4

Socioeconomic Disparities in Health

Comprehension Questions

Indicate whether the statement is true or false, and justify your answer. Be sure to cite evidence from the chapter and state any additional assumptions you may need.

1. In the United States, well-educated males can expect to live longer than poorly-educated males.

   TRUE. This is a classic example of a socioeconomic health disparity.

2. Unlike in the U.S., there are no socioeconomic status gradients in health in countries that provide universal health care coverage to all citizens. That is, in such countries, poorer and richer citizens have (on average) the same health.

   FALSE. Canada and the United Kingdom both provide universal health care, but disparities are still found there. This chapter covered evidence of disparities between rich and poor children in Canada, and between high and low-grade civil servants in the United Kingdom.

3. Health status earlier in life is a good predictor of wealth later in life.

   TRUE. Smith (1999) found evidence of this from surveys in the United States that tracked people over a long time period.

4. According to Smith (1999), nearly all of the differences in health outcomes between rich and poor in America can be attributed to differences in access to medical care.

   FALSE. Smith cites evidence that health shocks can actually affect income. In those case, the rich are rich due to their better health.

5. The thrifty phenotype hypothesis states that early life events after birth have a strong influence on health status even in adulthood.

   TRUE. This hypothesis, sometimes also called the Barker Hypothesis, is supported by evi-

dence from the Dutch Famine study and other studies of early childhood deprivation. It also emphasizes the importance of events that happen before birth.

6. People who have a newly-diagnosed chronic disease, such as diabetes, often suffer large declines in their wealth over time. This decline in wealth is entirely explained by decreased hours of work.

   FALSE. These people do suffer large wealth declines, but only a fraction of these losses are attributable to decreased income.

7. In the Whitehall study, access to health care was a key variable determining the relative health outcomes of high and low grade British civil servants.

   FALSE. Because all British citizens have access to health care through the National Health Service, variation in access to care can not explain the disparity in health outcomes between high- and low-grade civil servants.

8. One leading theory about why the poor are in worse health than the rich is that the rich enjoy a greater allostatic load.

   FALSE. Allostatic load is the psychological toll or stress of dealing with life's experiences. The allostatic load theory argues that less wealthy people are in worse health because of the greater stresses they face in life. The Whitehall studies present evidence for this hypothesis.

9. In a study of babies born during the Dutch famine toward the end of World War II, those exposed to the famine *in utero* were more likely than those not as exposed to be obese as adults.

   TRUE. This is considered evidence for the thrifty phenotype hypothesis, which states that individuals facing starvation conditions *in utero* and shortly after birth adapt by programming their bodies to store more fat.

10. In Canada, unlike in the U.S., the gap between rich children and poor children in health status does not widen as children age.

    FALSE. Currie (2003) showed that the gap does widen in Canada after age 10.

11. There is a consensus among health economists that socioeconomic status has a major impact on health, but health does not have a significant effect on SES.

    FALSE. There is a consensus that the relationship is bidirectional: wealth affects health and health affects wealth.

© Bhattacharya, Hyde & Tu 2013