenance refers to the dominant group's actions that intend to, directly or indirectly, preserve symbolic, status, interactional, and spatial territories between themselves and subordinate groups (Schwalbe et al., 2000). Boundaries are created and maintained to limit access to social and cultural capital such as knowledge, social networks, skills, and information that may be helpful in finding a job, securing a loan, getting into good schools and neighborhoods, buying a house, or participating in a good investment. For example, adolescents from poor neighborhoods, who have the requisite scholastic qualifications and achievements, may not have the appropriate socialization on how to apply for college or scholarships, which limits opportunities for mobility.

ICW students have a rare skill and provide information, guidance, and support to wealthier clients who lack that skill.

Reeves (2017) expands on the boundary maintenance feature of opportunity hoarding by focusing on upper middle-class families (UMC) or the top 20 percent with the highest income, rather than on the super wealthy elite. He argues that inequality persists because the UMC have the education, skills, wealth, and high standard of living, and they engage in activities that maintain their class standing for themselves and their children. Three activities are especially prominent among the UMC: exclusionary zoning in residential areas establishes a spatial divide between the UMC and others; college admissions processes that favor the UMC, including legacy preferences, continue the education advantage of the UMC; and the informal allocation of internships that ensures UMC children have the social networks that lead to high-paying jobs (Reeves, 2017). These activities prevent others from obtaining UMC status and lower the risk for the UMC to slip out of their status (Putnam, 2015).

Interventions Can Address Inequities

Legal and policy interventions will have the most substantive and far-reaching impact to deal with disadvantages linked to existing social institutions. Civil rights (including voter rights), earned income tax credits, and the Affordable Care Act (ACA) are some of the examples of legal and policy remedies that address inequities in opportunities in different areas. It is unlikely that the current political environment will produce progressive measures to reduce disadvantage and to increase equity on a wide range of issues. Instead, there are active attempts to scale back or eliminate remedies designed to provide more equitable conditions for people; these include the voter fraud commission, multiple attempts to repeal the ACA, and environmental protections meant to reduce toxic pollutants in disadvantaged geographic areas.

Accordingly, it may be instructive to provide an example of a program that works in a small space but addresses inequities. This program description is not an endorsement or an evaluation, but a heuristic means to highlight how equity may be achieved on a small scale. It may also offer insights for other programs and policies that eventually lead to a larger impact.

Dorchester is the largest neighborhood in Boston and has a rich social history, making it known as the Boston center of civil rights activism in the 1950s. It is home to more than 114,000 residents and has a diverse racial and ethnic com-

position, with blacks (42 percent) comprising the largest group, followed by non-Hispanic whites (22 percent), Latinos (17 percent), and Asian Americans (10 percent) (Boston Redevelopment Authority, 2014). While some Dorchester areas have high average incomes, other sections have child poverty rates above 30 percent. Crime rates in Dorchester, including violent crimes, are higher than in 80 percent of Boston's neighborhoods (Boston Foundation, 2011).

Inner City Weightlifting (ICW) started in 2010 in a gym with an undisclosed location in Dorchester. Most of its enrollees are in gangs, have associations with gangs, or are former gang members. Violent retaliation for past transgressions and conflicts is possible and serious injury and death pose daily threats for its enrollees. Since ICW aims to create and maintain a safe physical and social environment, its exact location is on a need-to-know basis. ICW works with students (as ICW enrollees are called) who have committed serious offenses, including gun- and drug-related offenses.

Current students come from poor neighborhoods and are mostly black males. ICW works to develop trust and rapport with students after they enroll in the program. ICW expects that weightlifting will instill hope and enable students to resist retaliatory acts to violence, remove themselves from criminal behavior and gang life, and develop a better future. While weightlifting is a primary activity, the main objective is to remove students from the streets and into the more supportive environment of the gym.

About 30 percent of the ICW students become certified instructors who train clients who work in prestigious positions and earn high incomes. Training can take place at the Dorchester gym, at a second ICW gym in Kendall Square (a neighborhood of Cambridge, Massachusetts), or in a private business setting. This facet of the ICW can influence exploitation and opportunity hoarding by reducing the social distance and blurring the boundaries between student and client. This is especially the case for seldom-studied interactional contexts where power and resources are under negotiation and the social tables are turned. In this case, members of historically disempowered groups (e.g., blacks; youth; the poor) may be in temporary positions of power relative to higher status or more privileged others (e.g., white upper-middle-class professionals). In their daily routines, clients with high incomes probably would not interact with people from backgrounds like those of ICW students (Anderson, 2011).

One could argue that teens from poor backgrounds who perform services (such as mowing lawns) in wealthy neighborhoods are similar to ICW student personal trainers. Both are paid for services, perform work in wealthy neighborhoods, receive pay for their effort, and have opportunities to interact with high-income residents. ICW personal trainers, however, have several distinguishing characteristics that make their circumstances unique.

First, they need to become certified to administer their skills, which makes their service scarcer and more valuable in the marketplace. This certification confers elements of a profession and heightened status for students (Jacobs and Bosanac, 2006; Kenschaft, 2008). The quantity and quality of social interactions will also differ. While service providers such as gardeners or house cleaners may interact with wealthier clients to some degree, the interaction often is limited to the exchange of service for payment. ICW students will have more extensive and intensive time with their wealthier clients, which provides for more opportunities for one-to-one interaction. Finally, ICW students have a relatively rare skill and provide information, guidance, and support to wealthier clients who lack that skill.

A recent study shows that stigmatized groups can reduce the social distance between themselves and others by demonstrating an ability and skill pertinent to dominant group members (Lucas and Phelan, 2012). Social relationships become more equitable when the social table is

temporarily turned and the power is switched and students become the trainers of clients. As ICW continues, it will be intriguing to learn how a temporary turning of the social and power tables can have lasting effects in establishing social networks between students and clients—effects that lead to the students having increased opportunities for social mobility.

Closing the Gap

ICW provides an illustrative example of how a small, community-based program could hold the components for wide-scale, meaningful individual and social change to promote equity in opportunities. ICW moves away from a transactional interaction between students and clients (i.e., the exchange of pay for services) to one that could build relationships. Relationship-building provides the means to resist the effects of othering and to blur boundaries between its students and the dominant, more powerful groups. A key component of the relationship between student and client is the fostering of hope. Hope provides students with the promise to invest in their own futures and to persevere against the social, economic, and political challenges in their communities (West, 2004). Hope can enable ICW students to move beyond the blurring of boundaries into actively engaging in building bridges between members of the dominant group and the stigmatized, oppressed group.

Freire (2000) contends this bridge-building process is critical to dismantling the structures that create inequality. For the dominant group, it involves a commitment to societal transformation through the experiences and insights of the oppressed: "Only through comradeship with the oppressed can the converts understand their characteristic ways of living and behaving, which in diverse moments reflect the structure of domination" (Freire, 2000).

The working relationship between the stigmatized youth and the advantaged members of the dominant group can help them to see each other more clearly, to reduce othering and break boundaries, and to develop an equitable relationship that leads to comradeship. Comradeship is the foundation for equality and equity, and it will only manifest within a society that is transformed through a restructuring of power. It allows for people disadvantaged by their past to share the same starting line with more advantaged members.

David T. Takeuchi, Ph.D., is a professor, associate dean for Research, and Dorothy Book Scholar at the Boston College School of Social Work in Chestnut Hill, Massachusetts. He can be contacted at takeuchi@bc.edu. *Tiziana C. Dearing, M.P.P., is a professor for Macro Practice at the Boston College School of Social Work. She can be contacted at* dearing@bc.edu. *Melissa W. Bartholomew, M.Div., M.S.W., J.D., is a doctoral student at the Boston College School of Social Work. She can be contacted at* barthome@bc.edu. *Ruth G. McRoy, M.S.W., Ph.D., is the Donahue and Difelice Professor of Social Work at the Boston College School of Social Work. She can be contacted at* ruth.mcroy@bc.edu.

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Unequal Places: The Impacts of Socioeconomic and Race/Ethnic Differences in Neighborhoods

By Jennifer Ailshire and Catherine García

Poverty, neighborhood disorder, social cohesion, and air pollution all play a part in older adults' physical and mental health.

The U.S. population is aging rapidly and many factors, from the predicates of policy to the assumptions of individuals, are raising expectations that older adults will be able to live independent, active, and engaged lives in their communities. Thus, it is increasingly important to determine how the environments in which older adults reside support or hinder optimal living. Equally important, however, is an acknowledgement that some older adults live in unequal environments—where they are more likely to be exposed to adverse economic, social, and physical conditions—and this can result in social disparities in health and well-being at older ages.

A fundamental aspect of social and economic inequality is the unequal environments to which people of different racial, ethnic, and socioeconomic backgrounds are exposed. The result of a historical legacy of racial residential segregation of U.S. neighborhoods is that the population is largely distributed across neighborhoods based on their race and ethnicity (Williams and Collins, 2001). The same political, economic, and social forces that produced race and ethnicity–based residential segregation also often led to social and economic problems in the neighborhood. Residential segregation has been linked, with differential exposure, to neighborhood-based social stressors, physical hazards, and community resources (Gee and Payne-Sturgis, 2004). Additionally, low-income individuals of all race and ethnic backgrounds are more likely to live in poor neighborhoods where stressors, hazards, and lack of resources are common problems. Any examination of inequality, therefore, must consider both race and socioeconomic differences simultaneously.

Poorly resourced and hazardous environments can have adverse impacts on health and well-being across the life course, but are particularly harmful in older age, when individuals are at greatest risk of declines in health and functioning. The social, economic, and physical envi-

→ABSTRACT The social, economic, and physical environments in which older adults live play a vital role in healthy, active, and engaged lives. But older adults live in unequal environments. Low-income older adults and older racial-ethnic minorities are more likely to live in neighborhoods characterized by poverty, disorder, lack of social cohesion, and pollution. At all income levels there is a greater proportion of older racial-ethnic minorities in neighborhoods with economic, social, and physical problems. Neighborhood inequality may contribute to disparities in the aging experience. **key words**: *neighborhoods, older adults, race-ethnicity, poverty, neighborhood disorder, social cohesion, air pollution*

ronments in which older adults live play a vital role in fostering opportunities to lead healthy, active, and engaged lives (Berkman et al., 2000; Clarke and George, 2005).

A growing body of evidence, for instance, has drawn connections between the social and physical environment and the processes implicit in disease and disablement, functional and cognitive decline, and general well-being (Clarke and Nieuwenhuijsen, 2009; Saelens and Papadopoulos, 2008; Yen, Michael, and Perdue, 2009). Older adults experiencing declines in physical and cognitive functioning, mobility limitations, and decline in social activities and contacts may be particularly dependent upon resources and amenities in their immediate environment, as well as more vulnerable to stressors and hazards in their residential environment.

Exposure to unequal environments can play a major role in generating and sustaining racial, ethnic, and socioeconomic disparities in the aging experience. Specific neighborhood-based exposures that have been identified as fundamental to this inequality include poverty, disorder, social cohesion, and air pollution.

Neighborhood Inequality

Neighborhood economic status, disorder, and lack of social cohesion have been linked to a range of negative physical and mental health outcomes in older adults.

Neighborhood poverty

Economic inequality is most clearly visible in the comparison of poor neighborhoods with affluent neighborhoods. Residents of poor neighborhoods, for instance, are more likely to be exposed to social stressors, crime, and physical hazards from decaying infrastructure. Furthermore, poor neighborhoods tend to lack the social, political, and economic resources that benefit the residents of more affluent neighborhoods.

Given the strong correlation with hazardous living conditions and lack of resources, it is no wonder neighborhood economic status has been linked with a range of physical and mental health outcomes in older adults. Based on a recent report summarizing research funded by the National Institutes on Aging, older residents of economically disadvantaged neighborhoods have a higher risk for chronic diseases, functional limitations, and mobility issues, cognitive impairment, and accelerated biological aging (Population Reference Bureau, 2017). Research cited in the report found the relationship between neighborhood economic status and health was independent of the older adult's own economic status, which suggests the disadvantage of living in poor places is not merely a byproduct of one's own economic circumstances.

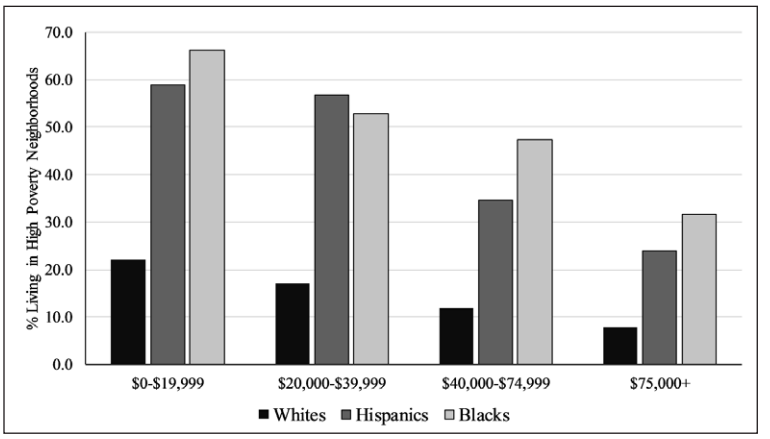
The U.S. population is largely distributed across neighborhoods based on race and ethnicity.

Residence in a high-poverty neighborhood can exacerbate the problems associated with low income, or can subject those with higher incomes to adverse environmental conditions not experienced by residents of more affluent communities. The distribution of older adults living in high-poverty neighborhoods by race-ethnicity and income is shown in Figure 1 (see page 22).

Not surprisingly, the share of older adults living in high-poverty neighborhoods declines as household income increases. But at every level of income, there are more older Hispanics and blacks living in high-poverty neighborhoods than whites of similar income. This difference is the most stark among older adults of lowest income.

Findings from the *Health and Retirement Study* (2010) and 2010 Census tract counts show that only 20 percent of low-income whites live in high-poverty neighborhoods, compared with nearly 60 percent of older Hispanics, and about 66 percent of older blacks. Importantly, the proportion of older Hispanics and blacks with annual incomes of $75,000 and greater living in

Figure 1. Distribution of Older Adults Living in High-Poverty Neighborhoods



Source: Data tabulated on adults older than age 50 from the *2010 Health and Retirement Study,* linked with 2010 Census tract counts of population with income below the poverty level.

Note: A high-poverty neighborhood is defined as a Census tract in which 20 percent or more of the residents have incomes at or below the Federal Poverty Level. All numbers are age-standardized and weighted to the U.S. population.

high-poverty neighborhoods is as high or higher (24 percent and 32 percent, respectively) than the proportion of older whites with incomes below $20,000 (22 percent).

Income inequality is a major factor in the economic segregation of neighborhoods. But neighborhoods are also segregated by race and ethnicity. As a result, older blacks and Hispanics are concentrated in the poorest neighborhoods in the United States. Residents of poor neighborhoods are more likely to be exposed to hazardous social and physical conditions that can further exacerbate existing inequalities in the aging experience. Moreover, poor older adults tend to lack the economic resources necessary to move to better neighborhoods and, as a result, become stuck residing in poor places.

Neighborhood disorder

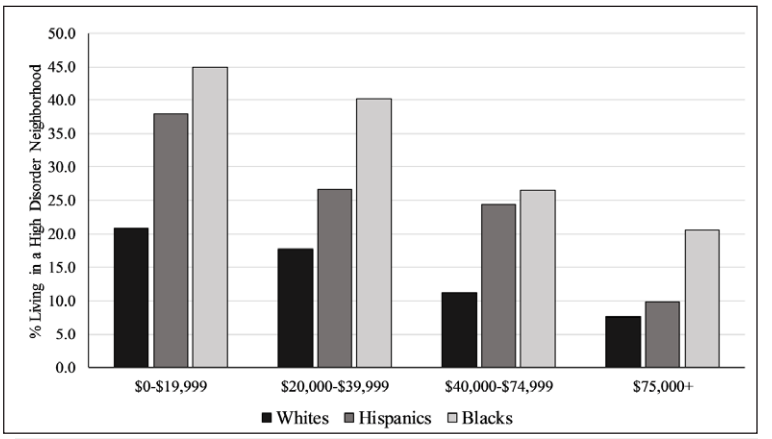
Perceptions of neighborhood problems, such as lack of safety and signs of criminal activity and neglect can be a significant source of psychological distress for residents (Steptoe and Feldman, 2001). Safety is an important consideration for older adults' decisions concerning neighborhood-based activities. Older adults who feel safe in their neighborhoods are more likely to engage in outdoor physical activities, such as taking a walk (Tucker-Seeley et al., 2009). In addition to reduced physical activity, older adults exposed to the stress of living in unsafe, deteriorating environments have worse health (Krause, 1996) and increased risk of functional decline (Balfour and Kaplan, 2002).

Some individuals live in neighborhoods where vandalism, graffiti, trash, vacant buildings, and fear of victimization are common, while others live in clean and safe neighborhoods. Older racial and ethnic minorities and low-income elders are more likely to live in the former and perceive their neighborhoods as being less safe. The distribution of older adults among neighborhoods characterized as having high levels of disorder by race-ethnicity and income is shown in Figure 2 (see page 23).

Findings on disorder from the *Health and Retirement Study* (2010) show that older adults with higher income perceive less disorder in their neighborhoods. More of older Hispanics and blacks see signs of disorder in their neighborhoods at all income levels under $75,000. At the highest income level, a higher proportion of blacks perceive neighborhood disorder than whites and Hispanics. A similar share of high-income blacks perceives their neighborhoods as having signs of disorder as the lowest income whites.

Living in unsafe and unclean places can have significant consequences for older adults. Any factor limiting the mobility and daily activities of older adults has the potential to generate significant inequality in the aging experience. Lower-income adults are more likely to live in

Figure 2. Distribution of Older Adults Living in High-Disorder Neighborhoods



Source: Data tabulated on adults older than age 50 from the *2010 Health and Retirement Study.*

Note: Reports of disorder were based on conditions in the local area defined as everywhere within a twenty-minute walk or about a mile of the resident's home. Residents who reported big problems with vandalism, graffiti, and litter, people being afraid to walk alone after dark, and many vacant houses or storefronts in the area were considered to live in a high-disorder neighborhood. All numbers are age-standardized and weighted to the U.S. population.

worse neighborhoods, and this means they bear the double burden of their own poverty and the stress that is associated with exposure to neighborhood-based problems.

Neighborhood social cohesion

Connecting with neighbors is critical for the health and well-being of older adults whose main activities and social interaction may be limited to their immediate environments. Socializing with neighbors has been linked with improved recovery from severe mobility limitation (Latham, Clarke, and Pavela, 2015). Older adults living among neighbors they consider friendly and trustworthy may feel safer and thus would be more likely to engage in physical activity outside the home. In addition, visiting with neighbors can be an important source of social interaction and support.

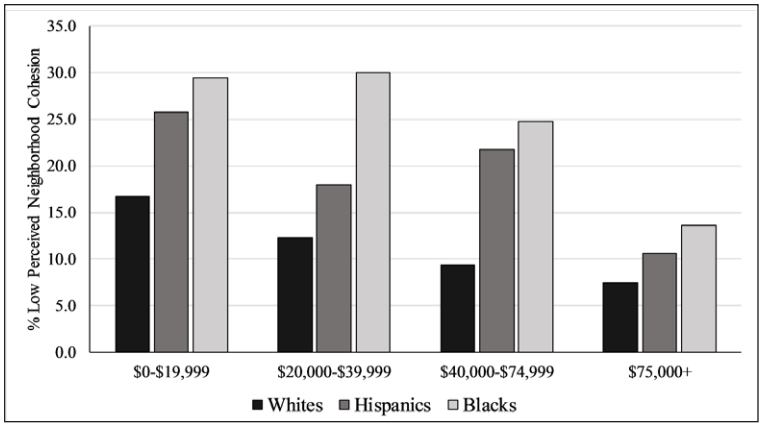
Conversely, older adults who think people in their neighborhood cannot be trusted or are unfriendly, and who do not think they can rely on neighbors for assistance may be less likely to be physically active. Moreover, older adults living in places that lack social cohesion may have fewer positive social interactions on a daily basis and experience more feelings of isolation. Inequality in the aging experience may, therefore, originate in the lack of cohesiveness with others in the neighborhood. The distribution of older adults living in neighborhoods with low cohesion by race-ethnicity and income is shown in Figure 3 (see page 24).

Findings on social cohesion from the *Health and Retirement Study* (2010) show that the proportion of older adults living in neighborhoods with low social cohesion declines with increasing household income. At every level of income, a larger portion of older Hispanics and blacks live in low-cohesion neighborhoods than do whites. Differences between the groups are quite small in the highest income range. About 30 percent of older blacks with income less than $40,000 live in neighborhoods they would characterize as being low on social cohesion.

Older adults living in places lacking social cohesion could have fewer positive social interactions and more feelings of isolation.

Older minorities and those with low income are more likely to live in neighborhoods where they may feel isolated from and mistrustful of their neighbors. These older adults lack a potentially important resource for maintaining optimal health as they age.

Figure 3. Distribution of Older Adults Living in Neighborhoods with Low Cohesion



Source: Data tabulated on adults older than age 50 from the *2010 Health and Retirement Study.*

Note: Reports of social cohesion were based on conditions in the local area defined as everywhere within a twenty-minute walk or about a mile of the resident's home. Residents who reported not feeling they belong in the area, that people are not friendly and cannot be trusted, and who feel nobody in the area would help if they were in trouble were considered to live in a low-cohesion neighborhood. All numbers are age-standardized and weighted to the U.S. population.

Air Pollution

Inequality also manifests in the air we breathe. Neighborhood social and environmental stressors, such as socioeconomic disadvantage and air pollution, tend to cluster together geographically. The accumulated evidence from decades of research indicates that racial and ethnic minorities and individuals of low socioeconomic status live in communities with a higher burden of air pollution exposure (Gee and Payne-Sturgis, 2004; Hajat et al., 2013).

Exposure to polluted air can have serious health implications for older adults. Although several air pollutants have been shown to be harmful to human health, small-particle air pollution, which is largely a byproduct of industrial activities and traffic-based emissions, is of particular concern to health researchers. Fine particulate matter ($PM_{2.5}$) includes particles that are 2.5um (microns) in diameter and smaller; a grain of fine beach sand is about 90um in diameter.

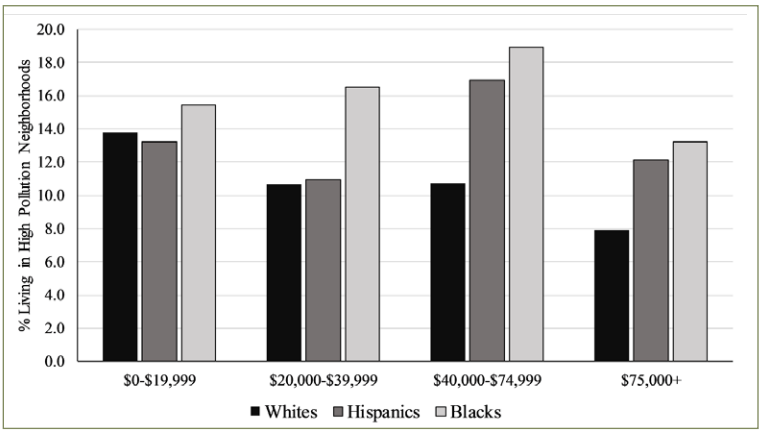
$PM_{2.5}$ is ubiquitous in the air we breathe and due to the particulates' small size, once inhaled, fine particles can do the following: irritate the lungs, causing damage to lung tissues and aggravating pre-existing lung conditions; pass into the body's circulatory system, leading to increased inflammation and risk of blot clots; and may even traverse the thin lining of epithelial cells separating the nasal cavity from the brain, where they can cause damage to the structure and function of the aging brain (Anderson, Thundiyil, and Stolbach, 2012).

What is the extent of inequality in exposure to hazardous air among older adults? A good way to quantify this is to determine the proportion of older adults living in areas with unhealthy levels of air pollution. The U.S. Environmental Protection Agency (EPA) sets air-quality standards for the nation for all criteria of air pollutants. This standard is the level at which the accumulated science has determined concentrations of an air pollutant create increased risk to human health. Individuals living in areas with annual average $PM_{2.5}$ concentrations above this level are living in high-pollution environments. The disproportionate burden of air pollution exposure among older adults by race/ethnicity and income is shown in Figure 4 (see page 25).

Findings from the *Health and Retirement Study* (2010) and 2010 Census tract estimates of seasonally weighted annual average $PM_{2.5}$ concentrations from the U.S. EPA's Fused Air Quality Surface Using Downscaling (FAQSD) (2018) files show the following: At every level of income, a larger portion of older blacks live in high-pollution neighborhoods than do whites. Among higher-income households, older Hispanics are also more likely to live in high-pollution neighborhoods than their white counterparts. This

difference is most pronounced among those with household incomes between $40,000 and $75,000; about 10 percent of older whites live in highly polluted places, compared with 17 percent of Hispanics and 19 percent of blacks. Exposure to high concentrations of air pollution declines with rising income, but only among older white adults. Nearly twice as many low-income older whites live in highly polluted areas, compared to those with high income. Household income is not related to pollution burden among older blacks and Hispanics, which suggests that increasing income does not confer the same ability to avoid living in polluted places for older minorities as it does for older whites.

Figure 4. Distribution of Older Adults Living in High-Pollution Neighborhoods



Source: Data tabulated on adults older than age 50 from the *2010 Health and Retirement Study* linked with 2010 census tract estimates of seasonally weighted annual average $PM_{2.5}$ concentrations from the U.S. EPA's Fused Air Quality Prediction Using Downscaling (FAQSD) files.

Note: A high-pollution neighborhood is defined as a Census tract with an annual average PM2.5 concentration above the EPA standard of 12 μg/m3. All numbers are age-standardized and weighted to the U.S. population.

Environmental inequality can lead to health inequality. Older adults, particularly those in poor health, are more susceptible to the adverse effects of both chronic and acute pollution exposure. Older minorities and low-income whites bear a disproportionate burden of air pollution in their communities and may, therefore, be exposed to increased health risks as they age. Furthermore, increasing income does not shield older blacks and Hispanics from neighborhood pollution as it does for whites. Neighborhoods tend to be segregated by race, regardless of income (Reardon, Fox, and Townsend, 2015), and neighborhoods with predominantly nonwhite populations are likely to be spatially isolated in more disadvantaged areas where there are higher air-pollution concentrations (Hajat et al., 2013; Jones et al., 2014).

This inequality in air pollution exposure is particularly concerning given emerging evidence that older adults living in more polluted areas have worse cognitive function and are at greater risk of cognitive decline and dementia (Power et al., 2016). Inequality in the aging process and outcomes of aging may be rooted in the differential exposure to hazards that results when older adults live in unequal environments.

Conclusion

The expectation and hope of individuals, their families, and policy makers is that older adults will age independently in their communities. Their ability to remain healthy and independent, however, depends greatly on whether the neighborhood conditions to which they are exposed help or hinder healthy aging.

Efforts to improve aging outcomes, whether at the individual or community level, need to consider the unequal distribution of older adults into neighborhoods. For instance, programs designed to promote physical activity or social engagement among older adults should consider potential barriers in the residential environment. Regardless of their motivations and intentions to be physically active and socially involved, older

adults living in unsafe and polluted places face unique challenges that may limit their ability to engage in activities outside of the home.

Neighborhoods may also play an important role in chronic disease management. Some older adults simply may not have the option to exercise more, obtain healthy food, and limit exposure to stress, for instance. These additional challenges should be factored into advice older adults receive about active and healthy living.

'Older adults living in more polluted areas have worse cognitive function.'

Furthermore, policies and programs promoting age-friendly communities need to consider whether they adequately meet the needs of the most vulnerable older adults—those living in socially, economically, and physically disadvantaged communities. Programs should be designed and evaluated to ensure that all older adults are given the opportunity to live in neighborhoods that safeguard and promote their health and well-being. Addressing the unequal environments in which the older population is aging is necessary to avoid further entrenching social and economic inequality accumulated over a lifetime.

Jennifer Ailshire, Ph.D., is an assistant professor of Gerontology, Sociology, and Spatial Sciences at the University of Southern California (USC) in Los Angeles. Catherine García, M.S., is a doctoral student in Gerontology at USC.

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Gaps Matter: Environment, Health, and Social Equity

By Manuel Pastor and Rachel Morello-Frosch

Social inequality in exposures to environmental hazards erodes environmental conditions for all people.

In recent years, public health advocates and researchers have promoted the idea that inequality is not just morally distasteful, but also potentially damaging to overall health and well-being. Among the most compelling advocates of this position have been Richard Wilkinson and Kate Pickett, who laid out the scientific evidence and policy implications in their book, *The Spirit Level: Why Greater Equality Makes Societies Stronger*. The authors argue that it is not only economic shortfalls such as poverty that impact health, but also the degree of inequality in the distribution of income and wealth that affects health, particularly in wealthier societies (Wilkinson and Pickett, 2011).

A parallel argument has evolved in economics, a field long associated with the notion of an efficiency-equity trade-off rather than an efficiency-equity complementarity. Economists at the International Monetary Fund have found that initial disparity in the distribution of income and assets is the factor most significantly associated with the inability to sustain growth over time (Berg, Ostry, and Zettelmeyer, 2012). Economists looking at metropolitan regions in the United States have offered similar findings of the relationship between inequality and economic performance, suggesting that tackling unequal opportunity for some could have broad benefits for all (Benner and Pastor, 2015).

An emerging frontier in this new work involves examining the relationship between social inequality and environmental degradation. Specifically, social inequality in exposures to environmental hazards can erode overall environmental conditions for everyone. For example, when low-income communities and communities of color are disproportionately exposed to harmful pollution (in air and water, for example), pollution can be viewed by those not in that community as someone else's problem. This then can result in a decline in the public and political will to implement environmental policies that reduce overall pollution exposure levels and protect community health (Boyce et al., 1999). While still nascent, this new research

→ABSTRACT Environmental justice often is seen as an issue of righting disparities in the exposures of low-income communities and communities of color to toxic hazards, air pollution, and other disamenities. An intriguing new wave of research finds that when environmental costs and benefits are unequally distributed, this can diminish the collective will to address the commons and hence worsen environmental conditions overall. While more studies are needed, this suggests that centering equity can be beneficial to policies and movements for sustainability. | **key words**: *environmental justice, climate change, public health, social movements, racial generation gap*

suggests that environmental inequality can reduce environmental quality.

What Is Environmental Inequality?

Environmental inequality refers to the tendency for environmental disamenities to be disproportionately located in low-income communities of color. This long-standing concern gained national traction because of 1982 protests against the placement of a hazardous waste landfill in Warren County, North Carolina, one of the poorest counties with the greatest proportion of African American residents in the state (McGurty, 2000). The protests prompted the first nationwide study of environmental disparities in the location of treatment storage and disposal facilities, which in turn led to a new wave of research by government agencies and academic scholars (United Church of Christ Commission for Racial Justice 1987; U.S. General Accounting Office, 1983).

By 1994, President Bill Clinton signed an executive order mandating that federal government agencies (including the U.S. Environmental Protection Agency [EPA], the National Institutes of Health, and the departments of Interior and Energy) consider the potential disparate environmental burdens of their programs and enforcement activities on low-income communities and people of color (Bullard, 1996).

Despite methodological challenges raised in response to some of the earliest research demonstrating disparities (Anderton et al., 1994; Mohai and Saha, 2006), the weight of the evidence and improvements in statistical and spatial techniques indicate patterns of environmental inequities by race, income, and other socioeconomic factors (including measures of civic participation). The patterns of race- and class-based disparities in exposures to environmental hazards are something we might expect given the nature of localized sources of pollution and the persistence of residential segregation by race and income. However, it is important to note that the pattern of environmental disparity seems more pronounced by race than by income, a trend that suggests that inequalities are not merely a function of market forces or of wealth, but also are due to structural racism and its interaction with power over processes of permitting decisions and the siting of toxic facilities (Hamilton, 1995; Pulido, 2000; Ringquist, 2005).

These deeply embedded environmental inequalities have adverse impacts on health, and much of the research has validated the concerns of community organizers worried about local environmental health issues (Morello-Frosch and Jesdale, 2006; Pastor, Sadd, and Morello-Frosch, 2004). Vibrant campaigns have sought to pressure decision makers to address the health effects on local residents of large industrial facilities—such as refineries, chemical plants, and traffic and truck-related air pollution—and the risks associated with living near landfills and hazardous waste processors (Cole and Foster, 2001; Matsuoka et al., 2011). Advocates also have broadened their demands to include not just relief from environmental "bads" but also equal access to environmental "goods," such as green space, fresh food, and better, affordable public transit (Pastor, Auer, and Wander, 2012).

'New research suggests that environmental inequality can reduce environmental quality.'

This mobilization for environmental justice, however, can be seen as a special-interest demand, one focused on addressing disparities rather than on improving overall environmental quality. Environmental justice concerns about California's cap-and-trade system to reduce greenhouse gas emissions were dismissed as a sideshow from the main task of addressing climate change (London et al., 2013). Yet, climate change policies to reduce greenhouse gas (GHG) emissions can yield significant public health benefits by also reducing emissions of hazardous co-pollutants, such as air toxics and particulate matter. Socioeconomically disadvantaged com-

munities are typically disproportionately exposed to these air pollutants, and therefore climate policy could also potentially reduce these environmental inequities.

For that reason, some economists and environmental justice advocates argue that efficient climate regulation requires deeper GHG reductions in areas where the health benefits of reducing co-pollutants are likely to be greatest, and that this objective cannot be accomplished with the geographically unrestricted trading characteristic of cap-and-trade, in which all GHG reductions are treated equally, regardless of location. In this case, revising specific policies to alleviate environmental burdens on disproportionately affected groups can address climate change goals and enhance short-term public health benefits. So while the equity case is strong, social movement and policy advocacy frames to address injustice can also be embedded in a broader set of concerns.

'It is important to be clear about which constituencies will be willing to fight hardest for change.'

Does Inequality Make a Difference?

So what is the relationship between environmental inequality and environmental quality? Just as the need to articulate this has become more pressing in the environmental justice advocacy space, a new wave of research is offering an interesting analog to earlier research on the relationship between inequality and economic growth or public health. In one article, "Is Environmental Justice Good for White Folks?" economist Michael Ash and colleagues look at the modeled distribution of risks from facilities required to report annual pollutant emissions to the EPA (Ash et al., 2012). Looking at metropolitan areas, they found that those regions where average exposures are distributed more unequally by race or ethnicity also have higher average exposures associated with ambient emissions for all population subgroups, including for whites.

Other research has found similar links between social inequality and environmental quality measures that can affect health and well-being, particularly in U.S. metropolitan areas. These studies include positive associations between racial residential segregation and higher exposures to cancer-causing ambient air toxics (Morello-Frosch and Jesdale, 2006) and noise exposure (Casey et al., 2017a); and the relationship between neighborhood poverty concentration and lack of green space (Casey et al., 2017b).

While the reasons are not entirely clear, this work generally echoes our political will argument above: more unequal metropolitan regions may experience a diminished collective public will to regulate and reduce pollution emissions overall, or to invest in improving green infrastructure, like urban forestry, parks, and other green spaces.

One intriguing experiment tried to directly explore the role of social cohesion in public will to address common environmental challenges. Participants were asked to play a game in which they started off with different sums of money and were asked to contribute to a public fund to prevent climate change. As it turns out, inequalities in the initial endowments of money did not impede collective action on climate change if it was thought that everyone would be affected by climate change. However, when told that the risks of harm from climate disaster were greater for low-income participants, wealthier participants in the game became less willing to part with their cash and more willing to let the planet warm (Burton-Chellew, May, and West, 2013).

Evidence and Public Will

While a recent review suggests that environmental inequality does have some impact on environmental quality—the research is just emerging and there are clear caveats to overgeneralization

(Cushing et al., 2015). For example, the negative impact of social and environmental disparities on environmental conditions is more consistent in "within-country" studies than in research comparing across countries, perhaps because it is too hard to control for differing political (and data collection) systems. In addition, the direction of causality—perhaps the higher overall pollution levels drive the disparities rather than the other way around—is not entirely settled by much of this ecological and cross-sectional empirical work.

Still, continuing to explore the relationship between environmental inequality and overall environmental conditions could enhance our understanding about the causal relationship between social inequality and environmental health. While more research is necessary, the mounting evidence that inequality has a dragging effect on public health, the economy, and the environment suggests that policy advocates and others have ample reason to be bold about emphasizing equity concerns.

'Toxic inequality hurts our economy, our environment, and our well-being.'

There is another reason to push concerns about environmental justice: while the general stereotype is that whites who tend to be more well off may be more concerned about the environment than other groups, polling in California suggests that African Americans, Latinos, and Asians are more positively inclined to see climate change as a serious issue and want authorities to address it (Baldassare et al., 2015). For those wanting stronger action on the environment, it is important to be clear about which constituencies will be willing to fight hardest for change.

Research and policy advocacy could benefit from a dimension of central concern to the readers of this journal: age. Older adults are markedly different than the young, not just in age, but also demographically, which can affect public will around policy change. The "racial generation gap"—the difference between the percentage of older adults who are non-Hispanic white versus the percentage of young people who are non-Hispanic white—has been shown to have an impact on collective investments in public education: the bigger the gap (controlling for all other factors that explain levels of local spending on education), the lower the per-student investment (Pastor, Scoggins, and Treuhaft, 2017).

According to projections, the racial generation gap is now at a peak in the United States, perhaps explaining some of our polarized national politics, including around the acceptance (and lack thereof) about the reality of climate change. Interestingly, one state where the racial generation gap long ago peaked (in the 1990s) and has since been shrinking—California—is also leading the nation on addressing sustainability and environmental justice. However, with the evidence of global warming being increasingly obvious, our nation cannot wait for demographic change to steer it toward a common understanding of environmental challenges. A bigger and broader movement must be built—one that can forge ties across groups, generations, and geographies; to do this, America needs to wed the concerns of climate change and climate justice. Solid research on the linkage has a role to play.

Making Change Happen

As researchers, we have been documenting environmental disparities since the early 1990s—one of us as an intrepid and focused graduate student and the other as, frankly, a less directly interested and somewhat scattered professor. For the latter, the path to studying environmental justice was not particularly intentional; a few undergraduate assistants wanted to work on the topic and produced a solid paper that, with some guidance, landed in one of the best journals in the field (Boer et al., 1997). Immediately tagged as an expert, the professor soon attracted the atten-

tion of the grad student–turned post-doc, and a partnership was born.

Together with our long-time colleague, James Sadd, we also attracted the attention of a variety of community organizers who wanted to move the policy needle on environmental disparities and found our research helpful. What we learned working with them and with decision makers was the way in which the environmental movement had managed to advance claims of universal rights that had eluded other arenas of social justice. When decision makers and the general public heard that children of color were subjected to worse air, there was an immediate desire to do something to correct the tragedy, mostly because they saw the environment as part of the "commons" to be enjoyed by everyone in equal measure. On the other hand, when they heard that those exact same children were exposed to worse schools, over-policing, and over-criminalization, concerns were more muted.

Part of the reason we have worked on environmental justice is that we care about the environment and the communities that find themselves overexposed and socially vulnerable. But another factor has been the hope that this work would provide a path to help others to understand the ways in which structural racism and other forms of inequality affect and limit human possibilities at every step in the life trajectory. In short, advancing environmental sustainability is critical to the future of the planet, but the arc of progress must also bend toward justice and equity in order to build collective will for the social and environmental change that is necessary to get us there.

It is our hope that the emerging body of work across the fields of economics, sociology, and environmental health will contribute to an understanding of how "toxic inequality" hurts our economy, our environment, and our well-being (Shapiro, 2017). No society this unequal can function at peak performance. Indeed, the evidence points to the fact that ultimately we are in this together and must work collaboratively toward a more prosperous, sustainable, and equitable planet.

Manuel Pastor, Ph.D., is professor of Sociology and director of the Program for Environmental and Regional Equity at the University of Southern California, where he holds the Turpanjian Chair in Civil Society and Social Change. Rachel Morello-Frosch, Ph.D., is a professor in the Department of Environmental Science, Policy, and Management, and in the School of Public Health at the University of California, Berkeley.

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Intersectionality and Stratification in the Labor Market

By Kyle K. Moore and Teresa Ghilarducci

Older women workers, viewed through the lenses of intersectionality and stratification, are economically disadvantaged, which anticipates their precarious retirement.

Older women and women of color age in an American economy that separates and stratifies people according to group-based identities. Analyzing data from the *Health and Retirement Study* (HRS)—a nationally representative panel study of Americans older than age 50—this article describes how older working women's health, work status, and retirement have changed from 1992 to 2014 within the framework of intersectionality.

Stratification and the intersection of identities are two different phenomena and together significantly affect a person's chances to age with dignity, health, and economic security. The intersectionality research framework posits that our social identities (race, gender, class, age, sexuality, nationality) affect us in multiple ways: our identities exist as more than the sum of their parts. Understanding the social position of older black women requires more than adding "the black experience" to "a woman's experience."

Stratification economics combines economics with sociology and social psychology to explain economic inequality. The stratification framework posits that identity-based inequality is the rational outcome of a market economy that does not work against it. Powerful social identity groups vie to maintain and improve their relative position in society, "stratifying" it through the development of laws, norms, and institutions so that inequality between groups persists over time (Darity, Hamilton, and Stewart, 2014). Stratification economics explains social and economic inequality in a way that shifts research and policy focus away from individual and cultural deficiencies.

How Women and Men Face Different Aging Landscapes

"Patriarchy" is gender-based stratification in which men dominate norms, create institutions, and develop laws to maintain social and eco-

→ABSTRACT Since the 1990s, women have made gains in education and work, but gender and racial stratification in health, work, and retirement create disparities in aging. This article explores the changing social and economic status of mature men, women, and women of color through a review of the health and aging literature, and analysis of the *Health and Retirement Study*. The article analyzes the ways women—black women in particular—are disadvantaged by racialized patriarchy, leading to strong dependence on government old-age programs. | **key words**: *stratification economics, racialized patriarchy, retirement income, older women of color, Health and Retirement Study*

nomic power over women (Fraser, 2012). Patriarchy takes many forms; its latest iteration appears as "patriarchal capitalism" (Folbre, 2012). Patriarchal capitalism supports a market and non-market division of labor based on gender—a system that distinguishes "women's" work from "men's" work. A gendered division of labor limits women's employment in high-paying jobs, and allows firms to pay women less than men in the same jobs. Male roles assign dominance, success, and stoicism that can lead to poor health in labor markets where male wages and jobs are eroding. Patriarchal capitalism makes the labor market experiences of most women and men worse, while benefitting a small, mostly male, group at the top.

'Stratification economics combines economics with sociology and social psychology to explain economic inequality.'

Patriarchal capitalism has weakened as more women work, obtain education, and move into previously male-dominated jobs. Weakening gendered work and closing pay gaps affect the life course of men and women and the health, work, and retirement status of older women and men.

Gendered health dynamics

Women live longer than men, but their morbidity (incidence of disease and disability) plays a significant role in women's lives as they age. Crimmins and Beltrán-Sánchez (2010), between 1998 and 2008, found significant increases in disease and mobility-functioning loss for women. They also found morbidity is not limited to the final years of life—people with longer lives have higher risks of poor and declining health. Long-term care plays a more important role in women's lives compared to men's.

Women's self-reported health status varies more with education than men's, and more education boosts women's health more than men's (Ross, Masters, and Hummer, 2012). In the 2014 wave of the HRS, 32 percent of older men (ages 55 to 64) with a high school education or less rated their health as "fair or poor," compared to 34 percent of women with a high school education or less. More education helped women more than men: 17 percent of college-educated men rated their health as "fair or poor," compared to 15 percent of college-educated women.

Gendered work dynamics

Women's work prospects changed throughout the latter half of the twentieth century, and continue to change. Cha and Weeden (2014) show the convergence in women's and men's wages slowed after the 1990s and stalled in the 2000s, despite women's increasing labor force participation and educational attainment. They attribute the slowdown in gender wage convergence to men's "overwork"—defined as work exceeding fifty hours per week. Because men are better able to "overwork" because they have a partner (often a woman) at home performing the necessary domestic labor and care work, organizations that support and reward overwork reinforce patriarchy and gender inequality.

Dwyer (2013) provides a macro-oriented perspective on care work in the U.S. economy, arguing the increase in the share of jobs requiring elements of care—ranging from surgeons to home health workers—accounts for a significant portion of job and wage polarization between the 1980s and late 2000s. Because women are disproportionately employed in care work jobs—from doctors and nurses to personal care aides—this could lead to increasing income polarization among women workers. However, women and racial minority groups have historically been concentrated in lower-paid care-work occupations.

HRS data confirm convergence between older women's and men's labor market experiences over the past twenty years. Between 1992 and 2014, the share of older women (ages 55 to 64) working full time (at least thirty hours per week and forty weeks per year) rose from 41 per-

cent to 45 percent, while the share of older men working full time fell from 66 percent to 59 percent. Full-time earnings converged as well, though, as is the case with convergence in labor force participation rates, this is due in part to falling annual earnings among men. Between 1992 and 2014, older women's median full-time earnings (in 2014 dollars) rose from $30,382 to $36,750, while men's median full-time earnings fell from $48,101 to $47,000, which may reflect the loss of unions and other sources of bargaining power (Madland and Rowell, 2017).

Jobs have become less physically intensive overall for both older women and men. In 1992, 38 percent of women and 41 percent of men reported their jobs required physical effort all or most of the time. By 2014, 31 percent of women and 34 percent of men reported their jobs required physical effort. However, stooping, crouching, and kneeling actions often are required in care and service occupations. In 1992, 23 percent of women reported needing to perform these actions at work, while 30 percent of men did so. By 2014, these statistics had largely converged, with women reporting needing to stoop, crouch, and kneel 25 percent of the time, compared to men's 27 percent. If certain aspects of jobs are becoming more physically intensive, then it may be more difficult for older workers to continue to work, making the option to retire more important than ever.

'Women need sources of retirement income that will guarantee security through to their final years.'

Gendered retirement dynamics

Women's retirement prospects are affected by their long lives, their higher morbidity, their familial position, and their experience in the labor market. Lusardi and Mitchell (2016) show that, compared to 1992, more recent cohorts of women plan on delaying retirement. This change in retirement planning over time is due to increased educational attainment, more marital disruption, and women having fewer children (all signs of declining patriarchal capitalism), but also is due to increased debt and financial fragility (a measure of whether one could come up with $2,000 in thirty days). Duberly, Carmichael, and Szmigin (2014) explore the differences between women's and men's career paths and experiences with retirement, noting women's reasons for continuing work or deciding to retire often are more relational than are men's, as women consider the needs of family members and other dependents. They also emphasize that the role of early disadvantage (such as low pay and underemployment) in the labor market affects how older women approach retirement (Duberly, Carmichael, and Szmigin, 2014).

Access to a retirement plan at work, the type of retirement plan at work, and retirement savings balances have undergone major changes for women over the past twenty years. As women's participation in the labor force has increased, so has their access to pensions at work; in 1992, 29 percent of older women had a workplace retirement plan, whereas by 2014, that number had increased to almost 38 percent. Much of this change is attributable to the rise in defined contribution retirement plans, and their gradual replacement of more secure defined benefit plans that characterized earlier periods of patriarchal capitalism. Of the older women who had access to pensions in 1992, 36 percent had a defined contribution plan as their sole source of workplace retirement savings. By 2014, that number had increased to 57 percent.

The increase in defined contribution plan coverage translated into an increase in defined contribution account balances for both women and for men, though men still have larger balances than women. In 1992, the median sums of all defined contribution plan balances for women and men (in 2014 dollars) were $10,000 and $40,500 respectively. By 2014, those bal-

ances had increased to $40,000 for women, and $70,000 for men. Women need sources of retirement income that will guarantee security through to their final years.

The slow decline of patriarchal capitalism has allowed women to attain increased economic prosperity and independence in some cases, though the disruption of existing systems has left some groups of women in economic insecurity. This is clear when examining differential outcomes among women by race. Analyses using intersectionality and stratification lenses bring this polarization of outcomes among women into stark relief.

'Neither black women nor white women have enough saved at older ages, but older black women are in a more precarious position.'

Aging Experiences of Black Women and White Women

While all women live experiencing the consequences of gender-based stratification under patriarchy, black women in the United States face the further burden of racial stratification under systemic white racism. White racism, though it is a younger system of social and economic stratification than patriarchy, is no less life-altering for those living within its bounds. Just as patriarchy refers to a system that subordinates women to men, white racism establishes a racial hierarchy which subordinates all other racial categories to those designated as white (Saunders and Darity, 2003).

Though there is no longer a formal legal system of racial stratification as there was in the United States up until the 1960s, its vestiges remain persistent in their effects on blacks and other racial minorities across the life course. While white racism serves its purpose of maintaining economic and social distance between blacks and whites, it also worsens living and working conditions for many white Americans by keeping wages low.

Intersectional analysis directs us to look for the ways in which white racism transforms black women's experiences within the patriarchy, such that they are distinct from white women's experiences, and for the ways white racism and the patriarchy reinforce one another (Brewer, Conrad, and King, 2002). In the following sections, this article describes how health, work, and retirement outcomes differ between black women and white women.

Racialized dynamics for women: health

Race and gender intersect, causing significant health challenges for black women as they age, including distinct challenges from the burdens of morbidity women generally face at older ages. Being black is associated with higher morbidity at older ages across gender, leading to a longer period of end-of-life morbidity for black women as compared to white women. Jeffries (2012) documents how "co-morbidities"—multiple health issues that develop together—impact black women in particular, and how they develop as a result of various economic and social factors.

Jefferies highlights obesity and mental health issues as being exacerbated by the mass incarceration of black men, and the attendant decrease of resources and increase in stress levels that may come from family disruption. Warner and Brown (2011) use an intersectionality approach, with an analysis of HRS, to examine the development of disability across the life course for older Americans. While they find that disability levels follow a predictable pattern, with white men having the lowest levels and black women and Hispanic women having the highest, black women are found to have increasing levels of disablement throughout old age.

Older black women are indeed sicker than their white counterparts, irrespective of college attendance: forty-three percent of older black women with a high school diploma or less education, and one-fourth of black women who had

attended some college rated their health as "fair or poor" in 2014. A significantly smaller share of older white women reported bad health: thirty-two percent of older high school–educated white women and 14 percent of college-educated women. Education was more protective of white than black women: more education reduced black older women's likelihood to rate themselves as having poor health by 43 percent, but for white women, the improvement was 57 percent.

Racialized dynamics for women: work

Older black women face unique challenges in the workplace at the intersection of white racism and patriarchy. The health effects of changing industry distribution fall heaviest upon black women, who already face a high risk of old age morbidity and higher mortality as compared to white women. Goh, Pfeffer, and Zenios (2015) show exposure to harmful workplace conditions accounts for a larger share of life expectancy reduction for black women, as compared to white women or white men, particularly for those with a high school diploma or less education. Duffy (2005) complicates traditional notions of care work, showing women of color often are stratified into those care-work occupations with the lowest pay and fewest opportunities for advancement.

While older women have improved economically relative to men over the past twenty years, closer inspection reveals increases in earnings and labor force participation have gone disproportionately to white women. While 40 percent of both older black women and white women were employed full time in 1992, by 2014, white women's participation rose beyond black women's to 46 percent, compared to 39 percent. In addition, the racial earnings gap between older women grew—older white women earned 6 percent more in 1992 than older black women and 20 percent more in 2014.

Older white women and black women were required to do less physical effort in the workplace in 2014 than they did in 1992, though racial disparities did exist. In 1992, half of all older black women reported having to exert physical effort at work all or most of the time, compared to 37 percent of older white women. By 2014, 44 percent of women needed to exert physical effort on the job, compared to 30 percent of older white women. Stooping, kneeling, and crouching actions on the job increased for white women between 1992 and 2014, rising from 22 percent to 25 percent, while black women's incidence of stooping, kneeling, and crouching barely changed and remains 15 percent higher than white women's. Black women still are disadvantaged in the labor market, and face a higher risk of exposure to working conditions that harm health.

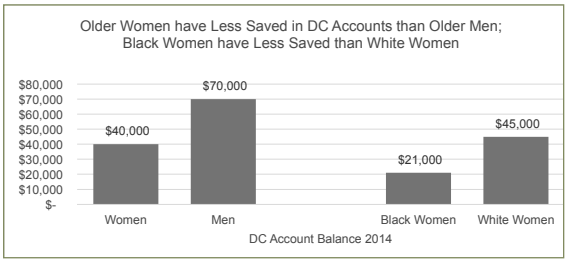
Racialized dynamics for women: retirement

Low career earnings and higher risk of work-related morbidity both diminish black women's prospects for retirement, including their ability to accumulate adequate retirement savings. Brown (2011) uses the HRS to analyze older black women's wealth trajectories, and finds their low levels of net worth during middle and late life are the result of living under racialized patriarchy—discrimination, state policy, and residential segregation all affect black women's wealth in retirement. Angel, Prickett, and Angel (2014) confirm that women of color are at higher risk of retirement insecurity, reap fewer economic gains from marriage, and will have to rely upon Social Security and other assistance programs as they age.

HRS data reveal that older black women are less financially secure in retirement compared to older white women, and are becoming less secure. We analyze women's pension wealth separately from their husbands'. Married women may be able to benefit from some of their husbands' pensions, but marriage is a fluid state: a woman's claim to her husband's pension is vulnerable if she becomes single or divorced.

While the share of older white women with retirement plans at work rose from 35 percent to 42 percent between 1992 and 2014, the share

Figure 1. Defined Contribution (DC) Account Balances



Source: RAND HRS Data, Version P., 2016. Depicts sum across defined contribution plans at work for full-time workers ages 55 to 64.

of older black women with workplace retirement plans fell from 31 percent to 28 percent. Among women with pensions, the share of older black women who only have a defined contribution plan more than doubled, from 26 percent to 57 percent, while the share of white women having only defined contribution plans rose from 37 percent to 59 percent. (Defined contribution—401(k)–type plans—are more risky than traditional workplace retirement plans, and employers are not mandated to provide 401k savings.) Though both black women and white women have some individual retirement savings, black women's balances lag far behind men's and white women's. Black women's median total defined contribution wealth in 1992 was only $6,329 and rose in 2014 to $21,000, while white women's defined contribution wealth grew from $11,533 to $45,000. Most Americans are not prepared for retirement (Ghilarducci, Papadopoulos, and Webb, 2017). Neither black women nor white women have enough saved at older ages, but older black women are in a more precarious position.

Political Economy of Race and Gender

Workplace and household patriarchy have created a gendered dependency of older people, in their older age, upon the state. Social Security, Medicare, and Medicaid are especially important to beneficiaries who will live a long time and who were lifelong low-wage workers in physically demanding jobs—a situation for which women—especially black women—are at risk. For racial and ethnic minorities, relatively lower life chances for high socioeconomic status, safe jobs, and low rates of old-age morbidity (Crystal and Shea, 1990) produce relatively more reliance upon the state. An intersectional approach to describing the health, work, and retirement of older Americans helps us understand the social and economic inequalities that leave all women, and especially women of color, disadvantaged in old age.

This article focused on and analyzed the ways in which older women, particularly older black women, are disadvantaged by racialized patriarchy. There are more dynamics in the political economy of aging in the United States that we have not explored. Hispanic and Asian ethnic identification also shape the aging process, and each requires separate analysis. Stratification in the labor market not only maintains a relative position for dominant social identity groups, but also serves the greater purpose of lowering wages for all workers to the benefit of the capitalist class. Class is no less an important identity than is race or gender; that said, we leave the class beneficiaries of stratification to further research.

The government can mitigate the harm done to disadvantaged groups and the inequity caused by racialized patriarchy. Government programs and policy should aim to provide access to affordable long-term healthcare and secure vehicles for retirement savings for all Americans (Ghilarducci and James, 2018), so that older women are able to retain the option of a secure retirement after a lifetime of work; this would promote healthier retirements and more options in the labor market.

Kyle K. Moore is a doctoral student in economics at The New School for Social Research in New York City. He can be contacted at kylekmoore90@gmail.com. *Teresa Ghilarducci, Ph.D., is the Bernard L. and Irene Schwartz Professor of Economics and director of the Schwartz Center for Economic Policy Analysis at The New School for Social Research.*

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The Public Cost of Low Earnings Across the Life Course

By Jacqueline L. Angel and Ronald J. Angel

Lifelong economic disadvantage disproportionately affects Hispanics and African Americans, and can translate into a Medicaid cost burden in California and Texas.

Income inequality in the United States has grown dramatically in recent decades, even as aggregate wealth has increased (Mather and Jarosz, 2014). Greater productivity benefits have not been distributed equally, and as has been well-documented, those who have benefitted least are racial and ethnic minorities (Brown, 2011; Crystal, Shea, and Reyes, 2016). In this article, we address an issue that has important implications for individuals, families, and society at large, and which is a direct outcome of lifelong income disadvantage among minority Americans. Specifically, we focus on the social costs of poverty in later life, and on the increasing burden to states of Medicaid support for the community and institutional care of growing impoverished and frail older populations who are living longer with serious health and functional limitations.

The focus is on California and Texas, two states with similar population profiles, which include large proportions of Mexican-origin Hispanics, but different Medicaid policies. As a result of low average levels of education and low lifetime earnings, the Mexican-origin populations of both states face a greatly elevated risk of inadequate retirement savings. The combination of inadequate savings and the longer life expectancy of this population when compared to non-Hispanic whites means that many are at high risk of old-age poverty and dependency on Medicaid for long-term care (Angel and Angel, 2015).

The Financial Challenge for the Sunshine and Lone Star States

Increasing life spans and low levels of retirement savings create a double-edged financial challenge for states because Medicaid, which is jointly financed by the federal and state governments, is the major source of long-term care for impoverished and infirm older adults (The Pew Charitable Trusts, 2014). Although the majority of Medicaid recipients are children, the majority of

→ABSTRACT This article discusses implications for frail Hispanic and African American elders of how California and Texas might reform Medicaid, paying particular attention to the consequences for Hispanic elders, who make up a large fraction of both states' older populations. Hispanics have longer life expectancies than non-Hispanic whites, but worse health and functional limitations in later life. Their families may struggle to care for them at home. African American and Hispanic elders will likely have to turn to Medicaid to pay for long-term care, further straining state budgets. | **key words**: *Hispanic, African American, state Medicaid expenditures, California, Texas*

Medicaid expenditures support people with disabilities and older adults (Hearne and Topoleski, 2013; The Pew Charitable Trusts, 2014).

Medicaid pays for 62 percent of all nursing home care (Henry J. Kaiser Family Foundation, 2017b). Although the federal government pays for at least half of the cost of Medicaid (50 percent in California and 56.9 percent in Texas in 2018), states are responsible for the remainder (Henry J. Kaiser Family Foundation, 2017a). As a consequence, debates over Medicaid eligibility, regulation, and funding can be politically charged in state legislatures.

The magnitude of the problem for states is readily apparent—California and Texas in particular. In 2010, 18.9 percent of total state expenditures in California went to Medicaid. In that same year, Texas spent 24.6 percent of its total expenditures on Medicaid (National Association of State Budget Officers, 2011). By 2017, that percentage had risen to 33.3 percent in California and 31.7 percent in Texas (National Association of State Budget Officers, 2017).

'Medicaid pays for 62 percent of all nursing home care.'

Because such a rate of increase is probably unsustainable, states must act quickly. Although the problem of low retirement savings and wealth is particularly serious for the African American– and Mexican-origin populations, it is important to emphasize that a substantial proportion of other Americans lacks adequate retirement savings (Morrissey, 2016). The issues raised in this article, then, may be particularly serious for minority Americans, but apply more broadly. The almost inevitable attempts to control Medicaid expenditures that states will be forced to consider could place many older Americans, particularly minority group elders, at risk of inadequate medical and long-term care.

The Economic Insecurity of African Americans and Hispanics

Other statistics reveal the unique vulnerabilities of African Americans and Hispanics. Although Social Security and Medicare have greatly improved the lot of most older Americans, serious poverty continues to plague minority groups. In 2013, 7 percent of non-Hispanic whites, 19 percent of Hispanics, and 18 percent of African Americans ages 65 and older had incomes below the poverty line (Johnson, Mudrazija, and Wang, 2013). Poverty rates are higher for women than for men among all racial and ethnic groups (Morrissey, 2016).

The late-life vulnerability of African Americans and Hispanics largely reflects dramatic lifetime earnings differentials. Projections of median earnings based on the 2013 Federal Reserve Board's Survey of Consumer Finances indicate that by age 61, non-Hispanic whites will have earned $2 million, while African Americans will have earned $1.5 million, and Hispanics, $1 million (Urban Institute, 2015).

While these earnings differentials are dramatic, wealth differentials are even more so.

A Long-Term-Care Conundrum: A Comparison of California and Texas

The problem of long-term care is compounded by the fact that both California and Texas have sizeable rural populations. In both states, Hispanics account for one-third of the rural population. Older individuals in rural areas often lack access to the acute and long-term-care services they need (Housing Assistance Council, 2012; Mather and Pollard, 2007). The consequences of isolation of Hispanics in rural areas is compounded by the fact that on average, older Hispanics spend half or more of the years they live past age 65 with serious disabilities (Angel, Angel, and Hill, 2015). The situation is especially serious in Texas, in which 15 percent of residents live in rural areas, and many are concentrated in counties along the Texas–Mexico border—areas that have been officially designated as medically underserved (Texas Health and Human Services Commission, 2014).

Wealth consists of cash, real property, stocks and bonds, housing equity, and the total value of all other assets, minus debt. For most Americans, their major asset is a home, and differences in total wealth largely reflect differential earnings and savings over the life course. In 2013, non-Hispanic white households had seven times the median wealth ($134,230) of African American families ($16,686) and six times the wealth of Hispanic families ($13,730) (Urban Institute, 2015).

Not only are these differentials in wealth large, but also they are growing (Urban Institute, 2015). From 2010 to 2013, the median wealth of non-Hispanic white households increased by $1,195. During that same period, the wealth of African American and Hispanic households decreased. For African Americans, median household wealth dropped $5,656, and for Hispanics, it declined $2,705 (Urban Institute, 2015).

Once again, we must note that although the situation of African Americans and Hispanics is particularly serious, the problem of inadequate retirement savings affects all groups, if to lesser degrees. In the *2013 Survey of Consumer Finances*, 23 percent of respondents between ages 45 and 59 reported that they had no retirement savings or pension (Board of Governors of the Federal Reserve System, 2014). What is most disturbing is that 15 percent of those ages 60 and older, including those already retired, had no savings.

African Americans' and Hispanics' financial situations in later life also are negatively affected by the fact that they have fewer sources of income and are more reliant upon Social Security than are non-Hispanic whites. For non-Hispanic whites, Social Security provides 37 percent of their total personal income, private pensions provide 23 percent, and assets provide 31 percent. By contrast, 49 percent of African Americans' total income comes from Social Security, 21 percent comes from private pensions, and 10 percent comes from assets. For Hispanics, 54 percent of total income is from Social Security, 14 percent is from private pensions, and 13 percent is from assets (Angel and Mudrazija, 2015).

The greater reliance of African Americans and Hispanics upon Social Security reflects an additional problem. Their average Social Security stipend is lower than that of non-Hispanic whites, who on average receive $14,939 per year, while African Americans receive on average $12,320, and Hispanics receive $11,459 (Waid, 2014). This fact means that African Americans and Hispanics are more likely than non-Hispanic whites to have to continue working full time past age 65 (Baer, 2015).

What Dangers Lie Ahead? Medicaid Financing Reform

As a candidate, President Trump vowed not to cut spending on Social Security, Medicare, or Medicaid (Angel, 2016). But after assuming office, the newly elected president and the Republican-dominated Congress proposed the American Health Care Act (AHCA) to replace President Obama's Affordable Care Act. This legislation would have capped the federal contribution (Rudowitz, 2017). Currently, federal matching funding to states is guaranteed with no cap and rises depending on program needs (Artiga et al., 2017). The proposed legislation would have limited the growth in funding to the growth rate of the medical care component of the Consumer Price Index, plus an additional 1 percent for older adults and disabled Medicaid enrollees. The legislation posed serious threats to states like California and Texas that have growing low-income older adult populations (McConnell and Chernew, 2017).

Fifteen percent of people ages 60 and older, including those already retired, had no savings.

Were the AHCA or similar legislation to pass, states would be faced with difficult decisions. The three big drivers of Medicaid spend-

ing are eligibility, benefits covered, and provider payment rates. Having to work within the constraints of a block grant would mean states would cover fewer people, cut benefits, reduce provider payments (which already are low), or raise taxes to make up for limitations in the federal contribution—all politically and socially unpalatable prospects (Rudowitz, 2017).

Reductions in federal funding would invariably increase out-of-pocket costs for frail elders and people with disabilities. What is certain is that proposals to replace the current matching system with a fixed allocation of federal dollars paid through block grants or other caps would have significant consequences. While these proposals would provide states greater flexibility than the current Medicaid funding model, the potential cost-saving is unknown due to the fact that most spending is driven by the needs of high-cost older enrollees and people with disabilities (Bachrach, Mann, and Karl, 2017).

Texas presents a number of unique fiscal and political challenges, most notably its historically low investment in Medicaid relative to other states, and its relatively low spending per enrollee (The Commonwealth Fund, 2016). Texas' eligibility levels are set at the federal minimum (Bachrach et al., 2017). Texas spends a smaller fraction of its Medicaid budget on older adult beneficiaries than does California (Kaiser Family Foundation, 2014). This reflects state differences in the mix of community and institutional care that each state funds (Angel, Caldera, and Angel, 2017; Kaiser Family Foundation, 2014).

Texas has kept spending on long-term services and supports relatively low by prioritizing less costly home- and community-based services over institutional care (Angel et al., 2017). Because community services are formally optional, limitations in federal funding could result in a serious reduction in those services (Solomon and Schubel, 2017). Unlike California, in which there are no waiting lists for home- and community-based services, approximately 150,000 Texans are on "interest" or waiting lists for these waiver programs (MedicaidWaiver.org, 2018). Were Congress to cap Medicaid funding, those lists would in all likelihood only increase.

Clearly, California and Texas have different political cultures, yet both have constitutional requirements for balanced budgets (National Conference of State Legislatures, 2010). Texas, however, has no state income tax to provide additional revenue for balancing budgets in economic downturns, while California does.

Conclusion: Implications of Changes in Medicaid

California and Texas, like all other states, face rapidly growing Medicaid expenditures as their populations live longer, often with seriously compromised health and autonomy. Before the latter half of the twentieth century, most individuals died at younger ages than is the case today, and they remained in their own home (or one of their children's homes) until their death. Few older individuals looked to federal or state governments for support.

Since Social Security was introduced, and certainly since the introduction of Medicare and Medicaid, the financial support of older adults has been increasingly "de-familized," a term meaning that responsibility for the support of older adults, and especially of seriously infirm elders, has been transferred from the family to the state. Families continue to provide a great deal of support and assistance to aging parents, and non-governmental and faith-based organizations do as well, but the modern welfare state has created the general expectation that the poor are largely the responsibility of the state.

We have focused on the consequences for state governments of rapidly aging populations with low incomes and few assets. Although the problem of inadequate retirement savings is a general problem, it is particularly serious for minority Americans. As the result of lifelong earnings and savings disadvantages, older African Americans and Hispanics are at elevated risk of poverty and dependency on Medicaid in

later life. Although Hispanics tend not to enter nursing homes, social and demographic changes, including smaller families, children's migration away from their parent's communities, divorce, the need for women to work, and more are undermining families' ability to provide for all of an infirm aging parent's needs.

Given the fact that Hispanics have longer life expectancies than non-Hispanic whites, many will live into their 80s, 90s, and even longer. In the future, a growing number of Hispanics may find they have no choice but to turn to Medicaid, a situation that portends ever-increasing pressures on state budgets. Attempts to control the growing fiscal pressures associated with both acute and long-term care for low-income populations may result in cost containment measures that could seriously undermine the support that both minority and non-minority elders need.

Because resources are not infinite, changes are inevitable, and the core question becomes what might be the most equitable way of controlling Medicaid costs? As noted earlier, nursing home care has traditionally represented the most expensive means of providing long-term care, and states are inevitably looking for savings. Although state Medicaid programs are required to cover nursing home care, they retain some control over expenditures. For example, they can set eligibility criteria for participation and decide how much to pay facilities and providers (Reaves and Musumeci, 2015). These amounts can be rather low. On average, state governments reimburse nursing home providers 89.4 percent of their total costs for providing care to Medicaid recipients (Eljay, 2016). Nursing homes in Texas lose approximately $30 to $60 per day, per person, when Medicaid is the primary payor.

Why would nursing homes accept any Medicaid clients if they lose money and are forced to make up the loss from other paying residents? First, nursing home operators who are licensed to receive Medicaid are required to reserve a certain number of beds for Medicaid recipients. Second, even though they are not required to accept Medicaid clients, most nursing home operators, and especially nonprofit operators, are motivated by a mission to serve the less fortunate and feel compelled to take in low-income elders.

As a result, though, many of these operators have to serve private-pay patients and provide other services (e.g., home health, independent living, assisted living, etc.) to supplement the shortfall. In Texas, some for-profit providers have homes in states with higher Medicaid reimbursement rates so they can use that money to help offset the losses to the homes in Texas. Nationwide, most providers have to pay close attention to the payor mix and the financial reality means that many nursing homes have reduced their number of licensed Medicaid beds.

On average, older adult Hispanics spend half or more of the years they live past the age of 65 with serious disabilities.

As the populations in need grow, budgetary pressures may force states to decrease Medicaid nursing home reimbursement rates even further. Although they may be inevitable, Medicaid cuts could have a serious impact on access to acute, as well as to long-term care for low-income and minority Americans. As previously mentioned, rural areas, especially counties along the U.S.–Mexico border, are poor and medically underserved. Providers along the Texas–Mexico border are particularly sensitive to potential cuts in Medicaid reimbursement rates. Medicaid serves only the poorest and sickest older adults but, under budgetary pressure, states could introduce more restrictive health- and income-qualification criteria, reducing access to many sick older individuals who have limited resources.

It is still too soon to predict the fate of Medicaid, but it is obvious that cutting benefits and increasing out-of-pocket spending by nursing

home residents and their families are likely to affect access to care, as well as the quality of care for all low-income elders, not just those on Medicaid. There are no clear solutions that enhance the quality of life for low-income frail elders, while reducing state Medicaid expenditures. What is essential, though, is that discussions of policy and program reforms must be informed by considerations of equity and the pact between the generations.

Jacqueline L. Angel, Ph.D., is a professor of Public Affairs in the LBJ School of Public Affairs and Department of Sociology at the University of Texas, Austin. Ronald J. Angel, Ph.D., is a professor in the Department of Sociology at the University of Texas, Austin.

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Mass Incarceration, Racial Disparities in Health, and Successful Aging

By Robynn Cox

An analysis of the impacts of mass incarceration on the African American community and on the cohort's long-term health consequences.

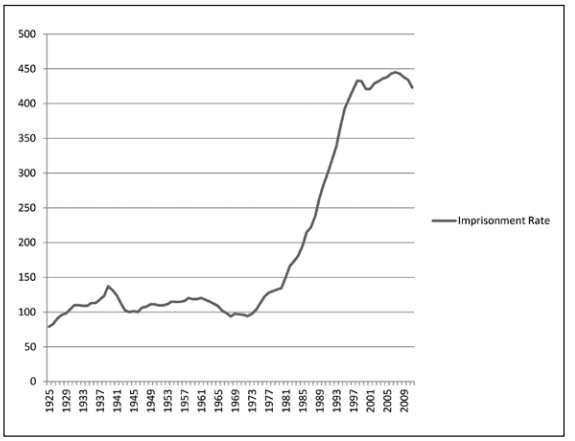
Over the past forty years, the United States has taken part in an experiment in mass incarceration. Incarceration rates up until the mid-1970s were relatively stable, after which they began to increase exponentially (see Figure 1, on page 49) due to an increase in the demand for more punitive (versus rehabilitative) criminal justice policies. Over this same time period, there has been a surge in the number of individuals with criminal records (it is estimated that more than 100 million individuals in the United States have a criminal record), longer prison sentences, and, ultimately, greater rates of incarceration. This article explores the impact that mass incarceration might have on successful aging and racial disparities in aging outcomes.

Although Americans (influenced by policy makers) demanded harsher punishments for criminal offenses, these policies clearly have had a differential impact by race. Figure 2 (on page 50) shows the imprisonment rate by race and ethnicity. It confirms substantial disparities in imprisonment rates between blacks, Hispanics, and whites: the imprisonment rate is 5.6 and 2.6 times the white imprisonment rate for blacks and Hispanics, respectively. This also is shown in Figure 3 (on page 51) by looking at the lifetime likelihood of going to prison over time, which increased from 13.4 percent for a black male born in 1974 to 32.2 percent for a black male born in 2001; for Hispanics, it increased from 4 percent to 17.2 percent during the same time period, with a much less pronounced change for whites.

Comparing prison admission rates of blacks and whites from 1926–1993 (see Figure 4 on page 52), it is clear that imprisonment has always had a disproportionate impact on the lives of African Americans compared to whites: the proportion of African Americans admitted to prison relative to their proportion in the population has been increasing over time, while that for whites has been decreasing. It is also clear from Figure 4 that, coinciding with the era of mass incarcera-

→ABSTRACT This article analyzes racial health disparities and aging in the context of mass incarceration. It reviews what we know about the impacts of incarceration on individuals, families, and communities, and discusses how mass incarceration might impact racial disparities in health and aging. Given the role of the criminal justice system in the lives of minorities, and the deleterious effects of this contact, racial disparities in aging and health cannot be completely understood without fully understanding the consequences of concentrated mass incarceration in minority communities. | **key words**: *mass incarceration, health disparities, aging*

Figure 1. Rate of Imprisonment in State or Federal Correctional Facilities, 1925–2011



Source: Author's calculation from Minor-Harper, 1986; Carson and Mulako-Wangota, 2013.

tion, after 1975, the unequal impact of imprisonment among African Americans increased exponentially. While the threat of exposure to an incarceration has always been greater for African Americans, this threat has greatly increased within the last forty years.

The U.S. experiment in mass incarceration has led scholars from across disciplines to investigate the impact of these policy choices on the lives of all Americans, and in particular African Americans. These scholars have noted that incarceration has a negative effect on labor-market outcomes through stigma, deterioration of human capital, decreasing access to social capital, and labor-market barriers to employment (Cox, 2010).

Spending extended periods in confinement hinders individuals from building social capital, which would otherwise enhance legitimate employment prospects (Cox, 2010). Moreover, confinement may favor developing negative behaviors essential to survival during incarceration, but disruptive to economic stability on release. These behaviors can further disrupt social networks, and could lead to the inability to obtain and maintain meaningful employment.

The impacts of incarceration are not restricted to the imprisoned individual. A plethora of research has identified the deleterious effects of incarceration on the mental and physical health and finances of loved ones exposed to a relative's incarceration. The well-being of children is particularly vulnerable to an exposure to parental incarceration and leads to intergenerational effects (Cox and Wallace, 2016; Johnson, 2009). There also is evidence that incarceration negatively impacts the identity, stability (Charles and Luoh, 2010; Clear, 2008; Petersilia, 2000), public health (Johnson and Raphael, 2009), civic engagement (Petersilia, 2000), and economic well-being of communities (Clear, 2008; Lynch and Sabol, 2004) having concentrated incarceration rates.

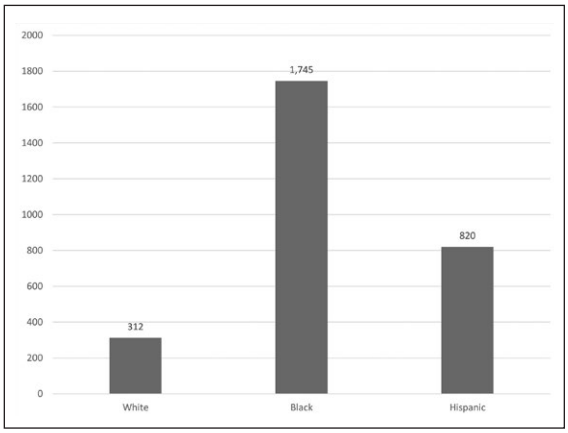
Incarceration has consequences at the individual, family, and community levels; and these are disproportionately borne by communities of color (Wildeman, 2014). Society can no longer address issues of poverty and racial inequality without also addressing the deleterious effects of incarceration.

'Between 1993 and 2013, the size of the ages 55 and older state prison population has increased by 400 percent.'

While there has been substantial research investigating the economic consequences of incarceration, less research has focused on isolating its effects on health and aging, specifically in the context of prisoner re-entry, even though the prison population has become older over time (Carson and Sabol, 2016). Between 1993 and 2013, the size of the ages 55 and older state prison population has increased by 400 percent. Moreover, 48 percent of state prisoners released are ages 35 and older.

When it comes to aging, most research has focused on aging while in prison; but 95 percent of prisoners are eventually released from

Figure 2. Imprisonment Rate of Sentenced Prisoners by Race



Source: Author's calculation from Minor-Harper, 1986; Carson and Mulako-Wangota, 2013.

prison. Although aging may create unique challenges for re-entry, there is a paucity of research on this topic, particularly on the effect of incarceration on racial disparities in health and aging outcomes. This article explores prisoner re-entry in the context of aging by first discussing the relationship between health and incarceration and then discussing how this relationship might impact aging outcomes.

The Direct and Indirect Effects of Incarceration on Health

Theoretically, mass incarceration may directly and indirectly place a strain on the immediate family unit and relatives (Cox and Wallace, 2016), as well as the community at large. It is difficult to isolate the direct effect of incarceration on health because those exposed to incarceration typically come from vulnerable populations, which tend to have higher rates of chronic illnesses and communicable diseases than the general population (see Figure 5, on page 53). Even if one could control for this selection bias, the impact of incarceration on health is ambiguous: while confinement often is a traumatic, highly stressful experience, there are opportunities for confined individuals to make human capital investments through social services offered to detained individuals. It is important to note that the quantity and quality of these services can vary depending on whether an individual is confined in a jail or a prison, the location of the jail or prison, and by the gender of the individuals housed in the facility.

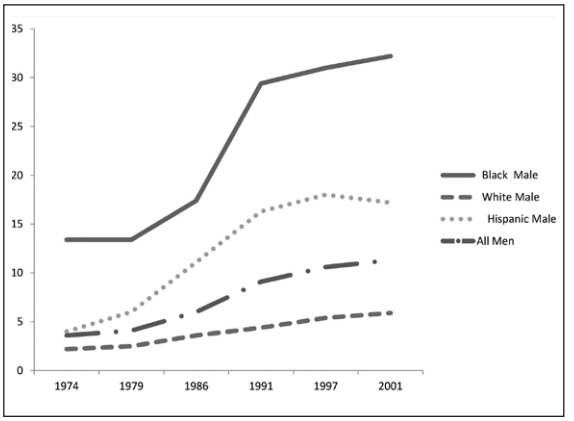
The protective hypothesis suggests that incarceration may help to stabilize the health of confined individuals, and possibly even prolong life. Evidence supporting the protective hypothesis has been found by researchers who have documented individuals' higher rates of mortality directly after release from prison due to homicide, suicide, disease, and cancer (Rosen, Schoenbach, and Wohl, 2008; Binswanger et al., 2007). Once individuals are released from confinement, they may have difficulty accessing required medication, or they may find it harder to comply with treatment regimens.

Behaviors essential to survival during incarceration are disruptive to economic stability back home.

According to Patterson (2010), these benefits may go beyond being protective, to actually improving the health of imprisoned African American men. She finds that the mortality rate of African American males during incarceration approaches that of white males who are not incarcerated, even after controlling for death from homicide and motor vehicles. Even so, she finds a negative impact of incarceration on the mortality rates of women and whites, suggesting that this effect is specific to African American males (Patterson, 2010).

Studies also have documented the negative effects of incarceration. Using administrative data to measure the dose response of an incarceration on the life expectancy of New York State parolees, Patterson (2013) finds that for every year in prison, the odds of death increased by 15.6 percent for parolees, which was equivalent to a two-year decrease in life expectancy for

Figure 3. Male Lifetime Likelihood of Going to State or Federal Prison by Race, 1974–2001



Source: Figure by author; data from Bonczar, 2003.

each additional year in prison. The risk is greatest immediately following release from prison and diminishes over time. While Patterson does not investigate the mechanisms leading to higher mortality rates, prior research suggests (as stated above) that this could be due to an elevated risk of death from suicide, chronic disease, and cancer immediately following release.

Other studies using quasi-experimental designs have found that the formerly incarcerated have inferior health outcomes when compared to observationally similar individuals who have not been exposed to an incarceration. These studies find that individuals exposed to an incarceration have greater health limitations (Schnittker and John, 2007), an increased likelihood of having an infectious disease, and stress-related illnesses (Massoglia, 2008a); in addition, incarceration may exacerbate racial health disparities (Massoglia, 2008b).

Incarceration not only worsens health outcomes, but also it may lead to additional stigma, stress, and a deterioration of other forms of human capital (e.g., on-the-job training, motivation, self-esteem) and social capital (e.g., social networks, familial support), which could lead to declines in economic resources and social support, in turn causing prolonged levels of stress post-release, all of which are associated with poorer health outcomes. Incarceration affects labor market outcomes through producing negative stigmas, deterioration of human capital, and decreasing access to social capital (Cox, 2010).

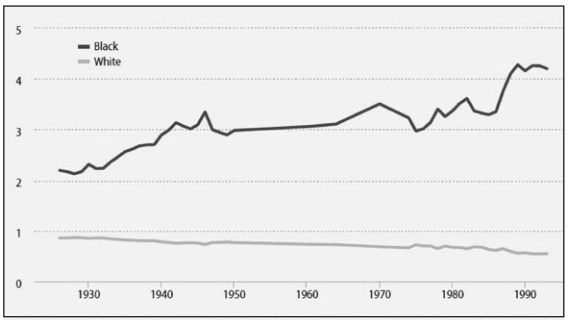
As a result, offenders often are unable to obtain relevant work experience and build prosocial networks that would otherwise enhance legitimate employment prospects. Moreover, behaviors essential to survival during incarceration are disruptive to economic stability after incarceration (Cox, 2010; Petersilia, 2000). Ultimately, incarceration may lead to the deterioration of social bonds and the development of negative social networks, which could give rise to poorer health because of limited economic resources and a worsening of psychological well-being post-incarceration. For African Americans, incarceration could bring about greater levels of psychological distress if this potentially traumatic experience causes a deterioration in familial relationships and more negative interactions among family members, as well as greater financial strain (Lincoln, Chatters, and Taylor, 2005).

One cannot discuss racial health disparities without considering the impact of the criminal justice system.

As previously mentioned, incarceration not only impacts the health of the exposed individual, but also has an effect on the health of family, relatives, and children. As in the case of the individual, the effect of incarceration on the health of family members is ambiguous because on the one hand, incarceration may remove a negative family member and free up additional household resources. On the other hand, incarceration might remove a positive contributing member of the family, which could lead to depleted household resources and social supports for the family members left behind.

Lee and Wildeman (2013) hypothesize mechanisms through which mass imprisonment may

Figure 4. Ratio of Proportion Admitted to Prison to Share of Population by Race, 1926–1993



Source: Cox, 2015.

increase hypertension, diabetes, and obesity among non-incarcerated African American women. They highlight the ways through which social bonds to incarcerated men can compromise the health of African American women, and assert that incarceration diminishes socioeconomic status, compromises family functioning, and adversely affects stress levels and mental health (Lee and Wildeman, 2013). Incarceration reduces a man's potential to earn and damages a woman's socioeconomic resources by destabilizing existing relationships. Stated differently, incarceration acts as an economic shock to the household, with potential long-term effects through diminished earnings and increased debt.

Grinstead et al. (2001) find evidence that prison is an economic shock to the household, especially to low-income families. They find that to remain in contact with incarcerated African American men, women in the study sample spend roughly $292 per month in 1998, the equivalent of $440 per month in today's dollars, or between 9 percent and 26 percent of their income.

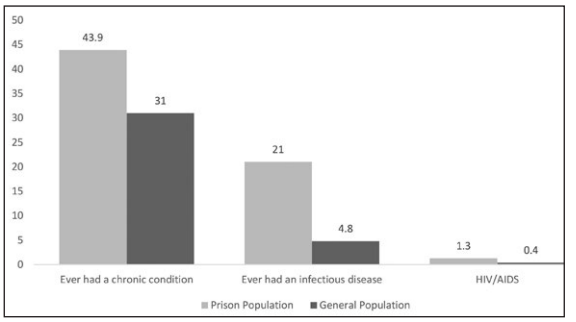
A more recent study by the Ella Baker Center for Human Rights finds that families lose income when a loved one is incarcerated, and often incur, on average, almost $14,000 in debt paying for court-related costs and fines (deVuono-powell et al., 2015). The study also finds that one in three families surveyed went into debt to maintain contact with an incarcerated family member, and incarceration disrupted social ties and familial relationships. Most of the families surveyed lost income due to a family member's confinement, and two out of three families could not afford their day-to-day basic needs. Finally, 83 percent of those left behind were women, and many family members reported negative health problems, such as PTSD, nightmares, anxiety, and chronic stress, due to a loved one's incarceration (deVuono-powell et al., 2015).

Charles and Luoh (2010) find that high levels of incarceration lower the number of men freely interacting in society, leading to lower marriage rates and economic well-being, specifically among African American women. Moreover, Lee et al. (2014) find that women with incarcerated relatives have statistically significant increased odds of cardiovascular risk factors and disease as measured by obesity, experiencing a heart attack or stroke, and self-reports of fair or poor health, presumably stemming from the added stress of having an incarcerated family member.

There also has been a plethora of research documenting the negative effects of parental incarceration on children. Incarcerated children face increased economic (Wildeman, 2014; Cox and Wallace, 2016) and residential insecurity (Wildeman, 2014), as well as developmental and behavioral problems that lead to intergenerational transmissions of incarceration (Wildeman and Western, 2010; Johnson, 2009).

While some research finds that incarceration has a negative effect on communities and families, other research has found that the confinement of an unstable family member might improve the well-being of affected family members (Finlay and Neumark, 2010) and the community at large (Clear, 2008; Lynch and Sabol, 2004). Nonetheless, while removing problematic members from a community through incarceration may initially lead to benefits, concentrated levels of incarceration are destabilizing to the community (Clear, 2008; Lynch and Sabol, 2004), and may lead to an array of social prob-

Figure 5. Prevalence of Chronic and Infectious Health Conditions Among the General Population and State and Federal Prisoners



Source: Figure by author; calculations by Maruschak, Berzofsky, and Unangst, 2015.

lems such as higher crime rates (Clear, 2008) and greater public health concerns (see Johnson and Raphael, 2009, for a discussion on the impact of male incarceration rates on racial disparities in HIV/AIDS).

Racial Disparities in Health, Incarceration, and Aging

In 2015, the National Institute of Aging proposed a new framework to research health disparities. Criminalization was included in this framework as one of the environmental factors to be considered by health disparities researchers (Hill et al., 2015). However, there has been little research investigating the role of the criminal justice system and criminal justice policies on health, aging, and racial disparities in aging. Most research has focused on the role of other environmental, socioeconomic, sociocultural, behavioral, and biological factors in racial health disparities. This research has provided insight into some of the possible mechanisms of racial disparities in aging. There is, however, a paucity of literature focusing on the relationship between aging, the criminal justice system, and prisoner re-entry (see Williams and Abraldes, 2007, for a brief discussion of aging and re-entry).

But, given the pervasiveness of the criminal justice system in the lives of minorities, it is impossible to completely understand racial differences in aging without incorporating how policies and institutions, such as mass incarceration and the criminal justice system, impact minority health and racial disparities in health.

Non-communicable, generally preventable diseases such as cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes are the leading causes of death across the world. This is true for the United States: even though largely avoidable, chronic illnesses continue to be widespread and very costly to society; they also are the leading causes of death among African Americans. While there is some overlap in the ranking of these diseases across racial and ethnic groups, minorities tend to experience greater morbidity and mortality from chronic illnesses than do non-Hispanic whites (Shuey and Willson, 2008).

Prior research has focused on three main explanations of racial health disparities: 1) biological; 2) race as a proxy for socioeconomic status; and 3) race and socioeconomic status as separate constructs (Kawachi, Daniels, and Robinson, 2010). The belief that racial disparities result from biological differences is largely discredited. There is, however, some debate about whether racial health disparities are solely attributable to class, or if race is actually a separate construct from socioeconomic status.

Nonetheless, research demonstrates that racial health disparities cannot be explained by class alone, and therefore race should be considered a separate construct from class (Kawachi, Daniels, and Robinson, 2010; Brondolo, Gallo, and Myers, 2009; Shuey and Willson, 2008). One hypothesized mechanism through which race affects health outcomes is through the psychosocial stressors resulting from cultural, structural, or interpersonal discrimination. Psychosocial stressors also are associated with greater economic barriers and changes in behavior and psychobiological processes, which could impact future generations (Brondolo, Gallo, and Myers, 2009). For example, while certain minorities may

participate at greater rates in behavioral risk factors (leading to greater racial health disparities), these behaviors may have developed as coping mechanisms to deal with greater life-stressors (see Jackson, Knight, and Rafferty, 2010).

Of particular importance to this article is the effect of discrimination on structural barriers that may lead to inferior health. As previously discussed, minorities in general, and African Americans in particular, are more likely to be exposed to an incarceration. Therefore, they are also more likely to suffer from the health consequences of an incarceration. If these disadvantages compound over time, the portion of the racial health gap attributable to incarceration should widen over time.

Given the magnitude of the incarceration crisis in minority communities, and the direct and indirect effects of incarceration on health, it is no longer possible to discuss racial health disparities or successful aging without considering the impact of the criminal justice system in general, and the carceral institution in particular, on the health outcomes of minorities. Moreover, given the indirect effects of concentrated incarceration on children, families, and communities, we must take an intergenerational life-course approach, one that not only focuses on individuals but also on their families and communities, to understand how these policies might impact the aging outcomes of certain communities across time and space.

Robynn Cox, Ph.D., is an assistant professor at the USC Suzanne Dworak-Peck School of Social Work and Schaeffer Center for Health Policy and Economics, in Los Angeles. She can be contacted at robynnco@usc.edu.

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Sexual Orientation, Socioeconomic Status, and Healthy Aging

By Bridget K. Gorman and Zelma Oyarvide

Sexual orientation relates to socioeconomic status, and the differences in this status directly impact the health and healthy aging trajectories of LGBT elders.

The older adult population in the United States is more diverse than ever before—including diversity based on sexual and gender minority status. Recent studies indicate that there are more than 2.4 million lesbian, gay, bisexual, and transgender (LGBT) adults ages 50 and older in the United States, and that this population will grow to more than 5 million by the year 2030 (Fredriksen-Goldsen et al., 2014). In recent years, LGBT older adults have been the focus of a small but growing body of research examining the characteristics and circumstances associated with their health and healthy aging (Institute of Medicine [IOM], 2011).

These studies paint a picture of a population that, on average, faces a variety of health challenges, including stigma, discrimination, and related stressors; barriers to receiving formal and informal healthcare services; and financial instability (Choi and Meyer, 2016). In this article, we discuss how sexual orientation relates to socioeconomic status (SES) among older adults, and the importance of SES differences for the health status and healthy aging trajectories of selected sexual minority (lesbian, gay, and bisexual) adults.

Socioeconomic Status, Sexual Orientation, and Health

While healthy aging relates to a variety of factors, socioeconomic resources loom large. Scholarship has firmly established the fundamental role of socioeconomic status for health (Link and Phelan, 1995). Socioeconomic differences in health impairment accumulate across the life course, and education is an especially important cause of healthy aging due to its key role in the acquisition of material assets (e.g., good jobs, health insurance, income, and wealth), as well as the development of health-related habits, skills, and abilities (Ross and Mirowsky, 2010). While education acts as an intrinsic resource that helps delay the onset of chronic health conditions and

→ABSTRACT The socioeconomic profile of older adults is crucial to shaping their likelihood of living a long life relatively free from disease and impairment. Compared to heterosexual and gay or lesbian older adults, bisexual elders have the lowest rates of completed schooling and live in lower-income households, which strongly contributes to their poorer health reports. Older gay men and lesbians have a more positive socioeconomic profile, including higher levels of completed schooling than heterosexual older adults—however, their annual household income is more similar to heterosexuals, especially for older gay men. | **key words**: *socioeconomic status, sexual orientation, bisexual, health, aging*

functional limitations, income operates more as a coping resource that helps slow the progression of health problems after they occur (Herd, Goesling, and House, 2007). Considered together, the education and income profile of older adults is a crucial factor shaping their likelihood of living a long life relatively free from disease and impairment.

Due to the fundamental role of education, income, and other aspects of socioeconomic status for healthy aging, the wide disparities seen in SES across sociodemographic groups is troubling, especially for older adults. To illustrate, we calculated estimates for SES by gender, sexual orientation, and age using data from the 2011–2015 waves of the Behavioral Risk Factor Surveillance System. Table 1 (opposite) shows how low education (less than a high school diploma) and high education (college degree or more), as well as low annual household income (less than $25,000) and higher income ($75,000 or more) differ by sexual orientation and gender among older adults in three age cohorts: ages 50 to 64, ages 65 to 79, and ages 80 and older. Overall, it shows that across groups, completed schooling and household income decline with increasing age.

Table 1. Education and Income Profile of Older U.S. Adults, by Gender, Sexual Orientation, and Age

	Completed Schooling		Annual Household Income	
	% Less than High School	% College Degree	% Less than $25,000	% $75,000 and higher
OLDER WOMEN				
Heterosexual				
50–64	10.1	30.1	24.5	33.8
65–79	12.6	22.0	35.2	15.3
80+	16.4	18.1	50.8	8.9
Lesbians				
50–64	2.3	48.3	23.8	45.0
65–79	6.6	45.7	27.8	28.1
80+	15.0	38.9	38.2	6.3
Bisexual				
50–64	15.8	31.8	35.5	28.0
65–79	22.4	33.0	53.9	12.7
80+	17.1	13.2	50.7	6.1
OLDER MEN				
Heterosexual				
50–64	12.7	30.8	21.8	38.4
65–79	14.5	28.4	24.6	24.4
80+	18.9	24.6	33.1	18.5
Gay				
50–64	5.4	41.3	28.5	37.9
65–79	7.9	50.9	23.1	24.9
80+	23.0	35.1	34.9	19.4
Bisexual				
50–64	18.8	34.7	46.6	25.7
65–79	12.6	25.4	48.4	17.2
80+	42.8	20.4	62.8	14.7

Source: Calculated by the authors based on Behavioral Risk Factor Surveillance System (BRFSS) data from 2011–2015 waves for the following 40 U.S. states (various years by state): AK, AZ, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NV, NM, NY, NC, ND, OH, OR, PA, RI, TX, UT, VT, VA, WA, WV, WI, and WY.

Socioeconomic and Health Status of Bisexual Older Adults

Table 1 also highlights the socioeconomic disadvantages of bisexual older adults. Across age groups, bisexual elders have the lowest rates of completed schooling, and they live in lower-income households than do heterosexual, gay, or lesbian older adults. While the percentages of their disadvantage vary by gender and age cohort, SES disparities can be quite high. For example, among older women ages 65 to 70, 22.4 percent of bisexual women did not complete high school—this compares to 12.6 percent of heterosexual women, and just 6.6 percent of lesbians.

As another example, Table 1 shows that annual household income varies strongly among the oldest men; while about one-third of heterosexual and gay men ages 80 and older report an annual income of less than $25,000, this rate is almost double among bisexual men (62.8 percent). As recent assessments have concluded (Fredriksen-Goldsen and Muraco 2010; IOM, 2011), previous research on older adults has disproportionately focused on gay men and lesbians, while bisexuals and other sexual minority groups rarely were examined. Yet the data patterns in Table 1 illustrate the risks associated with only considering gay or lesbian adults (or lumping together subgroups into an umbrella "sexual minority" category). Doing so would obscure or ignore the poorer socioeconomic standing of bisexual older adults relative to their heterosexual and gay or lesbian peers—a key factor shaping health disparities across the life course that are based on sexual orientation.

Bisexual elders have the lowest rates of completed schooling and live in lower-income households.

A recent study by Fredriksen-Goldsen and colleagues (2016) concluded that the poorer socioeconomic standing of bisexual older adults operated as a strong explanatory mechanism for their poorer health reports, compared to heterosexual and gay or lesbian older adults. Recent reviews of LGBT aging issues have discussed how financial instability is a major concern for many sexual minority older adults (e.g., Movement Advancement Project [MAP] and Sage, 2010).

As summarized by Choi and Meyer (2016): "Lifetime disparities in earnings, employment, and opportunities to build savings, as well as discriminatory access to legal and social programs that are traditionally established to support aging adults, put LGBT older adults at greater financial risk than their non-LGBT peers." The findings shown in Table 1 and from previous scholarship indicate that financial stress may be especially high among bisexuals in later life.

This finding about financial stress more generally reflects a growing body of research documenting substantial financial and other health-related risks among bisexuals. Scholarship focused upon adults in general has shown that, compared to heterosexual and gay or lesbian adults, those who identify as bisexual report poorer socioeconomic circumstances, higher participation in health-damaging behaviors like smoking and heavy alcohol use, and poorer mental and physical health status (Conron, Mimiaga, and Landers, 2010; Gorman et al., 2015; Veenstra, 2011).

Bisexuals also report lower averages of life satisfaction and less emotional support than either gay or lesbian or heterosexual adults (Gorman et al., 2015). Additionally, Fredriksen-Goldsen and colleagues (2016) show that older bisexual adults report more internalized stigma as well as a lower sense of community belonging and perceived social supports than their gay or lesbian peers. This study also showed a lower rate of sexual identity disclosure among bisexuals—a finding that applies not only to friends, family, and co-workers, but also to medical care providers (see also IOM, 2011).

Considered together, these studies indicate that a variety of health-related risks—including economic vulnerability, participation in unhealthy behaviors (e.g., smoking), stress, and lower levels of social support—may be elevated among bisexual older adults. Furthermore, the lower rate of sexual identity disclosure to medical professionals among bisexuals is worrisome, because research on the medical experiences of sexual minorities highlights the importance of sexual identity disclosure for a positive medical encounter (Daley, 2012; Sherman et al., 2014).

Analyzing SES Similarities

Looking again at Table 1, it also shows more positive socioeconomic profiles for gay men and lesbian older adults relative to same-age heterosexuals. Depending upon the contrast,

gay men and lesbians often report similar or better levels of completed schooling and annual household income. This is seen most strongly for education: with just one exception (among men ages 80 and older), gay men and lesbians report higher levels of completed schooling, on average, than their heterosexual peers. This educational advantage is especially stark when we look at the percentage with a college degree, where the proportion with a college degree is markedly higher among gay men and lesbians. For example, among adults ages 50 to 64, 48.3 percent of lesbians have a college degree, compared to 30.1 percent of heterosexual women. Among men ages 50 to 64, 41.3 percent of gay men have at least a college degree, compared to 30.8 percent of heterosexual men.

Looking at annual household income among older women, we see a more muted but generally similar pattern. The proportion of older women reporting a household income below $25,000 is lower among lesbians than heterosexuals in each age group, and (with the exception of women ages 80 and older) a higher proportion also report a household income of $75,000 or above.

U.S. adults (especially heterosexual men) hold more negative attitudes toward gay men than lesbians.

Among older men, however, the proportion in either income group is very similar between gay and heterosexual men in most age groups. The biggest difference occurs among men ages 50 to 64, where a higher proportion of gay men (28.5 percent) report an annual household income of less than $25,000, compared to 21.8 percent of heterosexual men.

Previous studies also have found higher levels of educational achievement among gay men and lesbians in comparison to comparably aged heterosexual adults (IOM, 2011). Additionally, work by Fredriksen-Goldsen and colleagues (2013) found a similar pattern wherein gay and lesbian adults ages 50 and older report higher levels of education, but fairly equivalent rates of poverty in comparison to similar-age heterosexuals—a pattern they attribute to discrimination and blocked opportunities across the life course, which limited the ability of sexual minorities to fully capitalize on the economic benefits associated with their educational achievement. That we see this more strongly among older gay men than among lesbians (in Table 1) may relate to elevated experiences with stigma and discrimination among gay men. Herek (2002) has documented that U.S. adults (especially heterosexual men) hold more negative attitudes toward gay men than they do toward lesbians, and gay men experience substantially higher rates of harassment, verbal abuse, violence, and property crimes than either lesbians or bisexuals (Herek, 2009).

Healthy Aging Among Sexual Minorities

As detailed in *Healthy People 2020*, improving the health and well-being of sexual minorities is an important public health goal for the United States (U.S. Department of Health and Human Services, 2010). Existing health disparities research provides a framework for understanding how SES contributes to sexual orientation differences in health status, because SES often is implicated as one of the strongest contributors to health stratification (Link and Phelan, 1995). Overall, the poor health standing of bisexuals documented across an increasing number of studies may be due in large part to their lower socioeconomic standing, on average, than members of other sexual orientation groups.

In particular, our understanding of how education and income relate to disease onset and progression is important, because the poorer socioeconomic profile of bisexual older adults suggests that they may face particular hardships in navigating the health challenges associated with aging. Older sexual minority adults are more likely to be single, living alone, and without children than heterosexual elders, and they rely more on partners and friends to provide

caregiving assistance (Fredriksen-Goldsen and Muraco, 2010; MAP and Sage, 2010).

The fact that bisexual older adults report elevated rates of low income and education indicates that they may face difficult challenges in securing quality housing and medical care services as they age. While survey data suggest that gay or lesbian adults do not experience the same education deficits as bisexuals, it appears that older lesbians and gay men especially have been less able to capitalize economically on their education. As such, policy makers and healthcare providers need to realize how financial stress and instability in later life may play a large role in shaping not only the health status of sexual minorities, but also how successful their management of health problems may be as they seek to maintain a high quality of life as they age.

Bridget Gorman, Ph.D., is professor and chair of Sociology at Rice University in Houston, Texas. Zelma Oyarvide is a doctoral student in the Department of Sociology, and a research affiliate at the Kinder Institute for Urban Research, at Rice University.

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African American Elders, Mental Health, and the Role of the Church

By Ann W. Nguyen

How might churches play a role in ameliorating congregants' discrimination-based generalized anxiety disorder?

Based on national surveys and polls, African Americans have the highest levels of religious involvement in the United States (Chatters, Nguyen, and Taylor, 2014). Among older African Americans, religion is particularly important. Compared to younger African Americans and older whites, older African Americans are more likely to attend religious services, participate in congregational activities, and read religious materials (Taylor, Chatters, and Brown, 2014; Taylor, Chatters, and Jackson, 2007). Older African Americans also are more likely than older whites to consume religious media (i.e., books, television, and radio), engage in private prayer, use religion to cope with stress, consider religion to be important, and consider themselves religious (Taylor, Chatters, and Jackson, 2007).

At the institutional level, the church has historically played a major role in African American communities. Not only is it a religious institution, but also is a social, civic, political, educational, and economic institution in many of the communities it serves (Lincoln and Mamiya, 1990). African American churches offer a wide range of community programs and services, such as anti-poverty and material aid programs, programs for older adults and their caregivers, counseling and intervention programs, and educational and awareness programs (Taylor et al., 2000). Moreover, African American churches' offerings of programs and services are more extensive than those of white churches (Taylor et al., 2000). These services and programs emerged partly from African Americans' difficulties with accessing these private and public services due to social and economic marginalization.

Given the prominence of religion and the church in the lives of older African Americans, congregants are important social network members for this population. In fact, some African Americans, particularly those who do not live near family, or who are estranged from family, consider church members to be their surro-

→ABSTRACT The African American church has played a major role in African American communities, and church relationships represent an important stress-coping resource for older African Americans. African Americans rely on the church and church members for assistance, in part because of difficulties accessing formal resources due to social and economic marginalization. Church can buffer against the negative effects of discrimination upon generalized anxiety disorder among older African Americans. Interventions that focus on the use of church members for support capitalize on a major strength among older African Americans. | **key words**: *African American, older adults, discrimination, church, stress-coping resource, generalized anxiety disorder*

gate family (Taylor, Chatters, and Levin, 2004). Church members are a critical source of social support for this population. The most common types of support exchanged among African American congregants are advice and encouragement, companionship, assistance during illness, prayers, and financial aid (Taylor, Chatters, and Levin, 2004).

Church relationships are an important stress-coping resource and are linked to better mental health. Some studies have found that church support, contact with church members, and subjective closeness to church members protect against psychological distress and depressive symptoms among African Americans (Chatters et al., 2018). The function of church relationships as a stress-coping resource is critically important to consider among African Americans, given that this population is particularly susceptible to discrimination, a type of chronic stressor that is prevalent among populations of color and other marginalized groups, such as older adults.

Discrimination and Mental Health

A recent national survey indicates that discrimination is pervasive in African Americans' lives (National Public Radio, Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health, 2017). Ninety two percent of African American adults (ages 18 and older) in this survey reported that they believed that discrimination against African Americans exists in the United States today. When asked about personal experiences with discrimination, at least one out of two African Americans reported experiencing racial discrimination in the workplace or in interactions with law enforcement, which were the most prevalent discriminatory experiences documented in this study.

Housing discrimination was the third most prevalent discrimination issue reported, with 45 percent of African Americans surveyed indicating that they have personally experienced this type of discrimination. Moreover, a majority of African Americans reported experiencing multiple types of individual and interpersonal discrimination, such as racial slurs and insensitive or offensive comments about their race. This survey's results clearly document the extensiveness of discrimination in African Americans' lives.

Discriminatory events, especially day-to-day unfair treatment such as being followed in stores or receiving worse service than others are particularly pernicious forms of chronic stress, as they often are unpredictable and uncontrollable; experiencing these can lead to feelings of lack of control and self-efficacy and can contribute to poor mental and physical health. Research on discrimination has unequivocally indicated that it is linked to a range of mental health problems, such as depression (Williams and Williams-Morris, 2000) and psychological distress.

Church relationships are a stress-coping resource and linked to better mental health.

In particular, discrimination is associated with anxiety and anxiety disorders (Gee et al., 2007; McLaughlin, Hatzenbuehler, and Keyes, 2010; Soto, Dawson-Andoh, and BeLue, 2011). For instance, Mouzon et al. (2016) found that older African Americans who were exposed to more frequent experiences of discrimination were more likely to have an anxiety disorder than older African Americans who were exposed to less frequent experiences of discrimination.

Soto and colleagues (2011) have demonstrated in a national probability sample of African Americans that racial discrimination is predictive of generalized anxiety disorder (GAD), which is characterized by excessive anxiety and worry. Further, McLaughlin, Hatzenbuehler, and Keyes (2010) found that discrimination predicted a wide range of anxiety disorders, including post-traumatic stress disorder (characterized by intense and disturbing thoughts and feelings following exposure to one

or more traumatic events), generalized anxiety disorder, social anxiety disorder (characterized by intense fear or anxiety of social situations in which the individual may be scrutinized by others), and panic disorder (characterized by recurrent, unexpected panic attacks) among African Americans and Hispanics.

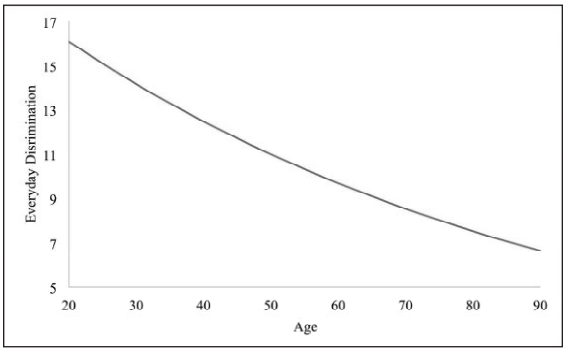
Gee and colleagues' (2007) investigation of racial discrimination and twelve-month psychiatric disorders in a nationally representative sample of Asian Americans found that respondents who reported more instances of racial discrimination were more likely to have an anxiety disorder.

Discrimination and GAD Among Older African Americans

GAD is the most prevalent anxiety disorder in the United States, affecting approximately 2.1 percent to 3.1 percent of Americans in any given twelve-month period (Revicki et al., 2012). The lifetime prevalence of GAD in the general U.S. population ranges from 4.1 percent to 9 percent (American Psychiatric Association, 2013). Among African Americans, the twelve-month prevalence is 1.37 percent, and the lifetime prevalence ranges from 3 percent to 4.9 percent (Himle et al., 2009).

GAD is highly comorbid with other psychiatric disorders, with other anxiety disorders and depression being the most prevalent comorbid disorders (Revicki et al., 2012). A wide range of impairments and high levels of social and occupational disability are associated with GAD (Revicki et al., 2012). Individuals with GAD experience substantial impairments in role functioning, especially in the social and occupational domains (Hoffman, Dukes, and Wittchen, 2008; Revicki et al., 2012). This disorder accounts for 110 million disability days annually in the United States (American Psychiatric Association, 2013). Moreover, GAD is associated with diminished mental health–related quality of life (Hoffman, Dukes, and Wittchen, 2008), life satisfaction (Revicki et al., 2012), overall well-being, and satisfaction with family life (Hoffman, Dukes, and Wittchen, 2008).

Figure 1. Perceptions of Everyday Discrimination Decrease with Age

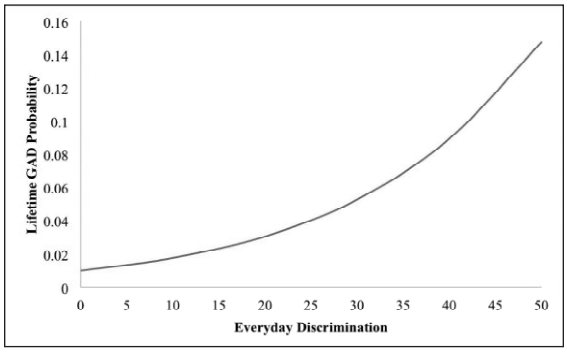


Source: *National Survey of American Life*, author's calculations.

Although there has been a fair amount of research on discrimination and its mental health effects among adults, there is little research on discrimination in older adults. I used data from the *National Survey of American Life: Coping with Stress in the 21st Century* (NSAL) to estimate the association between everyday discrimination and age among African American adults. The NSAL has a national probability sample based on 6,082 face-to-face interviews with individuals ages 18 or older, including 3,570 African Americans, 891 non-Hispanic whites, and 1,621 Caribbean blacks. The data were collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research. As illustrated in Figure 1 (see above), perceptions of everyday discrimination (i.e., day-to-day unfair treatment) decrease with age among African Americans.

There have been very few investigations into why this inverse relationship between discrimination and age exists. Some speculate that this pattern may reflect a cohort effect in which older African Americans were socialized to expect and tolerate higher levels of discrimination and more overt forms of discrimination than younger African Americans (Kessler, Mickelson, and Williams, 1999). Despite this, older African Americans are nevertheless adversely affected by these experiences. Among older African Americans, increases in experiences of everyday discrimina-

Figure 2. The Discrimination–GAD Association



Source: *National Survey of American Life*, author's calculations.

tion are associated with increases in the probability of meeting criteria for lifetime GAD, as shown in Figure 2 (see above).

Stress-Buffering Effects of Church Relationships

Numerous studies have documented the protective effects of social relationships against mental illness among older adults, protecting against numerous psychiatric disorders, depression, social anxiety disorder, and GAD (Krause and Hayward, 2015). Yet the mechanism by which social support and social relationships protect against mental illness is less understood. Emerging evidence suggests that particular aspects of social relationships can buffer against the harmful effects of stress. A study of older Korean women found that social support buffered against the effects of discrimination upon depression (Lee and Kim, 2016). Older Korean women who reported more frequent experiences of discrimination reported higher levels of stress, which, in turn, was predictive of depression. However, respondents who reported higher levels of support had lower stress levels and consequently were less likely to have depression.

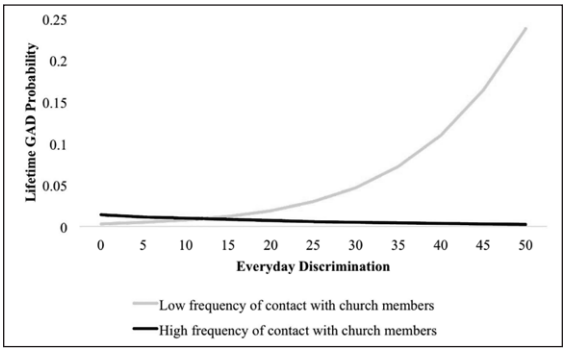
Krause's (2005) investigation of the stress-buffering function of social support among older adults found that family and friendship support acts as a stress-buffer in the negative association between financial strain and life satisfaction, but only in relatively older adults (i.e., older adults who experienced financial strain reported lower life satisfaction). However, for relatively older adults who experienced financial strain and had high levels of support from family and friends, the negative association between financial strain and life satisfaction was substantially weaker, indicating that social support can offset the harmful effects of financial strain, a chronic stressor, on subjective well-being.

Most studies on the stress-buffering effects of social relationships among older adults do not focus on church relationships, despite the heightened importance of religion in the lives of older adults and particularly in older African Americans' lives. One study that has examined the stress-buffering effects of church relationships found that church support offset the negative effects of financial strain on self-rated health for older African Americans, but not older whites (Krause, 2006). This suggests that church members may be an effective stress-coping resource for older African Americans when they are confronted with discrimination, and could offset its effect on mental illnesses, including GAD.

'Church support offset the negative effects of financial strain on self-rated health for older African Americans.'

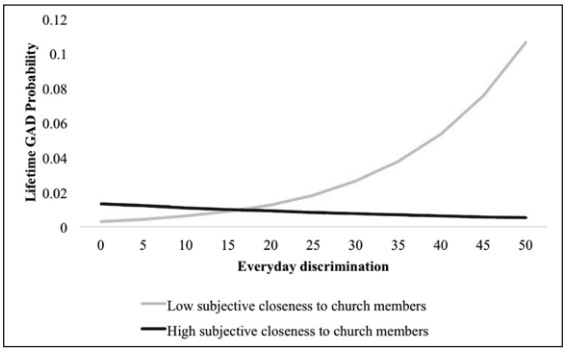
I used a subsample of older African Americans (N = 670; ages 55 and older) from the NSAL to test the stress-buffering effects of several aspects of church relationships in the discrimination–GAD association. Frequency of contact with church members and subjective closeness to church members buffered against the impact of everyday discrimination on lifetime GAD. Figures 3 and 4 (see page 65) illustrate that for older African Americans who had low levels of contact with and subjective closeness to church members, more discriminatory experiences were associated with greater risk for lifetime GAD. On the other hand,

Figure 3. Contact Frequency and Lifetime GAD Probability



Source: *National Survey of American Life*, author's calculations.

Figure 4. Subjective Closeness and Lifetime GAD Probability



Source: *National Survey of American Life*, author's calculations.

discriminatory experiences were not associated with lifetime GAD for older African Americans who reported high levels of contact with and subjective closeness to church members. This demonstrates that contact with church members and subjective closeness to church members can offset the detrimental effects of discrimination on GAD among older African Americans.

Conclusion

Given the importance of religion among older African Americans and the relatively high levels of church involvement in this population, church members are particularly meaningful and relevant social partners for these older adults and represent possible stress-coping resources for older African Americans dealing with discrimination. As a growing body of research has documented the deleterious consequences of discrimination, a more complete understanding of factors and processes that can mitigate the effects of discrimination on mental illness is paramount to developing interventions that can bolster the roles of such factors and facilitate effective coping resources in the lives of vulnerable older African Americans. This is particularly important, considering the fact that African Americans face a number of barriers to formal mental health services and are less likely to access mental health services than non-Hispanic whites (Alegría et al., 2008). Research on attitudes toward mental health services has indicated that prior to mental health service use, African American adults have more positive attitudes toward mental health services than whites (Diala et al., 2000).

However, after receiving mental health care, African Americans have less positive attitudes toward mental health services than do whites. This suggests that the mental health care received by African Americans may not be culturally competent or may be of lower quality (Alegría et al., 2008). Among those who seek mental health care, African Americans are less likely than non-Hispanic whites to receive quality care and care adhering to official practice guidelines (Alegría et al., 2008). An additional barrier to accessing mental health care for African Americans is the perception of discrimination. When experiences of discrimination are accounted for, African Americans are just as likely as their white counterparts to seek help for psychiatric problems (Woodward, 2011).

Similarly, among older adults, experiences of discrimination explain why older African Americans are less likely to receive help than older whites (Woodward et al., 2010). Given this racial disparity in mental health care access, church members are important and effective stress-coping resources that older African Americans can mobilize when facing discrimination. However, this is not to suggest that church members should supersede professional mental health

care for older adults suffering from mental illnesses; for these older adults, interventions could focus on training church members to help facilitate or encourage professional help-seeking. Interventions that employ the support of church members capitalize on a major strength among older African Americans to promote improved mental health outcomes in a population in that regularly confronts a number of chronic stressors, including discrimination.

The feasibility of church relationships as stress-coping resources for future cohorts of older African Americans must be considered within the context of declining church attendance in the United States. This is an important consideration because higher rates of church attendance are predictive of more frequent contact with congregants and higher levels of subjective closeness and social support exchanges among congregants (Nguyen, Taylor, and Chatters, 2016).

According to the Pew Research Center (2015), the percentage of African Americans who indicated that they frequently attended religious services (i.e., at least once a week) declined from 53 percent in 2007 to 47 percent in 2014. Despite this modest decline, attendance rates among African Americans are still substantially higher than those of the general population. Among African Americans, 83 percent reported that they attend religious services a few times or more a year (Pew Research Center, 2015). In the general U.S. population, only 69 percent of Americans indicated that they attend religious services a few times or more a year (Pew Research Center, 2015).

Given these patterns, church relationships should remain a viable stress-coping resource for future cohorts of older African Americans. Additionally, research on age differences in mental health service use has shown that younger adults are more likely to access mental health services than older adults (Alegría et al., 2008). This may be a cohort effect that would translate to higher rates of mental health service use in future cohorts of older African Americans, which could mitigate the modest decline in religious service attendance and its impact on access to church members as stress-coping resources.

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Ann W. Nguyen, Ph.D., M.S.W., L.M.S.W., is an assistant professor at the Jack, Joseph and Morton Mandel School of Applied Social Sciences, Case Western Reserve University. She can be contacted at nguyena@case.edu.

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Can Economic Interventions for Children Reduce Economic Inequality in Adulthood?

By Trina R. Shanks

Child Development Accounts offer economic support early in life that can institutionalize greater financial health.

Economic inequality in wealth and income has been increasing in the United States over the last third of a century. Households at the top income distribution have experienced rapid growth, while households at the bottom have stagnated (Henly et al., 2018; Grusky, Mattingly, and Varner, 2016; Saez and Zucman, 2016). Economic inequities are even more stark when viewed through the lens of both race and ethnicity, with households of color faring worse than national averages.

Such inequalities have implications for future generations. Children growing up in low-income, low-wealth households (especially when this poverty occurs in early childhood and continues across multiple years) experience worse educational and health outcomes, higher levels of stress, greater involvement in crime, and lower earnings and lower wealth in adulthood. All of these experiences come at negative costs to young people, as well as to society as a whole (Holzer et al., 2008; Williams Shanks and Robinson, 2013; McLoyd et al., 2009). Although the United States is generally described as a place of opportunity, since the 1940s, absolute mobility has declined and, for the first time, current generations of young people are not expected to earn more than their parents (Chetty et al., 2016).

Economic Disparities by Race, Ethnicity, and Gender Persist

Income inequality has increased for everyone since the 1970s, although it increased somewhat less among people ages 60 and older (Bosworth, Burtless, and Zhang, 2016). However, economic disparities by race, ethnicity, and gender that are found in households with children persist into old age. Older African Americans and Latinos are

→ABSTRACT American economic inequality often starts early in life and persists through adulthood and retirement. The disparities are starker when viewed through the lens of race, ethnicity, and gender. A promising policy recommendation to help lessen economic inequality is institutionalizing greater financial health through a structured matched savings account or asset-building program. One well-researched example is the Child Development Account (CDA), of which there are both long-standing and newly emerging examples. Using such accounts to build wealth could lead to less economic disparity in old age. **key words**: *inequality, wealth, financial health, asset-building, Child Development Accounts, life course*

more than twice as likely to be poor, have lower life expectancies, and be more dependent upon Social Security income than older non-Hispanic whites.

Older women are more likely to be poor than men (Mather, Jacobsen, and Pollard, 2015; Olshansky et al., 2012). Older African Americans have lower lifetime earnings, less wealth, less retirement savings, and are insecure across a range of indicators that lead to greater economic strain (Williams Shanks and Leigh, 2015).

If I were to recommend a policy response to lessen economic disparities across the life course—a response that also would reduce economic inequality in old age—it would be something similar to Aspen's Savings for Life model (goo.gl/m28Ho6). This approach recommends four subsidized accounts at key life stages: Child Accounts, Home Accounts, Individual Retirement Accounts, and Annuities (Mensah et al., 2007).

For the Child Accounts, the government would provide all children a beginning endowment to open an investment account, giving every child a chance to build financial literacy. The Home Accounts would provide a government match for low- and moderate-income families

Since the 1940s, absolute mobility has declined in the United States.

on savings toward a house down payment. The Individual Retirement Accounts would also benefit from a government match for low- and moderate-income Americans who have no access to retirement plans at work. And the Security "Plus" Annuities would provide additional guaranteed income as a complement to Social Security.

Although this might seem like a radical policy proposal in the U.S. context, a similar government-sponsored savings program exists in Singapore. Singapore has a Baby Bonus scheme that offers an unrestricted cash gift and matching funds for children from birth to age 12 to pay for child-related expenses; an Edusave scheme with an annual contribution and incentives for children between the ages of 7 and 16 to maximize educational enrichment; a Post-secondary Education account scheme that matches family savings to help pay for approved college and post-secondary expenses; and a Medisave account with a lump-sum grant for health-related expenses through age 21. Left-over money in any of these accounts follows the individual across their lifetime through the Central Provident Fund mandatory retirement savings system (for specific details on Singapore, see Loke and Sherraden, 2015).

Whether four separate accounts, as proposed by Aspen, or a lifelong account that offers progressive incentives at key life stages as suggested by Sherraden (1991), the potential benefits would be similar.

Asset-Building Tools for Children's Brighter Futures

Child Development Accounts (CDA; also sometimes called Child Savings Accounts) are one well-researched example that set a precedent for providing real opportunity and structured economic support across a major life milestone—transition to adulthood—usually with an emphasis on post-secondary education. Such accounts are a way to institutionalize financial well-being that includes everyone, not just those born into households at the upper end of income and wealth distributions. There is research on the best design features for CDAs, as well theoretical and empirical evidence on how they might influence child outcomes (Clancy and Beverly, 2017; Grinstein-Weiss, Williams Shanks, and Beverly, 2014; Elliott and Sherraden, 2013).

The Saving for Education, Entrepreneurship and Downpayment (SEED) initiative was a national policy and practice demonstration to test asset-building accounts for children, funded by a dozen foundations. It ran from 2003 to 2008 and piloted CDA programs in twelve communities across the country, partnering with local

organizations, including preschools, schools, nonprofits, and a foster-care program.

A 2010 report synthesizes findings across all the sites and offers lessons learned from these efforts (Sherraden and Stevens, 2010). Building upon SEED, a few foundations also funded a statewide CDA experiment with a random selection of newborns, a program that was launched in 2007 in Oklahoma. Called SEED for Oklahoma Kids (or SEED-OK), the experimental design tests policy features and demonstrates the feasibility of scaling programming at the state level without going through community partners

'Automatic enrollment, automatic initial deposits, and a progressive savings subsidy favor disadvantaged children.'

(Zager et al., 2010).

A promising result from SEED-OK is that automatic enrollment, automatic initial deposits, and a progressive savings subsidy favor disadvantaged children (Beverly, Clancy, and Sherraden, 2016). Such features help assure a CDA policy that reduces inequalities, rather than reproducing them.

Initial financial, parental, and child outcomes of the SEED-OK program (Clancy et al., 2016; Beverly, Clancy, and Sherraden, 2016; Sherraden et al., 2015) have piqued interest in other states and municipalities. New programs are starting throughout the country, but children participating in these emerging programs are still fairly young, so research evidence is limited (Prosperity Now, 2018; Shanks, 2014).

I was a researcher with the quasi-experiment set up in Michigan as part of the original SEED demonstration that is now one of the longest running CSA programs in the United States. As a site that enrolled Head Start students in 2004 and 2005, results coming from Michigan SEED (MI-SEED) provide longitudinal data on a CDA program from early childhood through high school graduation. As part of this initiative, 495 Head Start students were enrolled in a Michigan 529 college savings account and given an initial deposit of $800, which came from partnering foundations and which then made most families eligible for a $200 state match.

The program also offered MI-SEED households a dollar-for-dollar match of up to $1,200 for any additional money saved. As the formal program ended in December 2008, the median balance in the accounts was $1,131 (mean $1,483). By December 2015, the median balance had grown to $1,337 (mean $2,017).

Although the country went through the Great Recession soon after the program started (2007–2009), and many families faced severe economic hardships, less than 10 percent withdrew funds from these MI-SEED accounts. Caregivers (most respondents were mothers, but also grandparents and other caregivers) saw the money as an investment in their child's future. Although $1,300 may seem an insignificant amount given the increasing cost of college tuition, there is evidence that even small dollar amounts in child savings can increase the likelihood of college enrollment and completion—particularly for children in low-income households (Elliott, 2013).

Between 2014 and 2015, my research team contacted fifty MI-SEED families to conduct in-depth interviews with caregivers and youth. A summary report on MI-SEED, with longitudinal outcomes and these qualitative findings, will be released by the end of 2018. To offer a quick update, most families were still excited about the MI-SEED account ten years later, and some were having concrete conversations about how they would use the money to fund their child's post-secondary education. MI-SEED participants are expected to graduate from high school between 2017 and 2019. The final research task will be collecting data to examine who graduated from high school and went on to enroll in college and whether having this CDA account influenced post-secondary outcomes.

Prioritizing Young People: A Path to Financial Health

The Consumer Financial Protection Bureau (CFPB, 2015) defines financial well-being as "a state of being wherein a person can fully meet current and ongoing financial obligations, can feel secure in their financial future, and is able to make choices that allow enjoyment of life." Financial well-being is not tightly aligned with income, but having greater liquid savings and the ability to cover an unexpected expense are both associated with greater financial well-being. Relatively small amounts, such as liquid assets of $2,000, can provide a minimum floor to assure financial health (CFPB, 2017).

Prioritizing such financial health first among young people through child accounts and then across the life span could lead to less economic disparity overall and greater financial well-being in older age and retirement. For example, CDAs and similar age- and stage-appropriate accounts could promote investment that leads to greater educational attainment via post-secondary training; greater financial cushion as fewer households experience zero and negative net worth; more options for employment and self-employment, including business start-ups; and more opportunity to engage in saving and long-term investment vehicles that take advantage of compound interest, establishing a foundation for financial capability through one's working years and into retirement.

CDAs (or any well-run asset-building program) are not a panacea for all economic disparity. However, they are a way to offer economic support early in life that effectively institutionalizes greater financial health. If such accounts are introduced as part of a larger economic strategy that follows individuals over a lifetime, there is less danger of anyone facing severe economic strain in old age. Rather than being known as a society with extreme economic inequality where disparities start at birth and persist through death, Child Accounts can model how strategic investment at transformative moments make it possible to generate pathways of prosperity for all.

Relatively small amounts, like liquid assets of $2,000, can provide a minimum floor to assure financial health.

Trina R. Shanks, Ph.D., is an associate professor at the University of Michigan School of Social Work in Ann Arbor. She can be contacted at trwilli@umich.edu.

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Advocates for African American Elders: Engaging Our Older Adults in Education and Research

By Karen D. Lincoln

An outreach program provides culturally competent health education for older African Americans in Los Angeles County.

Los Angeles County (LAC), California, is the largest county in the nation. It contains California's biggest population of older adults, the majority of which are racial and ethnic minorities (Department of Finance, 2017). Due to LAC's size, it is divided into eight Service Planning Areas (SPA) (County of Los Angeles, 2018). These distinct geographic regions allow the Department of Public Health to develop and provide relevant public health and clinical services to the specific health needs of residents in these different areas.

A Model Program Responds to Racial Health Disparities

Advocates for African American Elders (AAAE) is an outreach and engagement program at the University of Southern California (USC) that provides culturally competent health education for older African Americans throughout LAC. Founded in 2012 to address racial disparities in health outcomes, AAAE partners with community-based agencies, governmental organizations, and health plans to address the persistent and growing needs of older African Americans.

AAAE educates and disseminates information about healthcare policies and resources through fact sheets, educational forums, and the AAAE website. It also collaborates with local healthcare providers to improve outreach, education, and care, assessing service needs and resources via surveys in LAC. The program also engages in community-partnered participatory research to provide real-world solutions for improving health outcomes and to build community research capacity.

AAAE selected SPA 6 (South Los Angeles) as its primary service area because of its social and economic disparities. A demographic snapshot of

→**ABSTRACT** Advocates for African American Elders (AAAE) is an outreach and engagement program at the University of Southern California, Suzanne Dworak-Peck School of Social Work. Founded by Associate Professor Karen Lincoln, AAAE comprises community advocates and graduate students who have since 2012 provided culturally competent health education for older African Americans throughout Los Angeles County. AAAE partners with community-based agencies, governmental organizations, and health plans to conduct community-partnered participatory research, raise awareness, increase knowledge and access to healthcare resources, and improve health outcomes for older African Americans and their families. | **key words**: *Advocates for African American Elders, Los Angeles County, healthcare access*

communities in SPA 6 shows that African Americans constitute more than 28 percent of the population, the largest concentration of African Americans in LAC. Within that African American population, 36.5 percent are ages 50 to 64 and 48.8 percent are ages 65 or older; these percentages represent the largest population of older adults in LAC (USC Edward R. Roybal Institute on Aging, 2015). Residents in SPA 6 have the lowest levels of education and income, and the highest poverty rate of all eight SPAs (Los Angeles County Department of Public Health, 2017).

'South Los Angeles has the County's highest rates of hypertension (64 percent) and obesity (34.1 percent).'

About 20 percent of SPA 6's population that is ages 50 or older has diabetes, and 20 percent has a depression diagnosis. South Los Angeles has the County's highest rates of hypertension (64 percent) and obesity (34.1 percent) (Los Angeles County Department of Public Health, 2017), and one of the County's lowest levels of access to dental care and healthcare. There are eleven licensed dental practitioners and thirty-nine physicians per 100,000 residents in the South Los Angeles area, compared to 225 licensed dental practitioners and 1,000 physicians in the West Los Angeles area (USC Edward R. Roybal Institute on Aging, 2015).

African Americans make up 5.7 percent of the West Los Angeles (SPA 5) population and non-Hispanic whites comprise 64 percent of the population. Residents in West Los Angeles have the highest levels of education, the lowest poverty rate (11.9 percent), and the lowest rates of obesity (10.3 percent), diabetes (4.5 percent), and hypertension (17.1 percent) of all eight SPAs.

AAAE in Action

The range of AAAE research activities include a community survey of 550 African Americans, a healthcare experience survey of 200 African Americans, a qualitative study to explore African Americans' knowledge about Alzheimer's disease and attitudes toward clinical research, and a randomized, comparative effectiveness trial to increase knowledge about Alzheimer's and to examine the effects of cultural mistrust and racial discrimination upon research attitudes.

The 2014 community survey

Findings from the 2014 community survey indicated that many older African Americans in LAC were healthy, connected, engaged, and received services that met their needs. However, survey findings also revealed service needs and gaps for many participants. Moreover, results revealed low computer and health literacy levels across age groups and educational levels, as well as a lack of knowledge about services and programs available for older adults. These findings were most prevalent among survey participants who lived alone, had low levels of education, were of advanced age, and had poor physical and mental health.

In 2014, AAAE released *Understanding the Service Needs of African American Seniors in Los Angeles County: Findings from the Advocates for African American Elders Community Survey*, a report of the findings the 2014 community survey (Lincoln, 2014). The report was disseminated to more than 500 policy makers and community stakeholders, resulting in numerous tweets, many of which were "favored" and re-tweeted. USC also provided access to the report's recommendations to inform and be included in the Los Angeles Department of Aging's strategic plan.

A second report from these data, titled *New Research Highlights the Benefits of Community Programs for Older African Americans in Los Angeles County* (Lincoln, 2015), outlined the benefits of community-based programs for older adults. Findings showed that participation in and access to quality community-based services resulted in better physical health and overall well-being, including better quality of life, less depression, less isolation and loneliness, and reduced risk of food insufficiency.

Survey findings leverage advocacy, outreach,and policy

I presented the survey findings as part of my oral and written testimony to the California State Legislature to emphasize the need for increased quality, access, and availability of services and programs for older adults who reside in poor, segregated, and under-resourced neighborhoods.

My legislative testimony and recommendations are included in the report, *A Shattered System: Reforming Long-Term Care in California*, which was published by the Senate Select Committee on Aging and Long-Term Care (Senate Select Committee on Aging and Long-Term Care, 2014). This widely disseminated report offers thirty legislative recommendations in eight issue areas (state leadership, legislative leadership, system integration, fragmentation/lack of integrated data, infrastructure, workforce, funding, and federal issues) for immediate action and provides the first blueprint for the country to achieve improved coordination and a high-functioning, comprehensive long-term-care system.

'The training has been delivered to more than 250 healthcare and mental health care providers.'

One finding from the AAAE community survey indicated that 81.5 percent of participants were unaware of new legislation authorized by the Affordable Care Act that established the Dual Eligible Demonstration Project in California called Cal MediConnect. Cal MediConnect is a complex healthcare system that combines a dual eligible's healthcare benefits, both Medicare and Medicaid services, into one benefit package administered by managed care organizations. Although participation in the demonstration project is voluntary, California, like many states, passively enrolled dual eligibles into the program. Passive enrollment highlights the critical need for beneficiary outreach and education in dual demonstration projects so that beneficiaries can make informed decisions about their healthcare and avoid any disruptions that passive enrollment into a new health plan might infer.

AAAE responded to the need for outreach and education in African American communities by developing an innovative and engaging talk show format to deliver information about Cal MediConnect. The talk show has been hosted by a variety of African Americans, including a professional actress, a licensed clinical social worker, and the co-director of AAAE. Culturally congruent presenters increase the participants' level of access to information because participants relate to the messengers. The set design is a replica of a talk show set that offers audio and visual learning via the host, guests, and a PowerPoint presentation (running in the background rather than being the show's focus) that highlights the conversation in graphic form.

AAAE partnered with the five health plans participating in the Cal MediConnect program to extend outreach and education efforts. AAAE also coauthored an issue brief in collaboration with staff attorneys from Justice in Aging. Titled *Thinking Outside the Box: Creative and Culturally Competent Outreach Strategies in Health Care Transitions*, the brief describes the AAAE outreach and education model, and highlights its effectiveness in reaching, engaging, and educating members of underserved communities (Chen, Lincoln, and Gaines, 2015).

A focus on training, brain health education, and research

AAAE's dedication to improving healthcare delivery to African Americans was the impetus for designing the *AAAE Cultural Competency Training*. To date, this is the only training of its kind for service providers focused on African American older adults and mental health. The training has been delivered to more than 250 healthcare and mental health care providers, including social workers, medical directors, psychiatrists, physicians, and health plan staff, and is cur-

rently being offered by the Los Angeles County Department of Mental Health (CMUs, CEUs and Certificates of Completion are available for participants).

Currently, AAAE is leading efforts at USC to increase education and participation in Alzheimer's disease clinical research among African Americans. AAAE's Brain Health initiative was created to address the higher risk and greater burden of Alzheimer's among African Americans, compared to other racial groups (Mayeda et al., 2016). *The Wisdom Project: Exploring Attitudes and Beliefs about Alzheimer's Disease and Clinical Research among African Americans* used focus groups to understand the beliefs, experiences, and informational and educational needs related to Alzheimer's disease, and barriers and facilitators to participation in clinical research among thirty-two African Americans ages 50 and older. Findings revealed that racism and discrimination were fundamental causes underlying previously reported barriers to participation in clinical research, such as mistrust and fear of experimentation (the first manuscript from these data has been submitted for publication to *The Gerontologist*).

AAAE is leading efforts to increase education and participation in Alzheimer's disease clinical research among African Americans.

Findings from *The Wisdom Project* were used to develop a curriculum for *BrainWorks: A Comparative Effectiveness Trial to Examine Text Message-Based Alzheimer's Disease Education for Community-Dwelling African Americans*. This three-pronged, randomized trial used the AAAE talk show format to deliver an Alzheimer's disease curriculum to a sample of 200 African Americans ages 50 and older. Daily text messages were sent to the intervention groups in order to support and reinforce the curriculum. The goal of this study was to increase Alzheimer's disease knowledge and positive attitudes about clinical research (Clay, 2017). Data collection was completed in December 2017 and data analysis has begun.

What's Next for AAAE?

We will publish our findings from *BrainWorks* and apply for funding to expand this study. AAAE will continue to further its mission of enhancing quality of life for African American older adults by leading outreach and engagement efforts informed by CPPR, growing the research capacity of community residents and organizations, providing training and research opportunities for graduate students, increasing the cultural competency of service providers, and advocating for quality and accessible healthcare for members of underserved communities.

Karen D. Lincoln, Ph.D., M.S.W., M.A., is associate professor at the Suzanne Dworak-Peck School of Social Work at the University of Southern California in Los Angeles.

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Recruiting Older African Americans to Brain Health and Aging Research Through Community Engagement

By Mark A. Gluck, Ashlee Shaw, and Diane Hill

Lessons from the African-American Brain Health Initiative at Rutgers University–Newark.

The African-American Brain Health Initiative (AABHI) at Rutgers University–Newark is a unique university–community partnership combining community engagement, education and training, and brain health research. Partnering with community-based organizations, we promote brain health literacy, Alzheimer's awareness, brain-healthy lifestyle choices, and participation in brain research for older African Americans in Greater Newark, New Jersey. Our research and training missions bring together undergraduates, graduate students, postdoctoral fellows, faculty, and clinicians for cross-disciplinary efforts that link neuroscience, neurology, public health, social work, and nursing.

African Americans have two to three times the prevalence of Alzheimer's disease as compared to whites (Barnes and Bennett, 2014; Tang et al., 2001). We do not fully understand the causes of this health disparity, nor how best to focus future interventional efforts to remediate it. Additionally, African Americans are underrepresented in biomedical research (Shavers-Hornaday et al., 1997; Corbie-Smith et al., 1999; Braunstein et al., 2008).

However, as a result of community-engaged outreach efforts, we have enrolled African American community members in several research studies on aging and Alzheimer's disease. In 2015, we recruited more than a thousand older African Americans of Greater Newark to participate in a short health and lifestyle survey, working in partnership with the New Jersey Department of Health's Office of Minority and Multicultural Health. Based on their positive experience with this study—which, for most, was their first biomedical or health research experience ever—many agreed to participate in additional research studies at Rutgers.

→ABSTRACT The African-American Brain Health Initiative at Rutgers University–Newark is a university–community partnership combining community engagement, education and training, and brain health research. Partnering with community-based organizations, it promotes brain health literacy, Alzheimer's awareness, brain-healthy lifestyle choices, and participation in brain research for older African Americans in Greater Newark, New Jersey. Our approach to recruitment relies on building trust through long-term relationships; communicating health knowledge through trusted community leaders; recruiting subjects through targeted efforts; and cultivating research participants as ambassadors. | **key words**: *Rutgers University–Newark, research study recruitment, African American, older men, community partnership, brain health*

We have two ongoing research studies within the AABHI. One study, funded by the National Institutes of Health's (NIH) National Institute on Aging, investigates how variations in lifestyle, weight, diet, sleep, and, especially, physical fitness, are correlated with cognitive and brain function in older African Americans, with the goal of identifying early predictors of cognitive decline and future conversion to Alzheimer's disease.

Our other study, funded by the Federal Office of Minority Health in partnership with the New Jersey Office of Minority and Multicultural Health, asks if participating in a biweekly dance-based exercise class, hosted by local churches and senior centers, can improve memory and brain function in older African Americans, reducing known biomarkers for Alzheimer's risk. For these two research studies, we recruit and test about 150 people per year, and all are African Americans ages 55 and older. The initial testing takes about two and a half hours and individuals who are medically and physically able may return on another day for optional brain imaging.

Research Recruitment Tactics

Our approach to research recruitment for both studies relies on extensive community engagement based on the following four key strategies:

√ **Build trust through long-term relationships that bring value to the community.**

All of our activities build on trust established from more than a decade of community engagement and service in Greater Newark. We have implemented a range of outreach and engagement approaches designed to enhance community health through brain health education programs that support older African Americans in adopting healthier lifestyles. Our community-engaged approach leverages community partnerships to develop a culture of trust between Rutgers and the community (Holland, 2005; Sandy and Holland, 2006; Silka and Renault-Caragianes, 2006; Post et al., 2016).

Key to this external outreach has been a cross-disciplinary partnership at Rutgers University–Newark with the Office of University–Community Partnerships, which is responsible for, and experienced with, external community relations. Community participants recruited to our research have come primarily from long-standing partnerships with local churches; senior centers; city, county, and state offices for health and aging; as well as from outreach to public and other low-income housing sites. Representatives from many of these partner organizations make up the AABHI Community Advisory Board, which meets every other month to guide our activities and provide a bridge to community needs and interests.

'African Americans have two to three times the prevalence of Alzheimer's disease compared to whites.'

With these partners, the Rutgers University–Newark AABHI hosts several large events every year, attracting about 250 older African American community members to each. Also, we run around two smaller "Lunch 'n' Learns" per month at our partner sites, which attract twenty-five to fifty people per event. All of these health education programs emphasize six key steps to brain health that our community members can and should take, and lifestyles and habits associated with reducing their risk for Alzheimer's disease: doing regular exercise, keeping mentally active, avoiding unproductive stress, and getting adequate sleep, social support, and proper nutrition.

Each event also includes a presentation on the benefits and importance of research participation by African Americans. Whenever possible, these presentations on research participation are given by African American students at Rutgers University–Newark (often they are students who grew up in Newark) who are working on our AABHI research studies as part of their

undergraduate or graduate training. For some of these events, we also partner with other local organizations with complementary missions, including the American Heart Association, the American Stroke Association and the Alzheimer's Association.

√ **Communicate health information through known and trusted community leaders.**

We hire and train known and trusted community leaders as health educators to deliver information about brain health and research information to community members at the events described above. These Community Brain Health Educators often are leaders from our partner churches and senior centers, including church deacons and pastors, as well as retired teachers, nurses, and other community advocates. In addition to leading and presenting at our brain health education events, they assist in nurturing, managing, and expanding our relationships with community organizations, while serving as locally "embedded" brain health experts.

√ **Recruit older black men through targeted efforts.**

Attracting older men to health education and research participation has been a challenge; in and around Newark, African American women ages 55 and older outnumber men by more than two to one, and the ratio is even more extreme within the community and church groups from which we recruit (the ratio is less extreme in senior public housing). We have developed a range of outreach and engagement approaches specifically designed to enhance recruitment of older black men to our research studies.

These approaches embody both of the first two strategies noted above, but re-focused specifically on men. These include the following: supporting the growth of a network of church men's ministries who offer a monthly "Men's Health and Wellness Breakfast Club," led by our Community Brain Health Educators; running health education programs for barbers to enlist them as ambassadors for brain health and brain research (see also Releford, Frencher, and Yancey, 2010); hosting an annual classic car show and men's brain health fair; supporting a summer picnic and health fair for older residents of public housing in partnership with the Newark Housing Authority; partnering with a local seniors bowling league; and hiring black men from the community, including local black graduate students, and black male nurses recruited through the Northern New Jersey Black Nurses Association, to work as our ambassadors and Community Brain Health Educators for recruiting men to our research. Through this multipronged approach, we are attracting increasing numbers of men to our studies.

'All of our activities build on trust established from more than a decade of community engagement.'

The need for additional efforts in recruiting men to our programs demonstrates that, even when working with an underrepresented population, additional, more targeted outreach may be necessary to capture a particular group within a population of interest. For example, we have found it useful to develop targeted programs for residents of low-income public and federally subsidized housing. As we become increasingly sensitive to the needs and interests of the many sub-communities within our broader community of older African Americans in Greater Newark, we have come to appreciate that a range of strategies may be required for each.

√ **Cultivate research participants as ambassadors for brain research.**

Once participants have participated in research, they become AABHI VIPs: Very Important Participants. All VIPs receive regular contact from us via phone and mail throughout the year. By hearing from us and seeing us in their churches and community-based organizations, participants know they are valued members of an ongoing university–community

partnership, in which Rutgers is committed to them, their community, and their health needs for years to come. All are asked to spread the word about brain health and to encourage friends and acquaintances to participate in our research studies. About 25 percent of recent participants in our studies have come via word-of-mouth from other participants, showing that the community members become engaged not only in the research, but also in working with us to expand recruitment through their own social networks.

Additional, targeted outreach may be necessary to capture a particular group within a population of interest.

Summary

The AABHI at Rutgers University–Newark began in 2006 as an occasional series of community brain health education events co-sponsored with local churches. Over the last few years, it has expanded in scope and impact so that it now integrates all three of our university's missions: community engagement, teaching and training, and research and scholarship. Each of these missions is a key part of the Rutgers University–Newark AABHI. Community engagement provides opportunities for Rutgers students and postdoctoral fellows to get interdisciplinary training, while working with faculty mentors and community members to pursue fundamental behavioral and biomedical research on aging and Alzheimer's disease.

All the strategies described herein are readily implementable by other universities and medical research centers doing aging and brain health research that are interested in working with African Americans and other underrepresented communities. All require a long-term commitment of time and effort to build trust and partnerships with local community organizations and community members.

Mark A. Gluck, Ph.D., is a professor of Neuroscience and co-director of the African-American Brain Health Initiative at the Center for Molecular and Behavioral Neuroscience, Rutgers University–Newark, in New Jersey. He can be contacted at gluck@rutgers.edu. *Ashlee Shaw, Ph.D., is a postdoctoral fellow and associate director of the African-American Brain Health Initiative. She can be contacted at* a.metshell@ gmail.com. *Diane Hill, Ph.D., is associate chancellor for University-Community Partnerships and co-director of the African-American Brain Health Initiative. She can be contacted at* dianeh@newark.rutgers.edu.

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Research in Social, Economic and Environmental Equity (RISE^3)

By Tiziana C. Dearing, Ruth McRoy, and Tess Mulrean

A collaborative initiative supports research and teaching at the intersection of race, place, and poverty.

Research in Social, Economic and Environmental Equity (RISE^3) was initiated to "reframe challenges and resolve problems around social, economic, and environmental equity in ways that impact local outcomes, while generating knowledge and policy of national or global significance." It is a dynamic effort led by faculty from multiple disciplines at the Boston College School of Social Work. The collaboration supports research and teaching at the intersection of race, place, and poverty.

RISE^3 is committed to the process and the impact of its work. Therefore, RISE^3 strives to conduct empirical studies in close connection with the communities that may be most affected by the problem or issue being examined. RISE^3 strives, wherever possible, to be physically present in marginalized neighborhoods or with marginalized populations; to actively include vulnerable populations in study design, in research processes, and in the distribution of findings; and to use the findings' impacts on people at the margins to measure research success. These are difficult commitments that require building new research strategies and metrics. RISE^3 is trying to implement this model as it proceeds in its work, and welcomes a community of practice striving for the same.

The Intersection of Race, Place, and Poverty

Social scientists understand that the intersection of distinctive demographic factors such as race, gender, or income affect outcomes for those who experience this intersectionality (Moradi and Grzanka, 2017). RISE^3's work recognizes the specific intersectionality of race, place, and poverty upon outcomes ranging from economic well-being to health, to quality of social connections (Tung et al., 2017; Putnam, 2015), and to disproportionate environmental impact (Teixeira and Krings, 2015). Regarding race, scientists, including geneticists, biologists, and social scientists, generally agree that race as a biological construct is an obsolete conceptualization and lacks empirical support.

→**ABSTRACT** Research in Social, Economic and Environmental Equity (RISE^3) is a collaborative initiative at the Boston College School of Social Work. Led by faculty from multiple disciplines, the initiative seeks to "reframe challenges and resolve problems around social, economic, and environmental equity in ways that impact local outcomes, while generating knowledge and policy ideas of national or global significance." RISE^3 engages in research, convenes scholars and practitioners, and supports teaching and student interactions that raise awareness of the intersection and impact of race, place, and poverty.
| **key words**: *social equity, economic equity, environmental equity, race, place, poverty*

Contemporary social scientists challenge genetic and biological notions of race by arguing that people make attributions about groups based on stereotypes and prejudices that are tied to physical traits (Winant, 2000; Omi and Winant, 1994). Nevertheless, *race matters*. Implicit and explicit images, beliefs, and biases are attached to racial categories that form the foundation and reason for unequal treatment (Takeuchi and Gage, 2003).

Images, beliefs, and biases that are attached to racial categories form the foundation and reason for unequal treatment.

Poverty is a persistent and robust correlate of a host of different social, political, and economic outcomes. It is frequently identified as the causal engine that directs inequalities in society. For example, children who reside in poor neighborhoods are more likely to have physical and mental health symptoms, experience social developmental delays, live in unsafe neighborhoods, perform poorly in schools, and die prematurely. Even more striking, in 2015 in the United States, 21 percent of children lived in poverty, but the child poverty rate for African Americans and Hispanics was 32 percent and 31 percent, respectively (Annie E. Casey Foundation, 2017). Given wage stagnation and growing income inequality in the United States (Chetty et al., 2017), *poverty still matters*.

Debate exists over which factor—poverty or race—is more important in explaining social, political, economic, and health outcomes. See, for example, findings associated with the racial and income achievement gaps in primary school education (Reardon, 2011). RISE^3 asserts that one way to move toward common ground is, as Gieryn (2000) does, to contextualize race and poverty around "place." Places, as defined here, create, exacerbate, maintain, or reduce social advantages and disadvantages (Stoll, 2008; Charles, 2003; Habraken, 2000; Gieryn, 2000). *Place matters*, especially as it concerns race and poverty.

While other academic institutions focus on some combination of race, poverty, and place, RISE^3's founders saw an opportunity to make new contributions, for three reasons. First, consider the extent to which a child's ZIP code is a powerful predictor of future mobility and status (Popkin, Acs, and Smith, 2009). Boston College is situated—geographically and with its networks—proximal to a handful of ZIP codes that, for Boston, have proven particularly pernicious. The Roxbury-Dorchester-Mattapan corridor, for example, has the highest concentration of people of color, with the highest child poverty rate and among the lowest levels of adult educational attainment in the city (Kahn and Martin, 2011).

Second, Greater Boston is home to a number of innovations in place-based and anti-poverty work, such as UTEC (formerly the United Teen Equality Center) in Lowell, and the nationally known Dudley Streets Neighborhood Initiative in Boston's Dudley-Newmarket area. RISE^3 faculty and other Boston College faculty have relationships with these and a wide range of other Massachusetts nonprofits that serve low-income, predominantly minority communities.

Third, the intersection of race, place, and poverty poses contemporary challenges that call for a recommitment to a core social justice value—the dignity of every person. RISE^3 is situated within Boston College, a Catholic, Jesuit institution with a strong history of high-quality secular thought, creating the potential for translational work in social science and human dignity that can affect policy and practice.

Examples of RISE^3 Research and Programs

RISE^3 is a young initiative, with team members who affiliate for specific projects. The range of work to date includes conducting research using national data sets; convening on public policy issues such as childcare and transportation; edit-

ing a special issue of the *Du Bois Review: Social Science Research on Race* on *Race and Environmental Equity* (Takeuchi et al., 2016); and holding a week-long seminar for young scholars of color working on RISE³-related research.

'A child's ZIP code is a powerful predictor of future mobility and status.'

In February 2016, the Obama Administration's Office of Science and Technology Policy (OSTP) launched an initiative to integrate and make publicly available a large number of federal data sets, in the belief that an "open data" approach would encourage communities, organizations, and businesses to use the data to help vulnerable families and neighborhoods improve their lives. OSTP invited RISE³ to become its first academic research collaborator on the initiative. With funding from Boston College, RISE³ launched The Opportunity Project.

In spring 2017, RISE³ released two reports using multiple federal data sets. Their focus was on the intersection of race–ethnicity and income on access to basic tools of opportunity. The goal was to determine whether and how the interplay of these demographic factors might affect access to, and use of, transportation and childcare, specifically. The first report produced was called *Are We There Yet? Race, Poverty and Equity in Neighborhood Transportation* (Dearing, Hawkins, and Takeuchi, 2017). The report examined the intersection of race–ethnicity and income, as data were not available to examine geography. The study revealed that income levels affect how long it takes to get to work, as does race–ethnicity—if one is of low income. Use of public transportation is generally associated with race–ethnicity, and among families using public transportation, lower-income families are more likely to use the bus.

The second report, *Race and Income Equity in Childcare: Examining Time, Costs and Parental Work Hours* (Hawkins, Dearing, and Takeuchi, 2017), primarily focused on the impact of time and money on childcare and childcare options. The study found that lower-income families and families of color spend more time transporting children to and from childcare. African American and Hispanic households spend a larger proportion of their income on childcare than white households, and low-income children were twice as likely to be in childcare during non-standard hours.

Overall, the two reports demonstrated that race–ethnicity and income each had an impact on one's access to and use of transportation and childcare, and the proportion of income spent on each. These studies represent only a sampling of the work done by RISE³ collaborators.

RISE³'s initiatives have begun to show practical impact. For example, of the eight young scholars who attended our week-long research seminar in 2015, five are now assistant professors and two are in post-doctoral fellowships. Further, several nonprofit organizations in attendance at the release of the transportation and childcare reports were able to use the reports' data to support their efforts to change state-level public assistance policies.

'African American and Hispanic households spend a larger proportion of their income on childcare.'

What's Next for RISE³?

In the 2018 academic year, RISE³ will host a series of public symposia that match scholars with community experts on topics related to outcomes across social, economic, and environmental equity. After each symposium, the RISE³ collaborators will host a private dinner for the panelists with doctoral fellows—chosen across academic disciplines and through an application process—to provide guidance to the students on their program of research. Pos-

sible topics for the four symposia include environment and health outcomes; child welfare; criminal justice; immigration; the racial wealth gap; and race, protest, and freedom of speech, among others.

In addition to the symposia, RISE^3 collaborators are engaged in ongoing research. Three faculty and several doctoral students are conducting a program evaluation of the St. Peter's Teen Center, an organization supporting Cape Verdean youth run by Catholic Charities of the Archdiocese of Boston. As noted before, collaborators come in and out of the RISE^3 "universe" based on current work and interests. This allows for dynamic growth, and the ability to take advantage of new research opportunities, when and where they arise, that support vulnerable communities.

Tiziana C. Dearing, M.P.P., is professor for Macro Practice at the Boston College School of Social Work, in Chestnut Hill, Massachusetts. She can be contacted at dearing@bc.edu. *Ruth McRoy, M.S.W., Ph.D., is the Donahue and DiFelice Endowed Professor of Social Work, at the Boston College School of Social Work. She may be contacted at* mcroy@bc.edu. *Tess Mulrean is an M.S.W. candidate for 2018, at the Boston College School of Social Work.*

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