

Socioeconomic Status and Health Disparities in the United States

Health disparities are defined by the U.S. Department of Health and Human Services as the differences in health outcomes associated with social, economic, and environmental disadvantage (Mio et al., 2020, p. 266). Health disparities often affect marginalized groups, or people who are disadvantaged because of their socioeconomic status (SES), and do so in the form of food insecurity and food deserts (Mio et al., 2020, p. 263).

Food insecurity is defined by the U.S. Department of Agriculture as households that are unable to get access to adequate food for at least one member of the household because of insufficient resources (Coleman-Jensen et al., 2020). According to a 2020 report, over 35 million Americans live in food-insecure households, and 35% of people under the federal poverty line are food insecure compared with 5% of those above the poverty line (Coleman-Jensen et al., 2020). This report demonstrates that SES impacts the likelihood of a person being classified as food insecure.

Food insecurity can lead to disparities in health, especially in *food deserts*, which are low-income areas where residents have limited access to healthy foods (Liese et al., 2017). A study by Testa et al. (2020) analyzed how food deserts impact the cardiovascular health of young adults and found a statistically significant positive association between residence in a food desert and cardiovascular health risk. Poor cardiovascular health can lead to a multitude of health problems including heart attack, heart failure, and stroke (Testa et al., 2020). The association between food deserts and poor cardiovascular health was found to be partially mediated by area and personal SES—factors that had been rendered null in previous studies (Testa et al., 2020). These findings support the claim that lower SES is related to a greater risk of cardiovascular health problems.

Cardiovascular health is not the only health area affected by SES; body mass index (BMI) and obesity risk are impacted as well. A study by Dubowitz et al. (2012) on food environment, neighborhood SES, BMI, and blood pressure in women found that as neighborhood SES

increased from the 10th to the 90th percentile, BMI decreased from 29.86 to 28.60. This may not seem like a significant amount of change, but as the authors pointed out, on a 5.5 ft (167.64 cm) woman who weighs 177 pounds, this is a difference of 7 to 8 pounds (Dubowitz et al., 2012). That change in weight can be the difference between being classified as healthy versus overweight. The study also found a positive association between fast food availability and BMI. This study illustrates not only that SES affects the BMI and subsequent health status of women but that the types of food available affect food choice and BMI.

This topic was further researched by Cantor et al. (2020), who examined the Supplemental Nutrition Assistance Program (SNAP), the largest federal domestic food and nutrition assistance program in the United States. SNAP, which many associate with food stamps, is not accepted everywhere, and smaller retailers that accept SNAP benefits have often been found to stock fewer healthy items (Cantor et al., 2020). Cantor et al. were in the unique position of being able to compare how food security and the quality of food intake changed between two groups of residents living in food deserts. Once a grocery store was introduced to the neighborhood of one of the groups, food security for those residents significantly improved (Cantor et al., 2020). There was also an improvement in their nutritional intake, specifically, a 4.25% decrease in calories from solid fats, alcohol, and added sugars in their diets.

Although the Cantor et al. (2020) study and others showed an association between grocery store access and improved BMI and cardiovascular health, the mere presence of grocery stores is not always enough to improve health, especially in low SES communities (Liese et al., 2017). In a study on food acquisition in relation to BMI among low-income residents, Liese et al. (2017) found that the more a person considered lack of access to healthy food to be a problem, the higher their BMI—an association that was independent of food shopping behaviors and food environment characteristics. *Allostatic stress*, or the impact of chronic stress on the body, as well as attitudinal problems can contribute to higher BMI and worse cardiovascular health (Mio et al.,

2020, p. 278). There are two possible reasons for this: the health belief model and contemplative practices.

The health belief model centers on the claim that people's perceptions of the health threats they are facing impact their health behavior and the effectiveness of health practices at reducing health problems (Mio et al., 2020). Greater research into this model may help with the development of strategies to reduce stress and negative thoughts about food acquisition.

Contemplative practices are another possible solution. All participants in the studies cited in this paper were adults, who may have had more difficulty learning new ways of thinking about the world compared with adolescents and children. One way to change patterns of thinking is to introduce the concept of transformative learning. *Transformative learning* involves learning new ways of seeing the world and unlearning previously held ideas (Le Pertel et al., 2020). Transformative learning can occur in many ways, but individuals' self-awareness and attentional focus on what is happening in the present moment are the most important factors needed for it to occur. Together, these two factors can create the "optimal state of awareness for learning in action and learning from experience" (Le Pertel et al., 2020, p. 811).

Relearning thinking patterns may be difficult, but it is a possible solution to the problem of high BMI and cardiovascular health risk. This goes together with meditation as well. Meditation is shown to reduce cardiovascular risk and blood pressure and to prevent a second heart attack or stroke (Le Pertel et al., 2020). As studies have demonstrated, cardiovascular risk is a major problem. Because meditation can be done for free anywhere, it is an affordable way to potentially reduce the risk of cardiovascular health problems for people who continue to lack wide access to food.

Although there are obvious disparities in health based on SES in the United States, simple solutions such as behaviors focused on the health belief model and contemplative practices may help reduce such health risks as high BMI and cardiovascular problems until larger societal changes can be made.

References

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