Social Inequalities in Health: The Role of Tobacco Control

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We Are Not the Healthiest

- U.S. ranks near the bottom of industrialized countries on health, and we are losing ground
- 1980 = 11th on Life Expectancy
- 2006 = 33rd , tied with Slovenia
- U.S. Ranked behind Cyprus, United Arab Emirates, South Korea, Costa Rica and Portugal
- And it is not just the minorities doing badly!
- In 2006, White America would be = 30th
- In 2006, Black America would be 58th

A Larger Context for Disparities

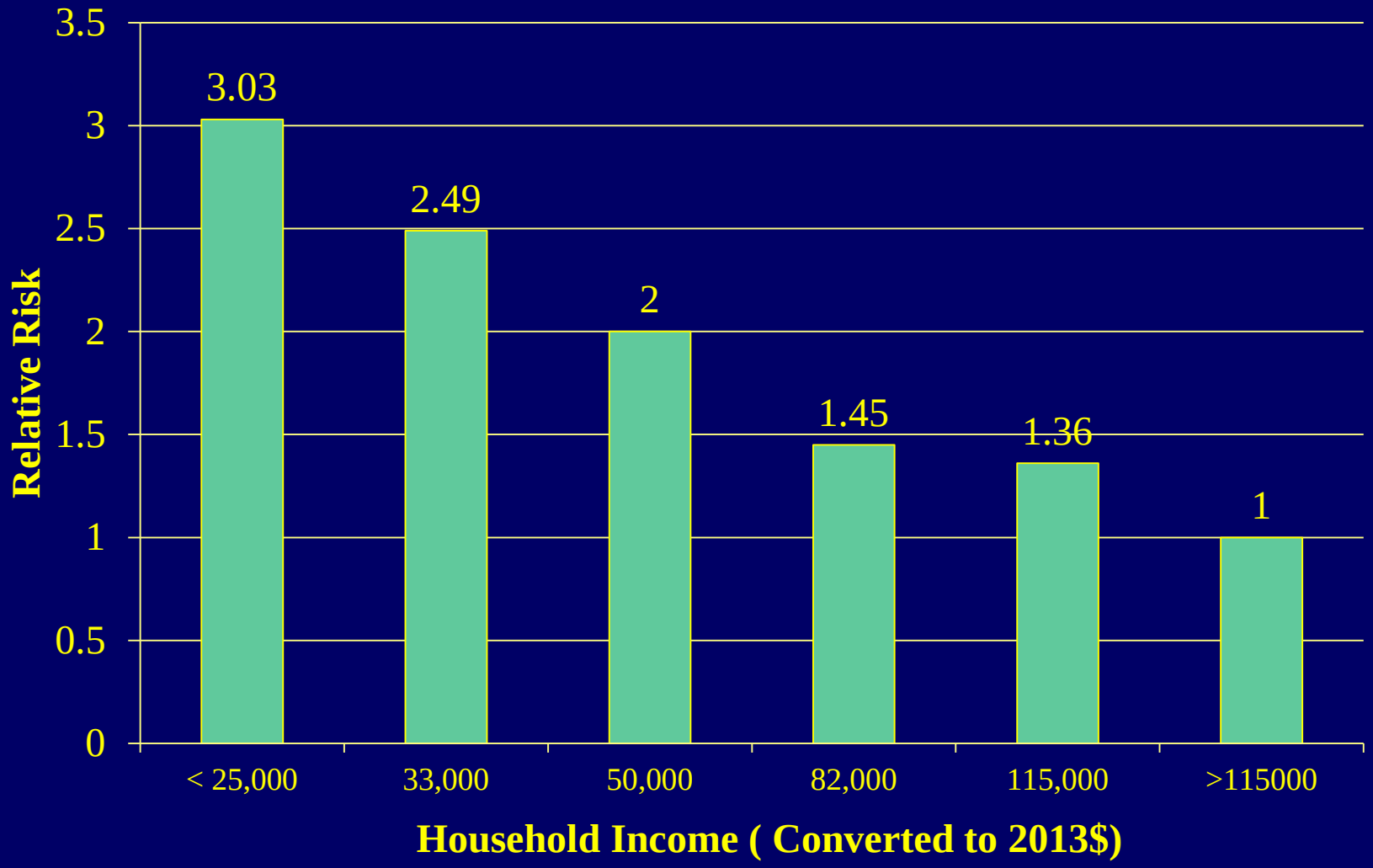
A 2013 IOM report indicated that the poorer health of Americans compared to people in other rich nations

- is evident at all ages, from birth to 75
- even the most advantaged Americans (high SES, healthy behaviors and health insurance) had worse health than their peers in other affluent countries

All Americans are far less healthy than we could, and should be

Woolf & Aron, *U.S. Health in International Perspective*, 2013

Relative Risks of All-Cause Mortality by Household Income Level: U.S. Panel Study of Income Dynamics



P. McDonough, Duncan, Williams, & House, AJPH, 1997

There are Large Racial/Ethnic Differences in SES

Median Household Income and Race, 2013

Racial Differences in Income are Substantial:

1 dollar	1.15 dollar	70 cents	59 cents
			
White	**Asian**	**Hispanic**	**Black**

U.S. Census Bureau (DeNavas – Walt and Proctor 2014)

Median Wealth and Race, 2011

For every dollar of wealth that Whites have,

Asians have 81 cents

Blacks have only 6 cents

Latinos have only 7 cents

U.S. Census Bureau, 2014

Race and Health: Two Patterns

- Racial groups with a long history characterized by economic exploitation, social stigmatization, and geographic marginalization have markedly elevated levels of poor health outcomes:
  - -- Blacks or African Americans
  - -- American Indians and Alaskan Natives
  - -- Native Hawaiians and other Pacific Islanders
- Immigrant groups tend to have better health than the U.S. average, but their health tends to worsen over time and across subsequent generations:
  - -- Asians
  - -- Hispanics or Latinos

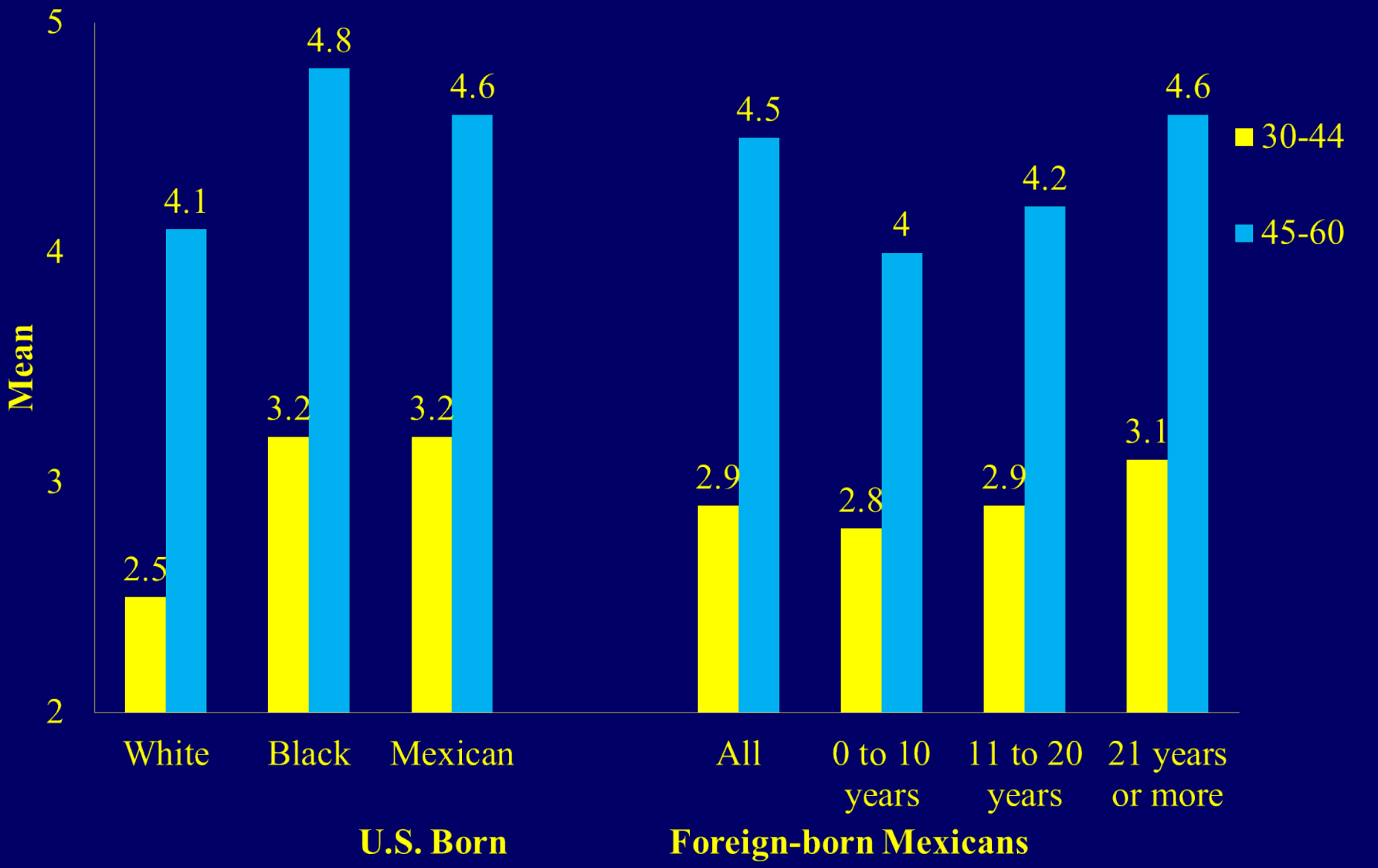
Allostatic Load

10 biomarkers	High-risk thresholds *
1.Systolic blood pressure	127 mm HG
2.Diastolic blood pressure	80 mm HG
3.Body Mass Index	30.9
4.Glycated hemoglobin	5.4%
5.Albumin	4.2 g/dL
6.Creatinine clearance	66 mg/dL
7.Triglycerides	168 mg/dL
8.C-reactive protein	0.41 mg/dL
9.Homocysteine	9 μmol/L
10.Total cholesterol	225

* = < 25th percentile for creatinine clearance; >75th percentile for others

Geronimus, et al., AJPH, 2006

Mean Allostatic Load, by Race & Nativity



Kaestner, et al., Social Science Quarterly, 2009

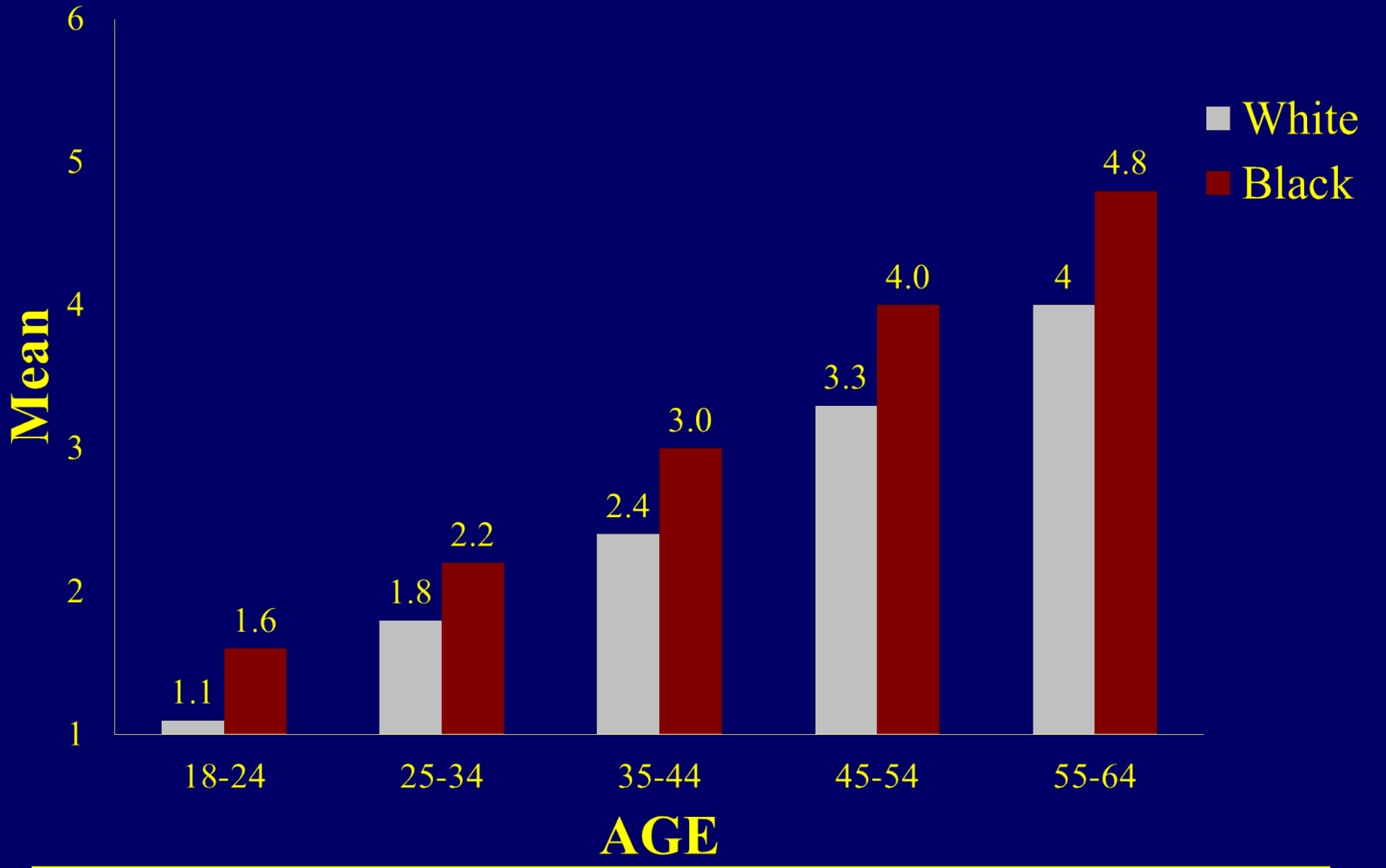
Research & Policy Challenge

What interventions, if any, can reverse the downward health trajectory of immigrants with length of stay in the U.S.?

Massive Loss of Lives

Levine et al., 2001

Mean Score on Allostatic Load by Age



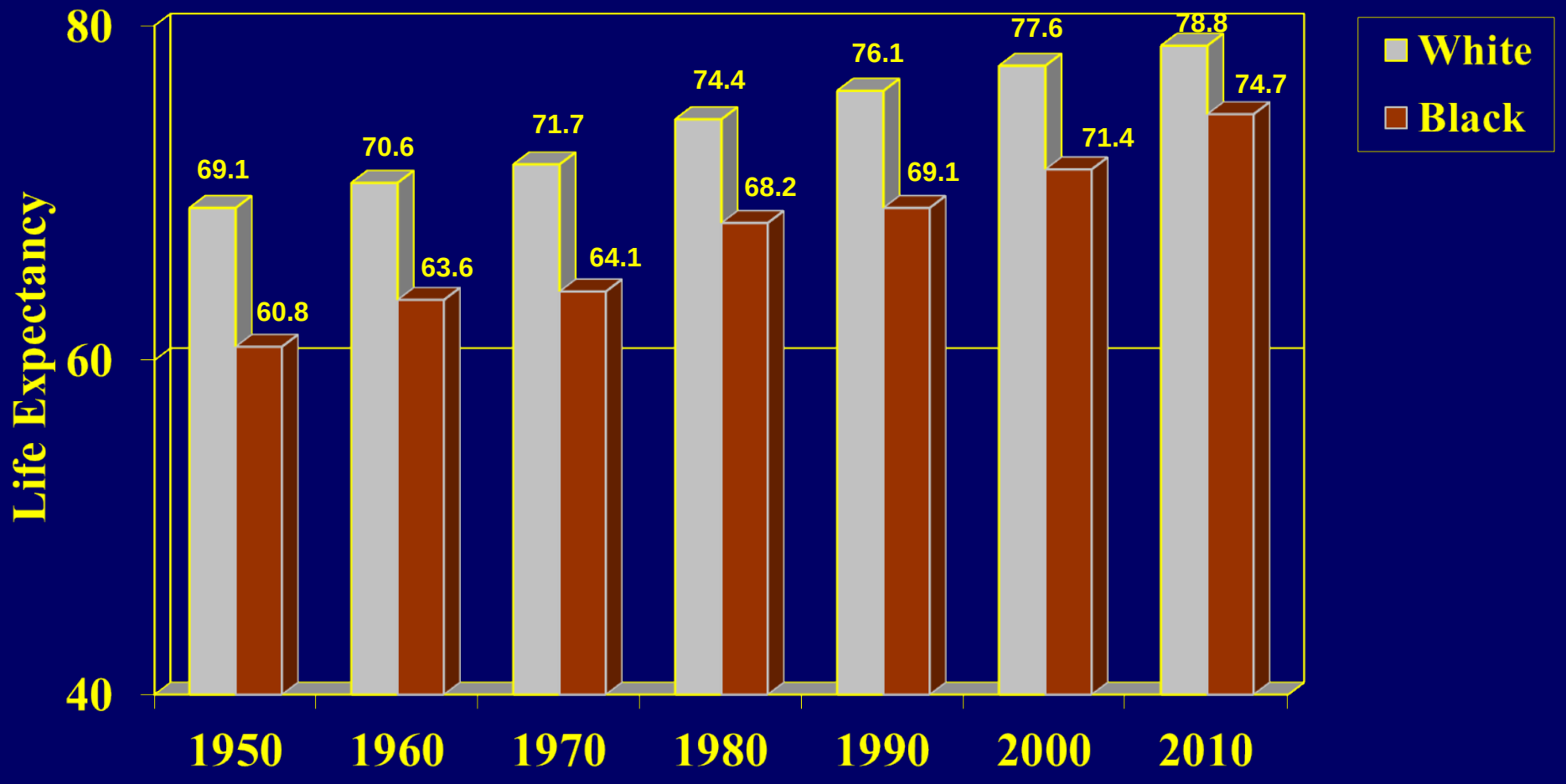
Geronimus, et al., AJPH, 2006

Biological Weathering

- Chronological age captures duration of exposure to risks for groups living in adverse living conditions
- U.S. blacks are experiencing greater physiological wear and tear, and are aging, biologically, more rapidly than whites
- It is driven by the cumulative impact of repeated exposures to psychological, social, physical and chemical stressors in their residential, occupational and other environments, and coping with these stressors
- Compared to whites, blacks experience higher levels of stressors, greater clustering of stressors, and probably greater duration and intensity of stressors

Geronimus et al, Hum Nature, 2010 ; Sternthal et al 2011

Life Expectancy Lags, 1950-2010



Source: NCHS, Health United States, 2013

Racial/Ethnic Disparities in Health:

More than just Socioeconomic Status

Life Expectancy At Age 25

Group	White	Black	Difference
All	53.4	48.4	5.0

Murphy, NVSS 2000

Life Expectancy At Age 25

Group	White	Black	Difference
All	53.4	48.4	5.0
Education			
a. 0-12 Years	50.1		
b. 12 Years	54.1		
c. Some College	55.2		
d. College Grad	56.5		
Difference	6.4		

Murphy, NVSS 2000; Braveman et al. AJPH; 2010, NLMS 1988-1998

Life Expectancy At Age 25

Group	White	Black	Difference
All	53.4	48.4	5.0
Education			
a. 0-12 Years	50.1	47.0	
b. 12 Years	54.1	49.9	
c. Some College	55.2	50.9	
d. College Grad	56.5	52.3	
Difference	6.4	5.3	

Murphy, NVSS 2000; Braveman et al. AJPH; 2010, NLMS 1988-1998

Life Expectancy At Age 25

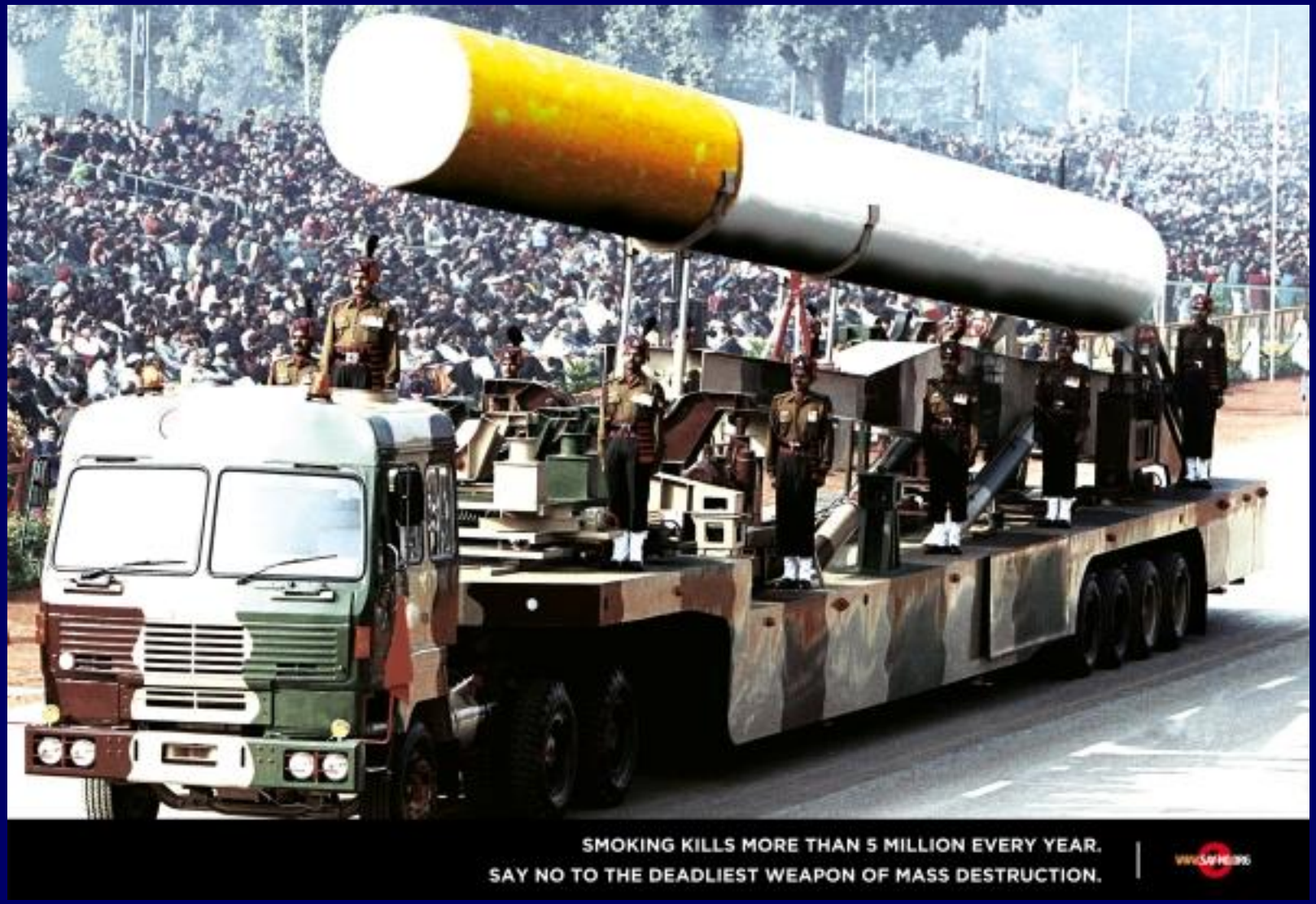
Group	White	Black	Difference
All	53.4	48.4	5.0
Education			
a. 0-12 Years	50.1	47.0	3.1
b. 12 Years	54.1	49.9	4.2
c. Some College	55.2	50.9	4.3
d. College Grad	56.5	52.3	4.2
Difference	6.4	5.3	

Murphy, NVSS 2000; Braveman et al. AJPH; 2010, NLMS 1988-1998

Why Race Still Matters

1. Health is affected not only by current SES but by exposure to adversity over the life course.
2. All indicators of SES are non-equivalent across race. Compared to whites, blacks & Hispanics receive less income at the same levels of education, have less wealth at the equivalent income levels, and have less purchasing power (at a given income level) because of higher costs of goods and services.
3. Personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health in multiple ways.
4. Higher Exposure to multiple stressors

Tobacco: Weapon of Mass Destruction



Smoking and Health

- Worldwide 5 million die from tobacco each year
- In the US: Almost 500,00 deaths annually
- Tobacco causes 1 in 5 deaths in the US
- 21 Diseases caused by smoking … and counting
- Death rates are 2 to 3 times higher for smokers than non-smokers
- On average, smokers die more than 10 years earlier than non-smokers

Danaei et al. PLOS Med 2009; Gruer et al BMJ 2009; Carter et al, NEJM, 2015

Most Preventable Cause of Death

- Despite declines in cigarette use, smoking is still the single most preventable cause of death
- Smoking causes more deaths than overweight and obesity, high cholesterol, alcohol, and the low intake of fruits and vegetables combined
- The gap in overall mortality between smokers and non-smokers is larger than that between low and high SES groups of the same smoking status

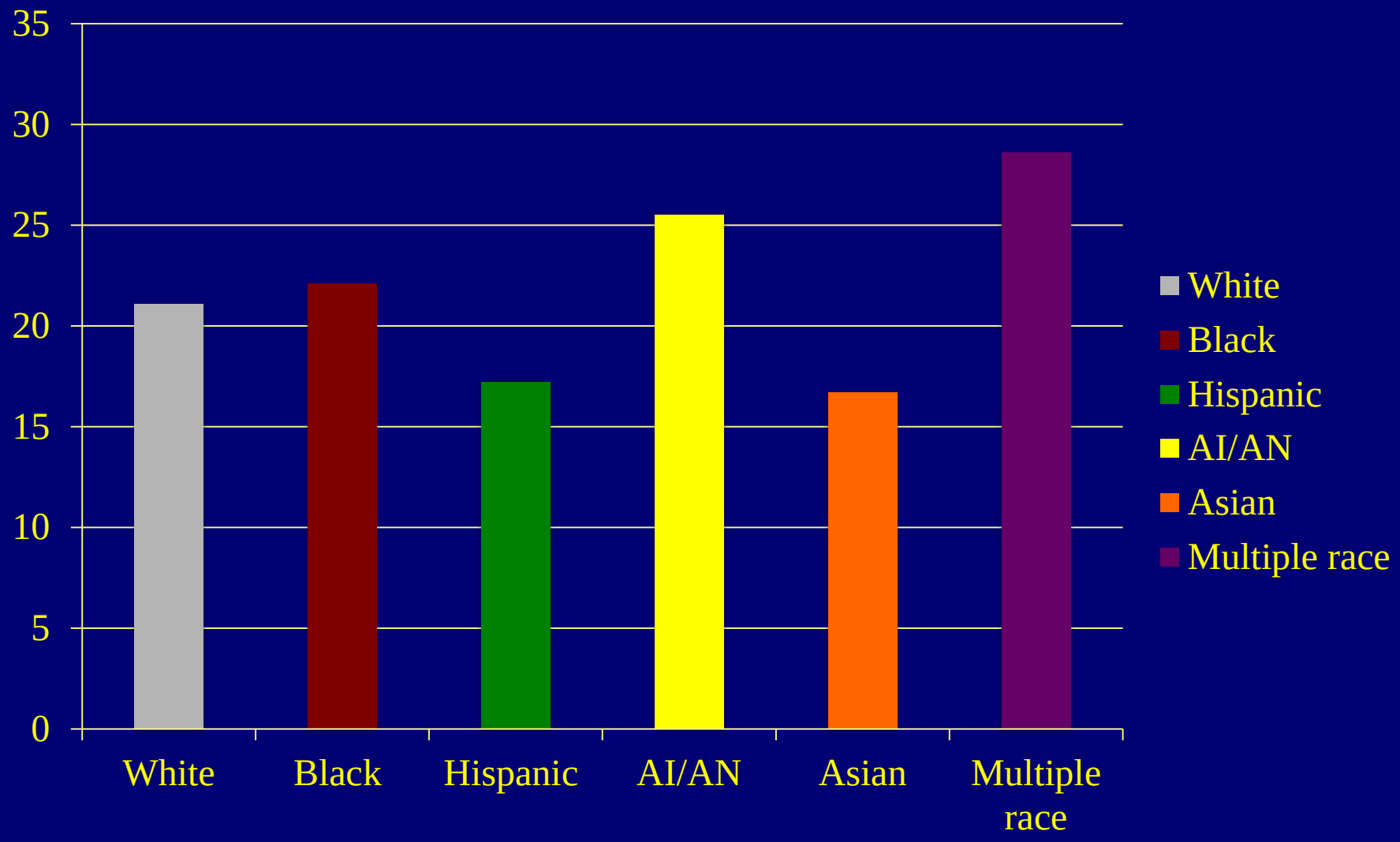
Danaei et al. PLOS Med 2009; Gruer et al BMJ 2009;

Lung Cancer

- The number one cause of cancer deaths in the US
- The number one cause of cancer deaths in the world
- Lung cancer is responsible for 80% of all deaths from tobacco-related illnesses
- Kills more Americans annually than breast, prostate, colon and pancreatic cancer combined!

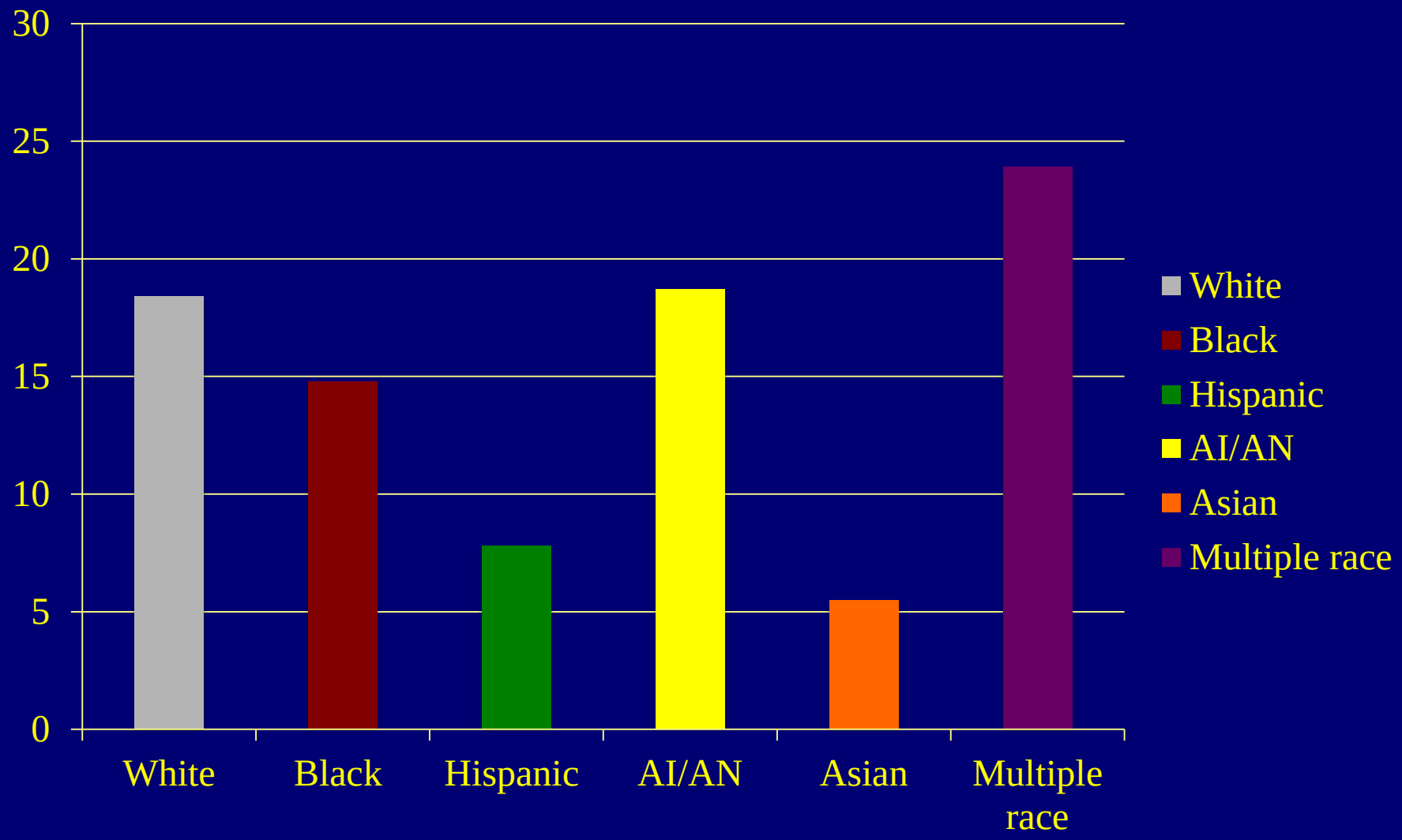
Thun et al JNCI 2006; BWH 2010; ACS Facts & Figures 2009

Race and Cigarette Smoking, Men, 2012



Source: Morbidity and Mortality Weekly Report, Vol.63/No.2

Race and Cigarette Smoking, Women, 2012



Source: Morbidity and Mortality Weekly Report, Vol.63/No.2

Lung Cancer: Racial Disparities

- Lung Cancer kills more black men and women and Hispanic men than any other cancer
- Compared to whites, Blacks have a higher incidence of lung cancer (primarily among men, especially for younger age groups)
- Blacks, Hispanics, and low SES persons have lower stage-specific survival rates than Whites
- A given level of smoking more adversely affects Blacks than Whites

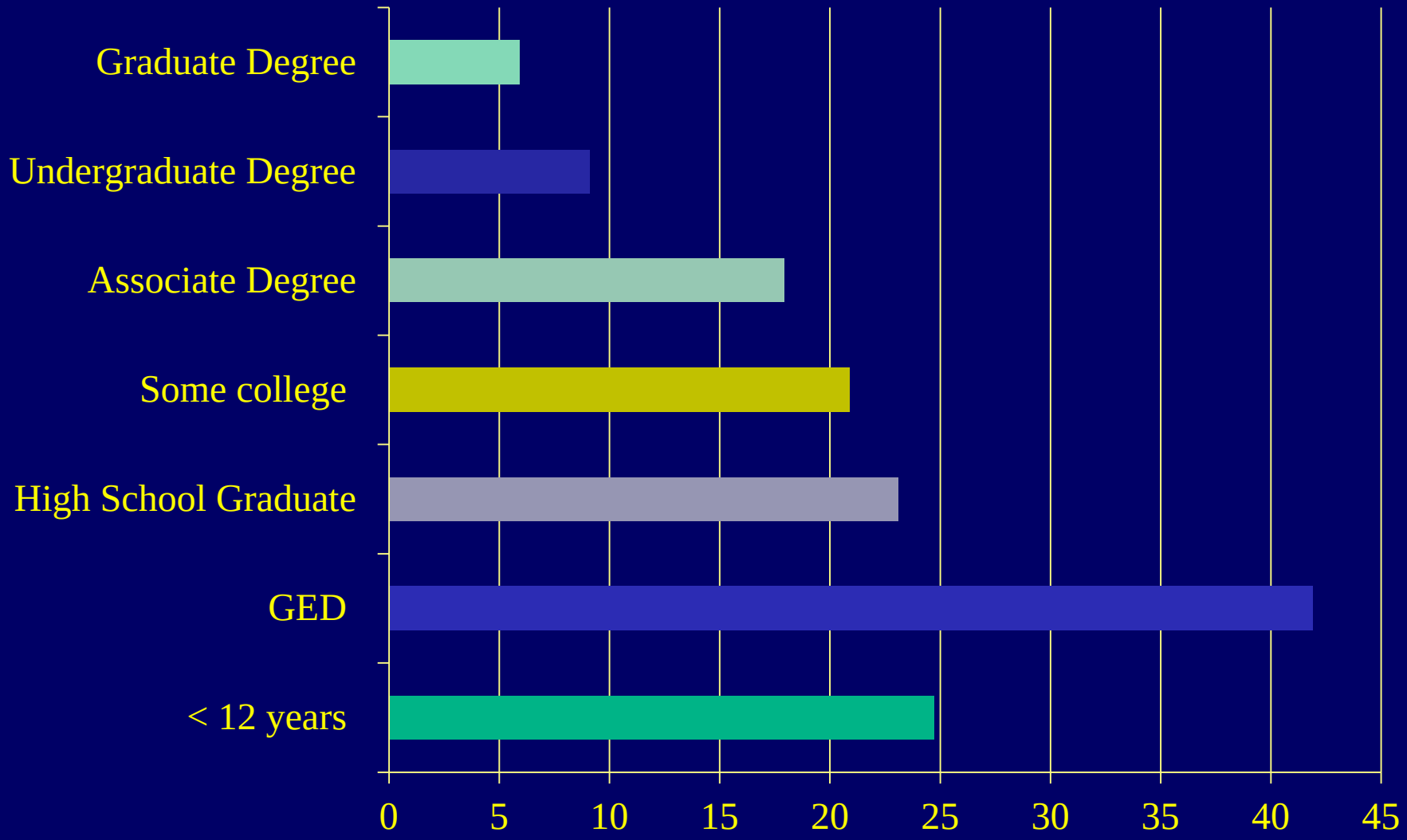
ACS, Facts & Figures 2009; Gadgeel, et al. Chest 2001; Lathan et al. J Clin. Oncol 2006 Haiman et al. NEJM 2006

Challenges for Hispanics

- Incidence and death rates for Hispanics are lower than for non-Hispanic whites
- The cancer burden for Hispanics in the U.S. is similar to that seen in their countries of origin
- With increasing time in the U.S. cancer rates increase for Hispanics
- Latinos more likely to be diagnosed with advanced stage of disease
- Hispanics have lower survival rates for most cancers

ACS; Cancer Facts & Figures for Hispanics/Latinos

Education and Cigarette Smoking, 2012



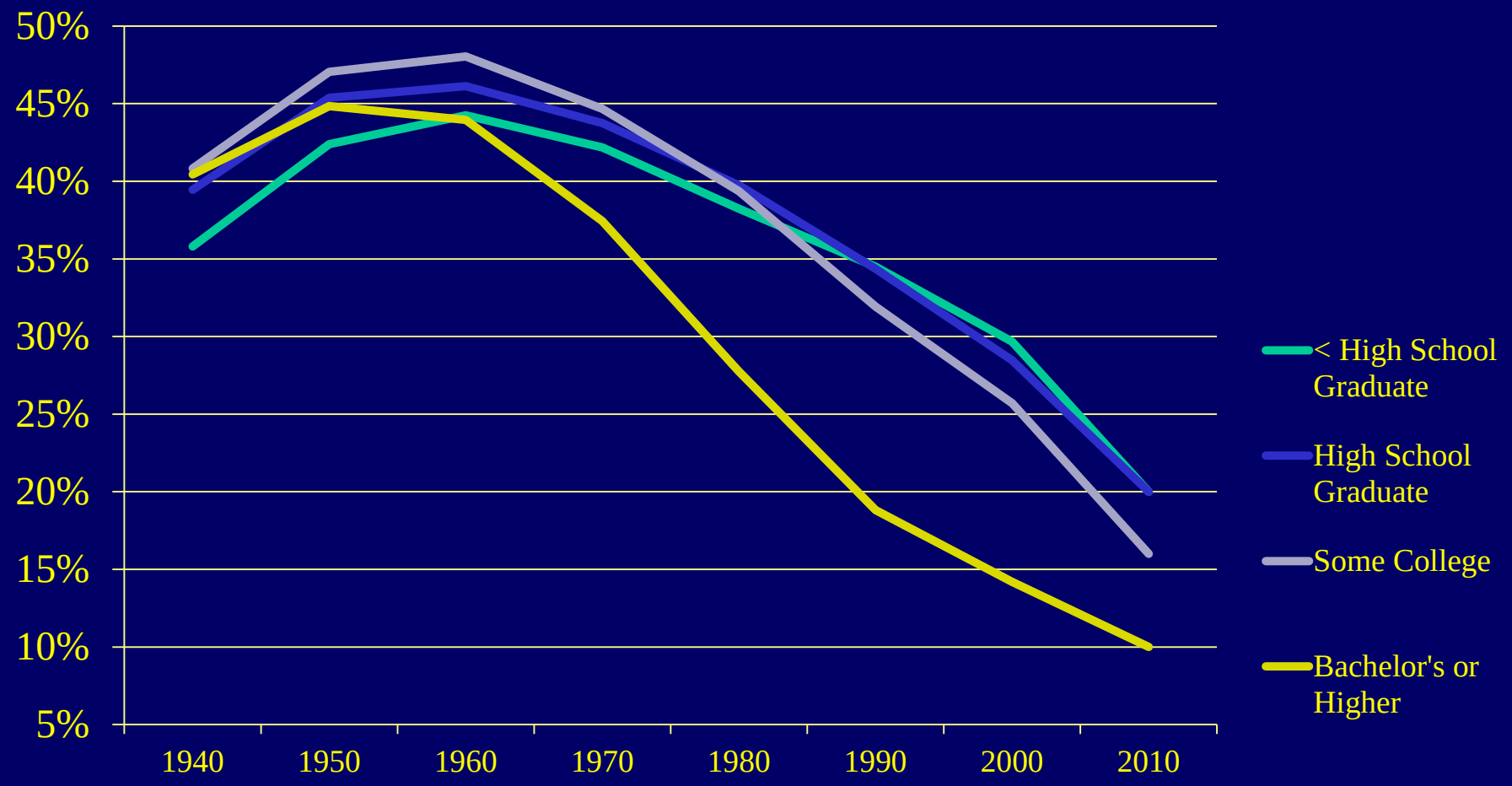
Morbidity and Mortality Weekly Report, 2014,Vol.63/No.2

SES Disparities

- Low income men and women, regardless of race and ethnicity, are more likely to be current smokers than higher income persons
- Differences in lung cancer mortality by education are markedly larger than those by race
- White men with 8 or less years of education have a lung cancer mortality rate that is 9 times higher than their peers with 17+ years of education
- Most of the decline in lung cancer mortality in recent years has occurred among highly educated

Haiman et al NEJM 2006; Ward et al CA Cancer JChin 2004; Albano et al JNCI 2007;

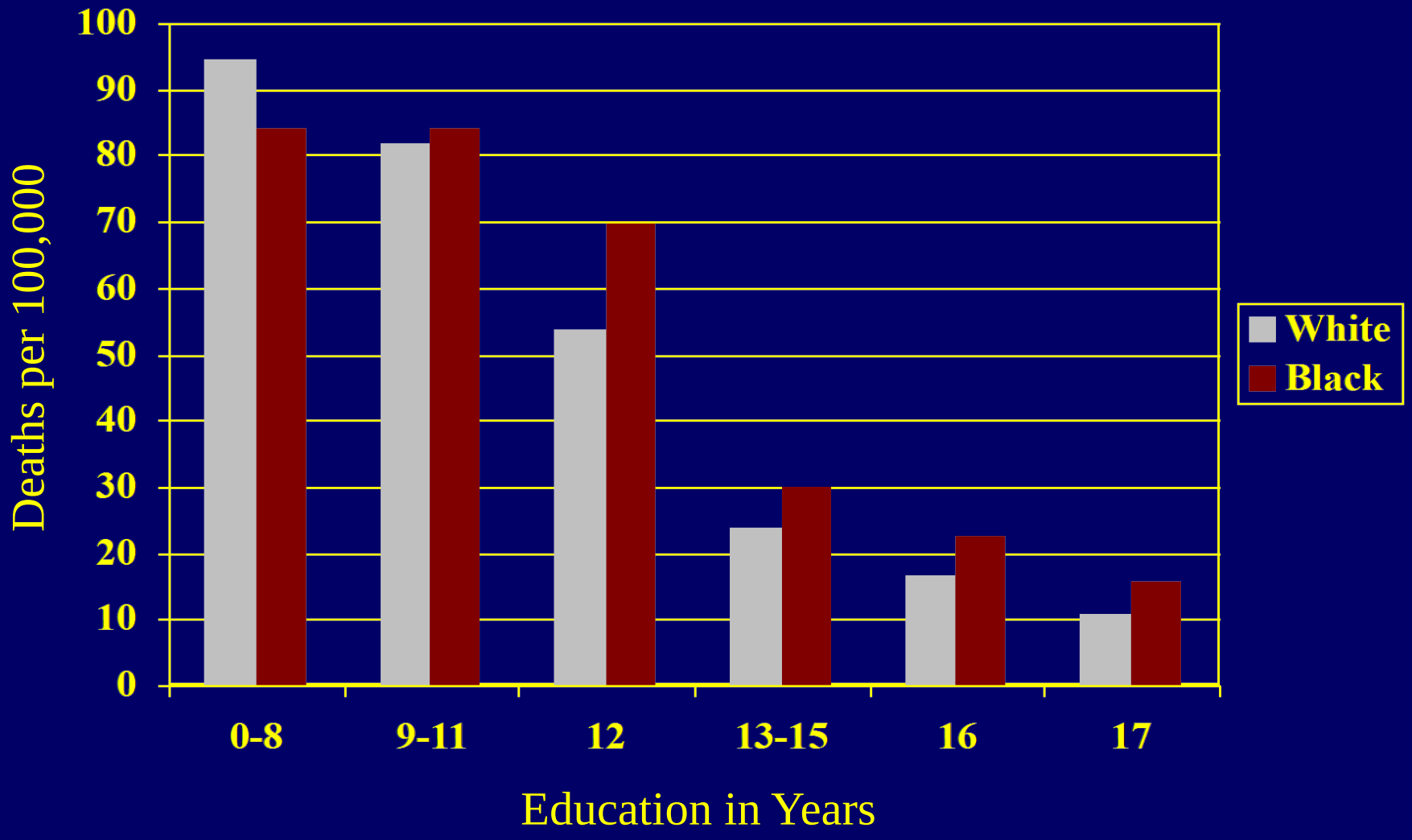
Smoking in the U.S 1960 -2010 by Education



Smoking Rates Among Individuals Ages 25 and Older, by Education Level, 1960–2010

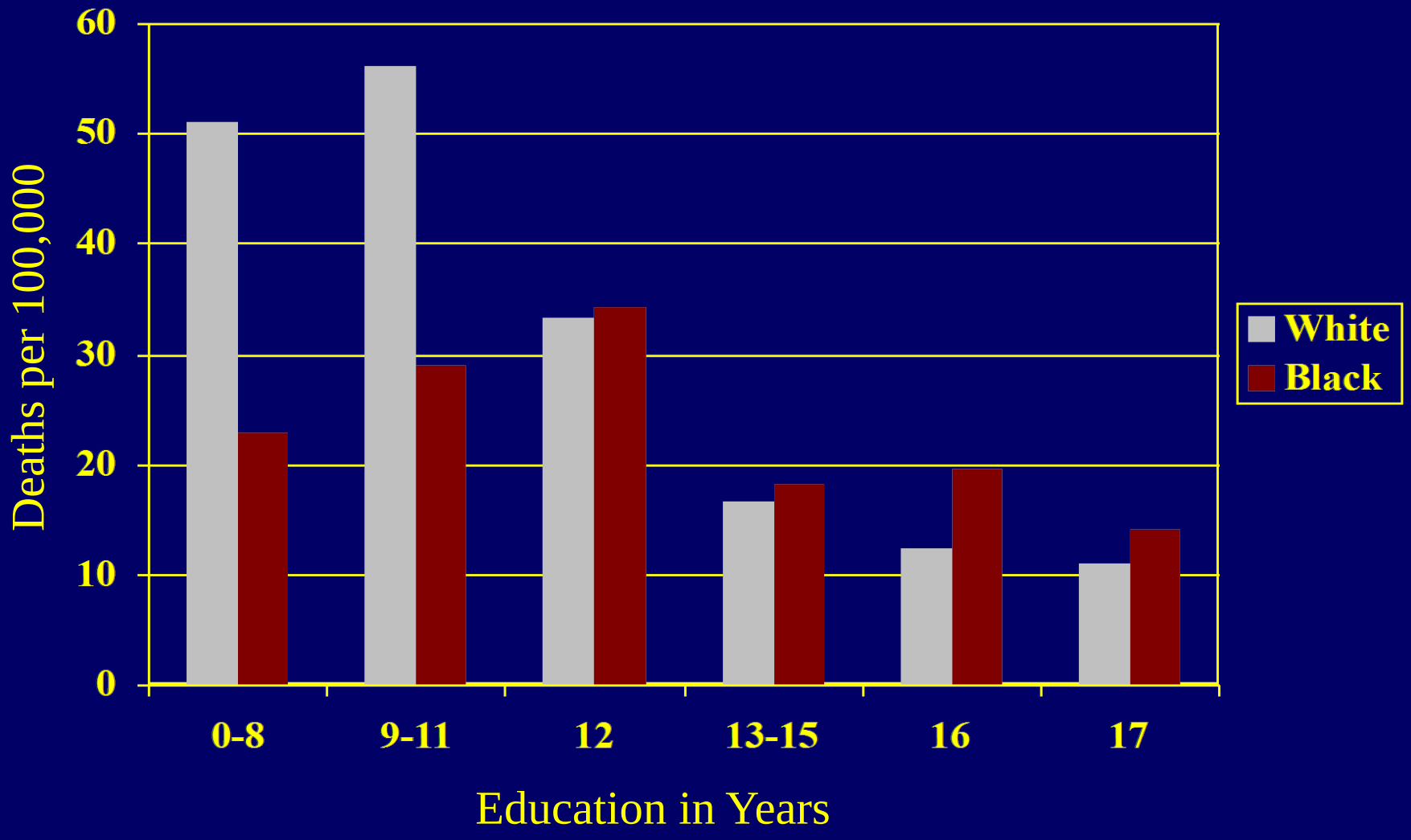
Source: DeWalque, 2004; National Center for the Health Statistics, 2009, table 61; NCHS 2014

Lung Cancer Death Rates, Men, 2001



Albano et al. 2007, JNCI

Lung Cancer Death Rates, Women, 2001



Albano et al. 2007, JNCI

Challenge of Tobacco:

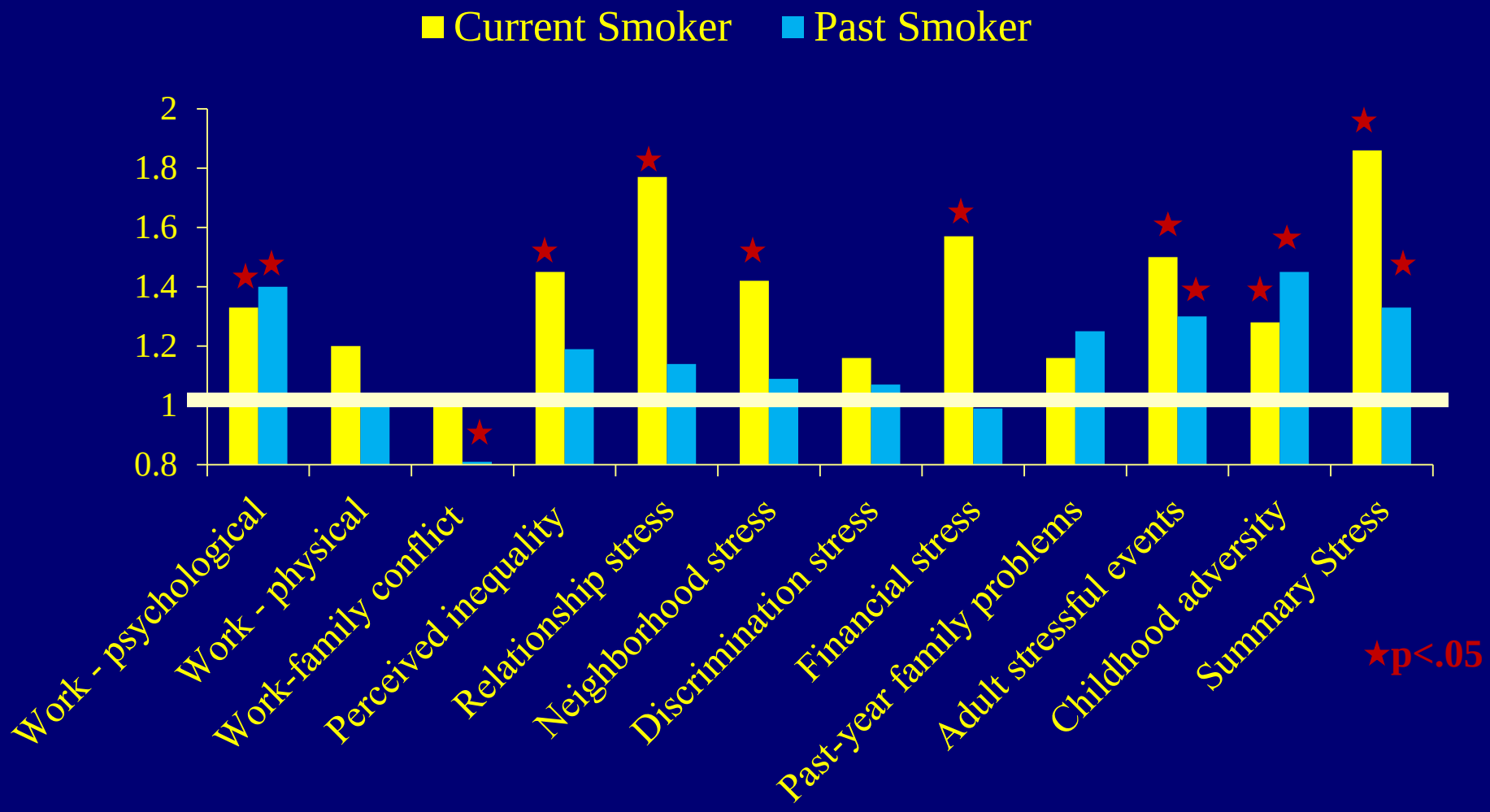
How to reduce smoking in low SES, economically marginalized and socially stigmatized populations

We need to address the underlying conditions that give rise to smoking in the first place

Psychosocial Stressors

Psychosocial Stress and Odds of Current & Previous Smoking

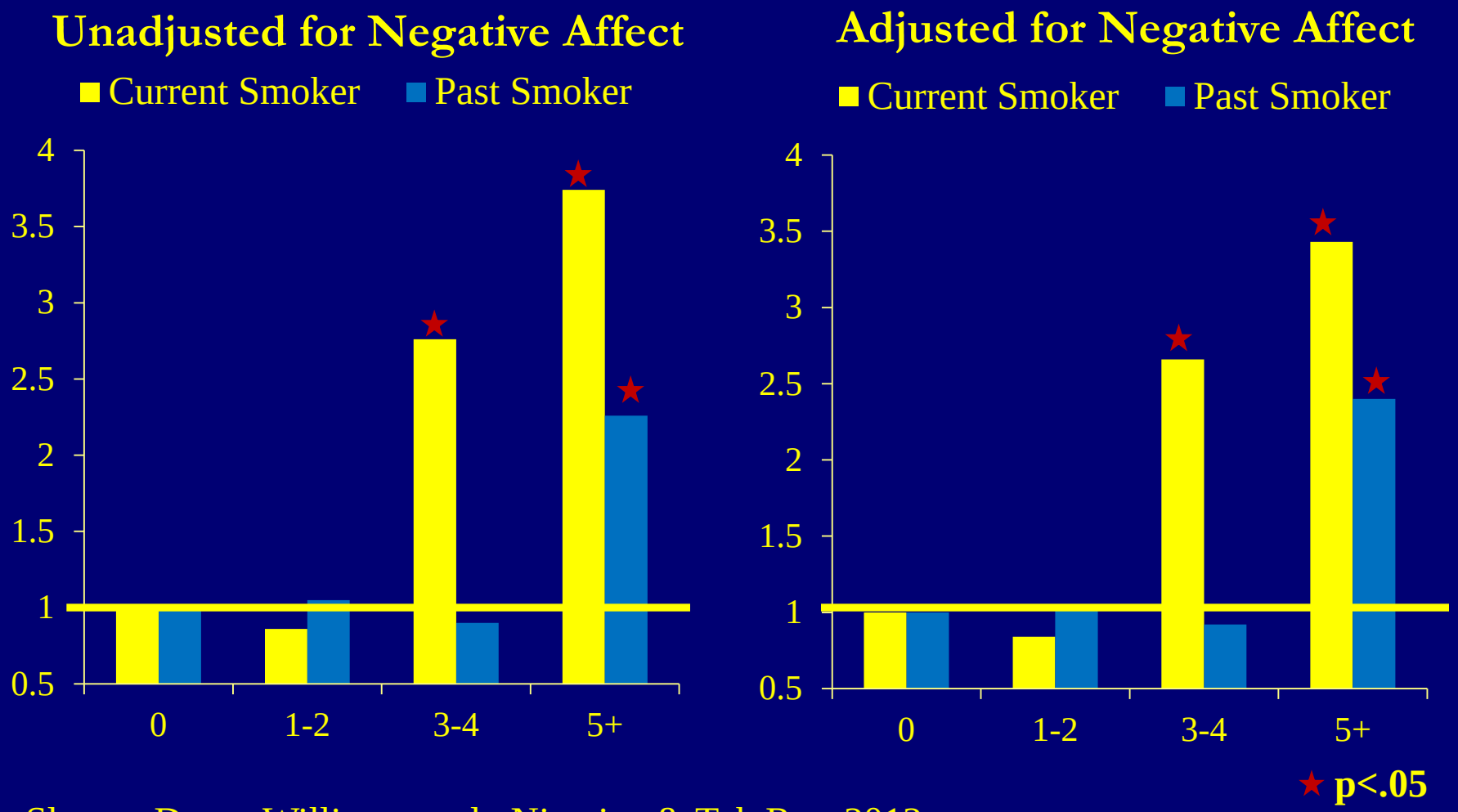
Multinomial models estimated independently; Reference Group = Never smokers



Slopen, Dutra, Williams et al., Nicotine & Tob Res, 2012;
adjusted for age, gender, education, & income.

Odds of Current and Previous Smoking By Number of Stress Domains

Reference Group = Never smokers



Slopen, Dutra, Williams et al., Nicotine & Tob Res, 2012;
adjusted for age, gender, education, & income

Stress and Quitting Smoking

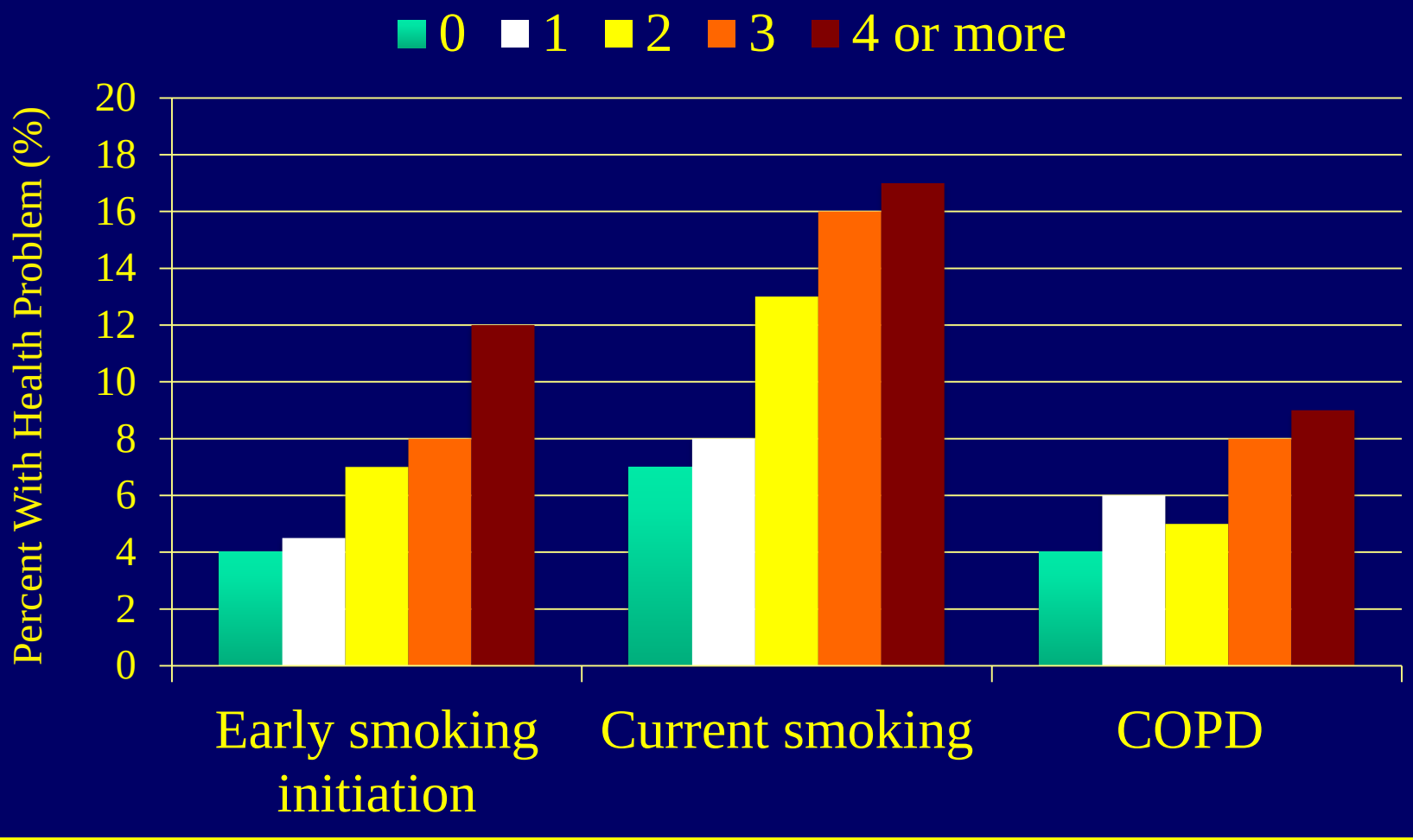
- National sample of adults followed for 9 to 10 years:
- Persons high on on 8 domains of stress (e.g., relationship, financial, work), at both interviews were more likely to be persistent smokers
- Persons persistently high on stress who tried to quit in past 10 years, were less likely to succeed
- Stress keeps people smoking & makes it harder to quit
- Creating smoke free environments requires interventions that reduce modifiable stressors, and enhance individual & community-level resources to cope with stressors

Slopen, Kontos, ……Williams, Cancer Causes & Control, 2013

Expanding our Understanding of the role of stress in Health:

-- Early Life Adversity
-- Experiences of Discrimination

ACE Score, Smoking, and Lung Disease



Anda RF, et al., (1999)

Perceived Discrimination:

Experiences of discrimination are a neglected psychosocial stressor

Chronic Stress: Every Day Discrimination

In your day-to-day life how often do the following things happen to you?

- You are treated with less courtesy than other people.
- You are treated with less respect than other people.
- You receive poorer service than other people at restaurants or stores.
- People act as if they think you are not smart.
- People act as if they are afraid of you.
- People act as if they think you are dishonest.
- People act as if they're better than you are.
- You are called names or insulted.
- You are threatened or harassed.

What do you think was the main reason for these experiences

Detroit Area Study 1995; Williams et al. 1997

Discrimination & Health: Tene Lewis

- Everyday Discrimination: positively associated with:
  - -- coronary artery calcification (Lewis et al., Psy Med, 2006)
  - -- C-reactive protein (Lewis et al., Brain Beh Immunity, 2010)
  - -- blood pressure (Lewis et al., J Gerontology: Bio Sci & Med Sci 2009)
  - -- lower birth weight (Earnshaw et al., Ann Beh Med, 2013)
  - -- cognitive impairment (Barnes et al., 2012)
  - -- poor sleep [object. & subject.] (Lewis et al, Hlth Psy, 2012)
  - -- mortality (Barnes et al., J Gerontology: Bio Sci & Med Sci, 2008).
  - -- visceral fat (Lewis et al., Am J Epidemiology, 2011)

Perceived Discrimination and Health

- Discrimination is associated with elevated risk of
  -- diabetes risk (Hemoglobin A1c)
  -- substance use (smoking, alcohol, other drugs)
  -- breast cancer incidence
  -- uterine myomas (fibroids)
  -- subclinical carotid artery disease (IMT; intima-media thickness
  -- Delays in seeking treatment, lower adherence to treatment regimes, lower rates of follow-up
- Discrimination accounts, in part, for racial/ethnic disparities in health, in U.S., and elsewhere

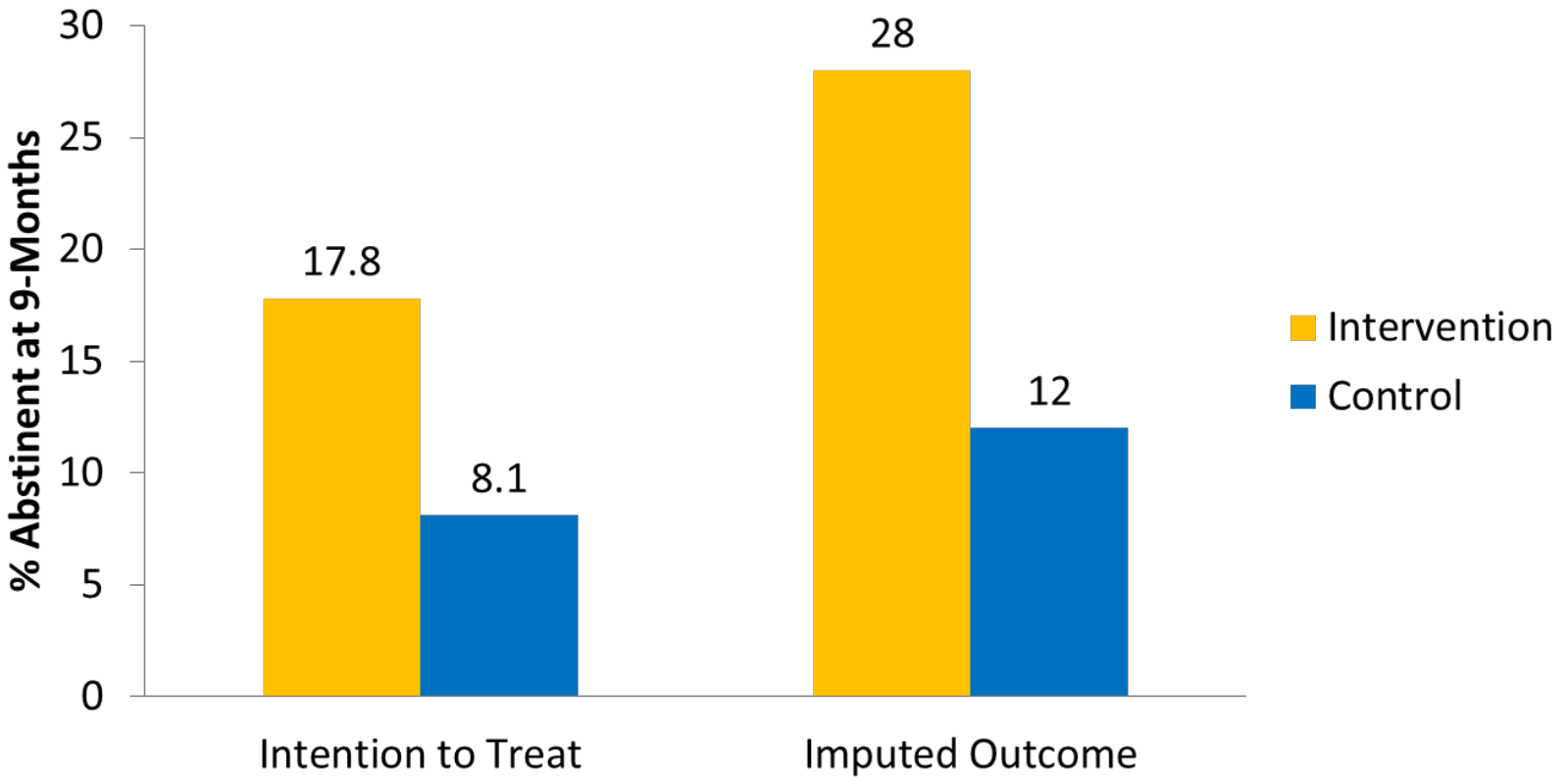
Williams & Mohammed, J Behav Med 2009

Addressing Stressors

- Outreach using (IVR) calls to low-SES/minority smokers from EHR
  - Nicotine replacement patches (NRT)
  - Phone-based counseling with tobacco treatment specialist (TTS)
  - Referrals to community resources (HealthSteps)
- Pragmatic trial
- Control patients referred to state quit line
- Outcome measure: 7-day tobacco abstinence @ 9 month follow-up

Haas, Linder, Gonzalez, ….. Williams, JAMA Internal Med, 2014

Primary Outcome: 7-day abstinence



We need to focus more on the equity impact of anti-smoking policies

Equity Impact: Tobacco Taxes

- Tobacco price increases is the intervention with the greatest potential to reduce SES gaps in smoking
- Low-income individuals are more responsive to price increases
- However, when the price of cigarettes increases, some low SES smokers may opt for lower cost or roll-your-own cigarettes
- The effectiveness of price increases my be diminishing over time as the baseline price of tobacco increases

Hill et al, Tobacco Control, 2014

Equity Impact: Smoking Bans

- Smoking restrictions (e.g. workplace) reduce tobacco including secondhand smoke exposure, and can lead to increased cessation
- Workplace restrictions have been more likely to be implemented in professional than in manual workplaces
- Some evidence that bans less likely to be enforced in disadvantaged areas and that bans could increase social isolation in older smokers
- Little clear evidence of greater benefit to low SES groups

Hill et al, Tobacco Control, 2014

Equity Impact: Media Campaigns

- Mass media campaigns against smoking or promoting quit lines tend to have similar effect by SES or greater benefit to high SES
- TV campaigns tend to have greater benefit for high SES but ads using personal testimony appear equally beneficial to all SES groups
- Internet campaigns less effective for low SES

Hill et al, Tobacco Control, 2014

The National Truth Campaign

- Developed and implemented with substantial involvement of youth
- Had a distinctive appeal to adolescents aged 12 to 17 years
- Focused on unmasking the deceptive practices and exploitative marketing strategies of the tobacco industry
- Greater effect on Blacks and Hispanics than on Whites

Farrelly et al., Am J Preventive Med, 2009

Equity Impact: Smoking Bans

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Hill et al, Tobacco Control, 2014

We need to create healthy living and working environments

Racism and Health: Mechanisms

- Institutional discrimination can restrict socioeconomic attainment and group differences in SES and health.
- Segregation can create pathogenic residential conditions.
- Discrimination can lead to reduced access to desirable goods and services.
- Internalized racism (acceptance of society's negative characterization) can adversely affect health.
- Racism can create conditions that increase exposure to traditional stressors (e.g. unemployment).
- Experiences of discrimination may be a neglected psychosocial stressor.

Residential Segregation: Example of Institutional Discrimination

How Segregation Can Affect Health

1. Segregation determines quality of education and employment opportunities.
2. Segregation can create pathogenic neighborhood and housing conditions.
3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
4. Segregation can adversely affect access to high-quality medical care.

Source: Williams & Collins , 2001

Residential Segregation and SES

A study of the effects of segregation on young African American adults found that the elimination of segregation would erase black-white differences in

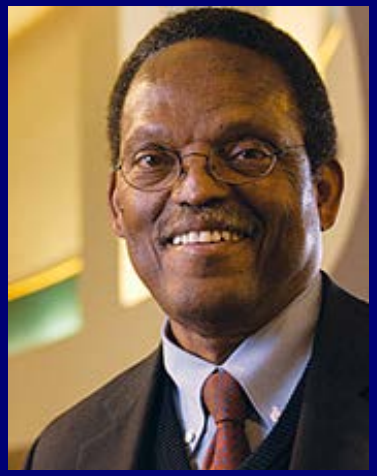
- Earnings
- High School Graduation Rate
- Unemployment

And reduce racial differences in single motherhood by two-thirds

Cutler, Glaeser & Vigdor, 1997

Racial Differences in Residential Environment

- In the 171 largest cities in the U.S., there is not even one city where whites live in equal conditions to those of blacks



- “The worst urban context in which whites reside is considerably better than the average context of black communities.” p.41

Sampson & Wilson 1995

ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

Our Neighborhood Affects Our Health

Unhealthy Community	vs	Healthy Community
Unsafe even in daylight		 Safe neighborhoods, safe schools, safe walking routes
Exposure to toxic air, hazardous waste		 Clean air and environment
No parks/areas for physical activity		 Well-equipped parks and open/spaces/organized community recreation
Limited affordable housing is run-down; linked to crime ridden neighborhoods		 High-quality mixed income housing, both owned and rental
Convenience/liquor stores, cigarettes and liquor billboards, no grocery store		 Well-stocked grocery stores offering nutritious foods

ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

Our Neighborhood Affects Our Health

Unhealthy Community		vs	Healthy Community	
Streets and sidewalks in disrepair				Clean streets that are easy to navigate
Burned-out homes, littered streets				Well-kept homes and tree-lined streets
No culturally sensitive community centers, social services or opportunities to engage with neighbors in community life				Organized multicultural community programs, social services, neighborhood councils or other opportunities for participation in community life
No local health care services				**Primary care through physicians' offices or health center; school-based health**
Lack of public transportation, walking or biking paths				Accessible, safe public transportation, walking and bike paths

Tip: Healthy Behaviors Travel Together

- Smokers drink more, eat worse & exercise less
- The gap in exercise progressively increased over 10 year period for smokers who quit compared to those who remained smokers
- Those who quit exercise more than continuing smokers
- Two factors:
  - -- declining exercise among ongoing smokers
  - -- increases in exercise among ex-smokers
- Engaging in other healthy behaviors enhances long-term success

Auer et al., Addiction, 2014

Community Resources and Smoking

- Poor, rural children at age 9 followed to age 17
- Poverty at age 9 predicts smoking and BMI at age 17
- Community youth resources markedly reduces this association

  -- Community cohesion (social ties and interdependence)

  -- informal social control (adult supervision and willingness to intervene)

  -- Youth (9 yr olds) reports of supportive ties (I feel there are adults I can talk to for help or advice)

Evans & Kutcher, Psychological Sciences, 2011

Purpose Built Communities

Instead of addressing poverty, urban blight, failing schools, crime and unemployment piecemeal, community activists and philanthropists in Atlanta took them on at once (integrative strategies include cradle-to-college educational opportunities, mixed-income housing, early child development, recreational opportunities).

Atlanta's East Lake District results:

- A 95% reduction in crime since its launch in 1995
- Employment rate of low-income: from 13% to 70%
- Striking school achievement: East Lake students at or above grade level increase from 5% at start to 96%
- Purpose Built Communities in Atlanta, New Orleans, Indianapolis, Charlotte, among others.

We need to start early

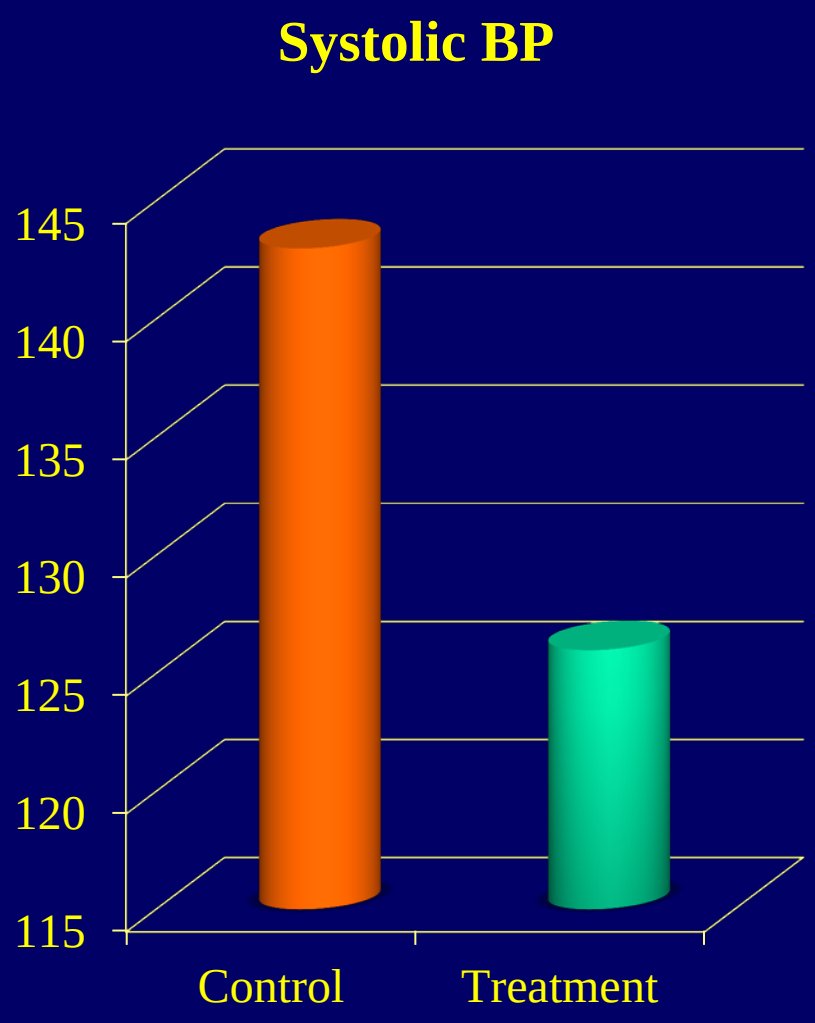
Carolina Abecedarian Project (ABC)

- 1972-77, economically disadvantaged children, birth to age 5, randomized to early childhood program
- Program offered a safe and nurturing environment, good nutrition and pediatric care
- At age 21, fewer symptoms of depression, lower smoking & marijuana use, more active lifestyle, & educational & vocationl assets benefits
- In mid-30's, lower levels of multiple risk factors for CVD and metabolic disease. Effects stronger for males

- **Campbell et al. App Dev Science, 2002; Campbell et al, Science, 2014**

Carolina Abecedarian Project (ABC)

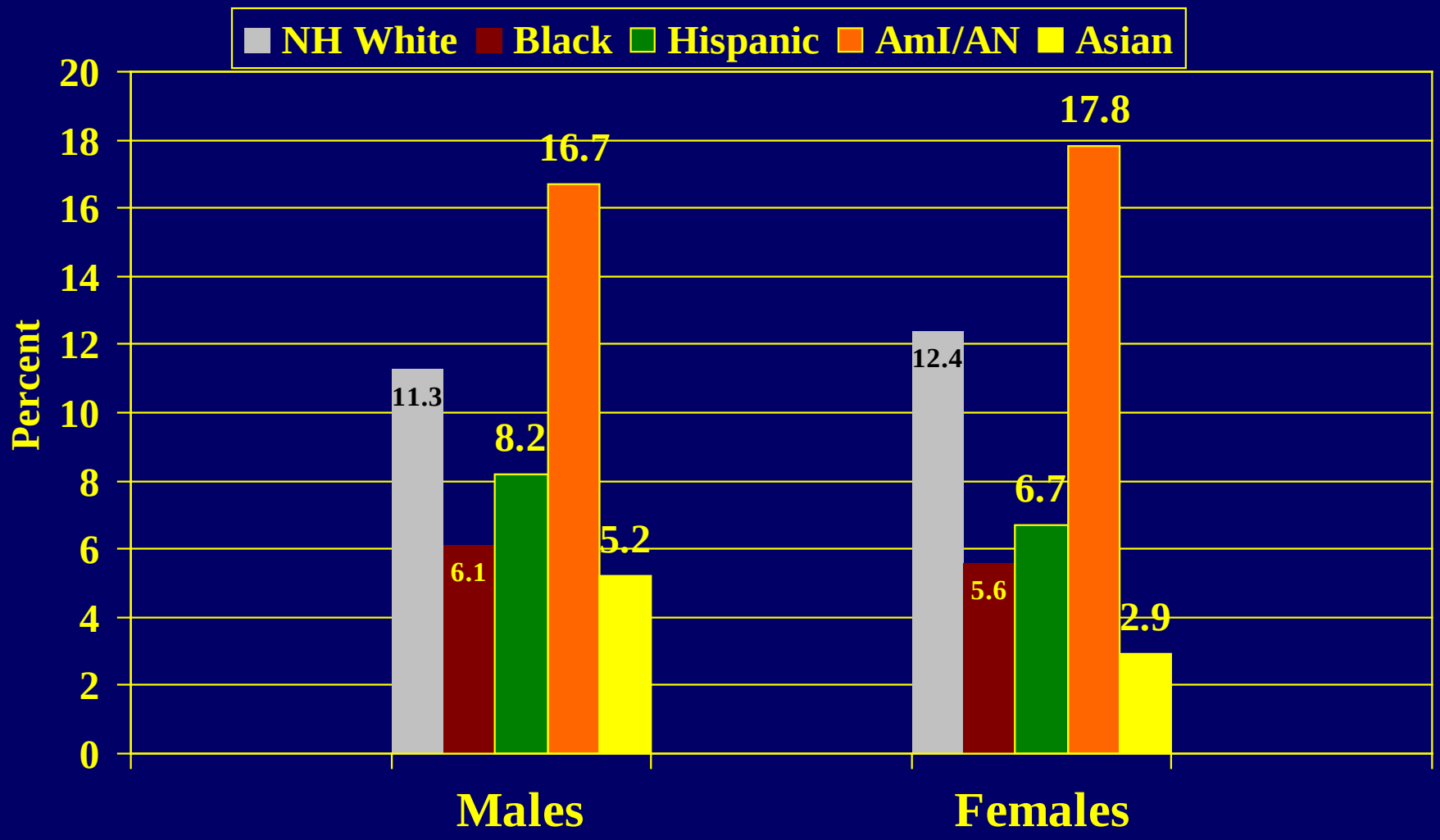
- Example: systolic BP 143 mm Hg in male controls vs. 126mm Hg in the treatment group
- One in 4 males in control group met criteria for metabolic syndrome compared to none in the treatment group
- Lower BMI at zero to 5 yrs equals a lower BMI in their 30s



Campbell et al. AJPH, 2008; Campbell et al, Science, 2014

Resilience and Protective factors

Smoking among 12-17 year olds, 2006-2008



CDC, MMWR 2011

Religion and Adolescent Risk Behavior

- Religious high school seniors less likely than non-religious to
  - -- Carry a weapon (gun, knife, club) to school
  - – Get into fights or hurt someone
  - – Drive after drinking
  - – Ride with driver who had been drinking
  - – Smoke cigarettes
  - – Engage in binge drinking (5 or more drinks in a row)
  - – Use marijuana
- Religious seniors were more likely to
  - – Wear seat belts
  - – Eat breakfast, green vegetables and fruit
  - – Get regular exercise
  - – Sleep at least 7 hours per night

Wallace and Forman 1998; Monitoring the Future Study, *Health Education & Behavior,*

Alameda County Study

- Began in 1965 with 6,928 adults aged 17- 95
- Alameda County is on San Francisco Bay and includes Oakland and Berkeley
- 2,676 survivors from 1965 to 1994
- Examined the association of 1965 frequency of attendance with 1994 improved or maintained healthy behaviors
- Adjusted for age, sex, education, and self-rated health

Improved Healthy Behaviors for Weekly Attenders

Quit smoking	1.78
Started physical activity	1.54
Stopped being depressed	2.31
Got and stayed married	1.57
Increased personal relationships	1.62
Stopped heavy drinking	1.39
Started medical checkups	0.98

We need to build a science base that will guide us in developing the political will to support the needed policies to effectively address social inequalities in health

Effective Communication Strategies are Vital

The Need to Build Empathy in order to Build Political Will

Recent research suggests that we think with our hearts

The role of emotion is central in inter-racial interactions and preferences for policy

Creating the Conditions for Change

The Empathy Gap?

"The most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have… been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference"
W.E. B. Du Bois (1899 [1967], p.163).

Emotions: Consequences

- Across 4 countries in Europe, the absence of positive emotions was a strong predictor of opposition to policies regarding immigrant out-groups
- This measure of subtle contemporary prejudice was a stronger predictor than measures of traditional prejudice
- Feelings are a good covert indicator of subtle prejudice

Pettigrew and Meertens, European J Psych, 1995

Brief measure of No Positive Emotions

- Two questions captured the absence of positive emotions:

  How often do you feel sympathy for Blacks?

  How often do you feel admiration for Blacks?

  Response options: 5-point scale of very often to never

  Variable coded so that a high score equals a lack of sympathy and admiration

  • The absence of positive emotions is an important component of subtle prejudice

Williams et al. Social Problems, 1999

Power of No Positive Emotions

- The absence of positive emotions for Blacks was the strongest predictor of White's opposition to affirmative action in employment and opposition to an active role of government in reducing racial inequalities

- Other predictors considered included: age, gender, income, education, individual and group self interests, political party preference, stratification beliefs (economic individualism, social dominance), conservatism, traditional prejudice, modern racism scale

Williams et al. Social Problems, 1999

Stereotypes in Our Culture

- BEAGLE (Bound Encoding of the Aggregate Language Environment) Project contains about 10 million words from a sample of books, newspapers, magazine articles, etc.
- A good representation of American culture
- Equivalent to what the average college-level student has read in her lifetime
- Statistically analyzed the associative strength between pairs of words
- Provides estimate of how often Americans have seen or heard words paired over their lifetime

Verhaeghen et al. British J Psychology, 2011

Stereotypes in Our Culture

BLACK	poor	.64	WHITE	wealthy	.48
BLACK	violent	.43	WHITE	progressive	.41
BLACK	religious	.42	WHITE	conventional	.37
BLACK	lazy	.40	WHITE	stubborn	.32
BLACK	cheerful	.40	WHITE	successful	.30
BLACK	dangerous	.33	WHITE	educated	.30
FEMALE	distant	.37	MALE	dominant	.46
FEMALE	warm	.35	MALE	leader	.31
FEMALE	gentle	.34	MALE	logical	.31
FEMALE	passive	.34	MALE	strong	.31

Verhaeghen et al. British J Psychology, 2011

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BLACK	charming	.28	WHITE	ethical	.28
BLACK	merry	.28	WHITE	greedy	.22
BLACK	ignorant	.27	WHITE	sheltered	.21
BLACK	musical	.26	WHITE	selfish	.20

Verhaeghen et al. British J Psychology, 2011

Keys to Long-term Success

- Building the perspective of Health into all policy-making
- Including an explicit focus on health equity into policy-making
- Convening, enabling and supporting cross-sectoral collaborations
- Developing institutional mechanisms to provide policy coherence and the constant need for action
- Developing consensus-based standard data and methods for surveillance systems linking health, health equity and their determinants
- Ensure data is available at the local level
- Investing in strengthening community capacity and the potential for community advocacy

Sustaining Action

- Identify and nurture a core of champions in the public, private and voluntary sectors
- Develop and maintain a steady drumbeat of policy-relevant data and information with regards to how factors outside the healthcare system can improve population health and reduce shortfalls in health
- There should be explicit communication strategies targeted at policy-makers and the engaged public
- Emphasis should be given to highlighting interventions that are working now.

Scientific and Policy Opportunity

- Smokers at all levels of SES have elevated mortality risk
- Smokers at all levels of SES have poorer survival than never smokers
- Thus, the potential to reduce overall SES (and racial) disparities in health is limited unless low SES smokers can successfully quit smoking
- There is a unique opportunity to save millions of lives if we can effectively focus on both the causes and exemplar solutions to lung cancer

Gruer et al BMJ 2009

Conclusions

- Inequalities in health are created by larger inequalities in society.
- SES and racial/ethnic disparities in health reflect the successful implementation of social policies.
- Eliminating them requires political will for and a commitment to new strategies to improve living and working conditions.
- We need research that takes the complexity of the social context seriously
- Our great need is to begin in a systematic and comprehensive manner, to use all of the current knowledge that we have.

A Call to Action

“Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and those ripples build a current which can sweep down the mightiest walls of oppression and resistance.”

- Robert F. Kennedy