

Article 60

Health Inequality: What Counselors Need to Know to Act

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Abstract

The United States is known as the land of opportunity. Many have immigrated to the United States hoping to find a better future. Among the developed countries, the United States is ranked 29th for inequality (Bezruchka, 2012). Furthermore, the gap has widened over the past decade (Blank, 2011). An individual's social position can reveal much about their health trajectory. This social position is associated with an individual's context—place matters (Subramanian, Jones, & Duncan, 2003). This paper examines the consequences of inequality that bring about persistent poor health outcomes using ecological counseling theory, Pierre Bourdieu's theory, social determinants of health frameworks, and avenues for ameliorating the impact of health inequalities.

Keywords: inequality, context, social determinants of health, mental health

Economic inequality has gradually increased over the past three decades in the United States (Blank, 2011). For example, a CNBC report stated that the gap between the top wealthiest 1% and all other categories is equivalent to the “Roaring ‘20s” (Wiseman, 2013). This 1% represents 19% of the total U.S. household income; the top wealthiest 10% accounts for 45% of the total household income in the United States.

Why is understanding economic inequality important for counselors? How does this calculate into the life of the everyday individual and specifically for the work we do as professional counselors? The primary purpose of this paper is to illustrate how inequality impacts the health and specifically the mental health of our clients. To do this, we will first examine the ecological counseling framework, sociological theory, and social determinants of health. Next, we will review inequality along with an examination of the interaction between inequality and health. Finally, we will propose interventions following the integrated review.

Theoretical Backgrounds

Ecological Counseling

The ecological counseling theory, adopting the framework of Urie Bronfenbrenner's ecological model of human development and behavior, conceptualizes that a person functions as the result of interaction within his/her environment (Conyne & Cook, 2004). Behavior is inexplicably tied to the context of the person. Bronfenbrenner's ecological model of behavior is made up of four subsystems. These subsystems are the microsystem, mesosystem, exosystem, and macrosystem. The microsystem is defined as the individual's interaction with their context/environment. This may include the individual's dynamics at home, work, or school. The mesosystem is characterized as the interaction between environmental systems, i.e., school interacting with the workplace. The exosystem consists of subsystems. These subsystems influence the individual indirectly. Examples of this are the influences of neighborhood factors on the individual's behaviors (Cook, Heppner, & O'Brien, 2005). Finally, the macrosystem is the milieu of the society, which consists of its values or norms. Each system is nested within another, like a wooden Russian doll set.

Besides the subsystems, Conyne and Cook (2004) offered terms for conceptualizing through an ecological lens—ecological niche, life pattern, and life space. The ecological niche includes aspects of the ecological systems that directly influence the individual. This includes both animate and inanimate aspects of the ecology. These are the proximal aspects such as regional weather or characteristics of the individual's residence. It provides content for the "where." Next, the life pattern develops around the meaning-making process of the individual. This pattern is a habitual response to the contextual meaning-making that perpetuates across time and space. Finally, the life pattern illuminates the "why" aspects of life. Life space is a composite term. It is the combination of life pattern and ecological niche; it is a combining of the where and why for the individual. The life space is a "sum total of the contexts we occupy and the meanings we express throughout them" (Conyne & Cook, 2004, p. 19).

Sociological Perspective

Pierre Bourdieu was a French sociologist who aimed to bridge the theoretical with the practical in what he called *Theory of Practice*. Via *Theory of Practice*, Bourdieu developed *field*, *habitus*, and *capital* constructs (Grenfell, 2008). In the following paragraphs, these constructs are deliberated.

Historically, sociologists focused on class as the dominant structure and influence. Bourdieu, along with Max Weber, advocated for an expansion. From this expansion, the *field* concept emerged. *Fields* are theorized to be autonomous units within society. They have a unique set of rules. Suggested *fields* are education, law, politics, economy, and arts (Grenfell, 2008). *Habitus* is the persistent disposition that an individual acquires. In terms of cognitive behavioral therapy, it is akin to schemas. In other words, it is the disposition an individual has within a certain context. Finally, *capital* has historically been defined in monetary terms such as hourly or annual income. Bourdieu expanded this concept outside of monetary terms, e.g., social, cultural, and economic *capital*. Social *capital* can be understood as the resources that an individual or group inherits. Cultural *capital* is the assets that influence mobility within a society; the greater the cultural

capital, the better the skills, competencies of the individual and/or group and, therefore, legitimacy. Additionally, symbolic *capital* was offered. Symbolic *capital* includes the sources of power, such as prestige. It is suggested that the influence of symbolic *capital* is implicit. This is evident when examining the hierarchical structure of occupations in the United States (Grenfell, 2008).

In addition to Bourdieu's theory, other sociologists have developed theories around the *agency-structure*. *Agency* can be understood as the individual mind and *structure* is a construct capturing the social laws. Bourdieu believed that *structure* influenced the individual mind. The objective reality of the *structures* inculcated the individual mind, which in turn embodied the social laws driving the individual's behavior or patterning behavior (Grenfell, 2008)

Social Determinants of Health

The U.S. Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have examined the social determinants of health. The CDC provided the following definition for social determinants of health:

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequalities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and world. (CDC, 2014b, para. 14)

From these efforts (CDC and WHO), the U.S. government has established a goal for social determinants of health in HealthyPeople 2020, which is a national program to improve health. The specific goal is to "Create social and physical environments that promote good health for all" (HealthyPeople.gov, 2013, para. 1). The objectives created for this goal address areas such as economic stability, education, health and health care access, built environments, and social and community context (HealthyPeople.gov, 2013).

Understanding Inequality and Health

Defining Health Inequality

In 2006, Paula Braverman examined health disparities and health equity. Her aim was to understand the current classification and provide a more robust definition of health inequality. One of her first points was that inequality and disparity are used interchangeably. After she described the historical construct of health inequality, she provided the following amalgamation defining health inequality:

A health disparity/inequality is a particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups. (p. 180)

She later noted that the understanding of inequality is robust. It not only includes individual aspects (gender, race, ethnicity, age) but also individual context—where they live, work, and go to school. Moreover, the CDC (2010) defined health inequality not only as the difference in health outcomes, but as something that can be changed.

Impact of Inequalities on Health

Many studies have compared, by country, population health indicators and economic inequality. From these, increased economic inequality has been associated with an increased infant mortality rate and murder rate, and a negative correlation has been found with average life expectancy (Babones, 2008). This is further evidenced by a 2014 report found in the *The Wall Street Journal*, “The Richer You Are the Older You’ll Get” (Zumbrun, 2014). Succinctly, the report describes the research by economist Barry Bosworth. Bosworth discovered that those in the lowest 40% by income at age 55 actually had a loss of life expectancy, especially for women. Conversely, as one moves up the economic ladder from the lower 41% to the top 10% of the wealthiest, there is a positive effect for life expectancy.

Contemporarily, and in the field of counseling, the intersection of inequality and health is important. As noted above, there is a strong correlation between infant mortality rates with inequality. Historically, the infant mortality rate has been a barometer for a country’s health (Reidpath & Allotey, 2003). The infant mortality rate is defined as the number of infants who died within the first year of life per 1,000 live births. Based on a 2014 estimate, the infant mortality rate for the United States is 6.17. This ranked the United States 169 out of 224 countries (Central Intelligence Agency, n.d.). From 2008 data, compared to other developed counties, the United States was ranked 29th (MacDorman & Mathews, 2008). This is striking when examining the United States’ expenditures on health. In 2010, the United States spent \$2.6 trillion or about 17.9% of its Gross Domestic Product, or \$8,402 per capita (CDC, 2014a), on health care. In contrast, other countries that ranked favorably for infant mortality, such as France, Sweden, and the United Kingdom, spent 2.5% of their Gross Domestic Product or less.

In 2003, The Institute of Medicine published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, & Nelson, 2003). They reported that racial and ethnic disparities are remarkably consistent across illnesses and health care. These persistent disparities have been found with cardiovascular care, cancer diagnostic tests, diabetes care, maternal and child health, mental health, and others (Smedley et al., 2003). Of particular interest is the impact of social economics. Socioeconomic status (SES) accounts for a great deal of this variation and in some studies accounts for nearly all variation (Sudano & Baker, 2006; Williams, Yu, & Jackson, 1997). SES is defined as a measure that combines income, education, and occupation prestige (LaVeist, 2005). Yet other studies have not found persistent racial and ethnic disparities, even when controlling for SES (Shavers, 2007).

Impact of Inequalities on Mental Health

Inequality has been found to impact mental health (Wilkinson, 2005). Reiss (2013) conducted a literature review of 52 studies linking mental health of children (aged 4 to 18) and socioeconomic inequalities. Markers of socioeconomic status, such as occupation, household income, parental education, family affluence, or poverty, indicated

these inequalities. From this review, SES and mental health were found to have a negative correlation and a strong effect was found—a low SES child was three times more likely to have mental health problems when compared to a high SES child. Furthermore, a child's improvement of SES led to a decrease in both new mental health problems and occurrences of existing mental health problems. Finally, SES related disparities were associated with increased risk of comorbidities for children (Reiss, 2013).

Implications for Counselors

Margaret Whitehead stated that inequality is a condition that can be avoided and is unfair (Braveman, 2006). When applying this to the field of health, there is a strong correlation between inequality and infant mortality. This relationship is not only found in infant mortality, but also with cancer, heart disease, and mental health (Craig, Hanlon, & Morrison, 2009; McCartney, Collins, & Mackenzie, 2013). Sufficient evidence links inequality with health outcomes. Based on this evidence, a great deal of work over the past decade has been aimed towards the understanding and amelioration of these social determinants of health. An integrated model provides a more robust understanding of this phenomenon and avenues for counselor intervention.

Integration

Bourdieu offers societal constructs that help to conceptualize the associations found between inequality and poor health outcomes (Grenfell, 2008). From a Bourdieuian perspective, societies are stratified, and this stratification has consequences. A power differential arises. This differential then allocates resources strategically; those who possess the power allocate the resources in their favor explicitly and implicitly. From this, *fields* are established that maintain social structure. Over time, individuals are socialized based on this inherited *structure*. Children then inculcate norms and values based on their experiences, which then become habits into adulthood—*habitus*. Therefore, inequality becomes an aspect of the establishments (Lareau, 2011). From this inherited *habitus*, the individual learns the social rules based on their context. Based on the rules they engage in and their societal positioning, *capital* varies. This in turn maintains the status quo.

The concept of *capital* provides a unique conceptualization of the inherit power differential that impacts the life of the individual and group trajectory. By understanding that *capital* comes in different forms such as economic, social, and symbolic, a counselor can further conceptualize the client and their context. Furthermore, the counselor can now engage in advocacy within a modified lens.

The ecological counseling theory delivers a multidimensional conceptualization of the individual and context. The individual does exist within a *field*, but the theory lacks the understanding of multiple field influences concomitantly. The ecological counseling theory gives such support. This instills a more integrated *agency* and *structure*.

The social determinants of health are suggested to be poorly supported by theory. In contrast, by integrating Bourdieu and ecological counseling theory, a strong theoretical foundation is established; specifically, the understanding of *fields/systems*. As stated above, *fields* are unique structures within society. The concept of systems in ecological

counseling adapted within the *fields* concept allows for a multilevel understanding of context and the individual. For example, an individual is influenced by his/her setting. Within a specific time, an individual is set within a specific context or *field*. This individual within this *field* is surrounded by concentric circles that represent the different systems—microsystem to macrosystem—integration of Bronfenbrenner and Bourdieu.

Further, with this integration, a stepwise examination of social determinants of health arises. Based on Bronfenbrenner's formula of PxE (person is influenced by their environment) and the understanding of *habitus* and *capital*, it provides a pathway for understanding poor outcomes associated with an individual's context. For example, a person who experiences major depressive disorder can be understood via the power differential that is evident across the life course. Take an African American woman as an example. She would have less power than a Caucasian male in the United States, increasing her risk for depression. Their *habitus* would be differentiated and the African American woman would be at a disadvantage across her life. This is evident by less pay for the same job, discrimination, poor housing, and lower social status. All of these determinants are driven by systems in which she resides and interacts—fields that influence her *habitus* and the social resources (*capital*) or lack thereof across the life course. Therefore, she is at greater risk for a myriad of health outcomes based on her inherit disadvantage (her inequality) for being an African American minority; a woman living in the United States of America has an inherit inequality across gender, income, social position, education, and race.

Putting It Into Practice

Blas et al. (2008) noted that social determinants of health prescribe a unique approach because the “conventional biomedical” approach is not generally appropriate. This is due to the fact that many of the causal pathways for mental health are not inherently biological but social (Craig et al., 2009). An example of the impact of laws at state and national levels that contribute to maintaining the status quo social positioning in the United States is public school funding based on local housing taxes. Furthermore, a person at a low SES position has an increased risk for mental disorders (Reiss, 2013). This is where ecological counseling and Bourdieu's work becomes imperative; because an individual's biology is impacted from the macrosystem down, limitations are inherent within the biological model for bringing about change.

With this in hand, Blas et al. (2008) recommended three approaches that a government can take to reduce negative health outcomes associated with inequality. The first is to provide equality of services or equal access and quality of health services across SES. This not only includes health services but also education. This is exemplified by the welfare systems put into place after World War II. Blas et al. found that this has helped reduce the impact of poverty and enhanced social cohesion. Additionally, these welfare programs have been particularly important for improving child health (i.e., nutrition, childcare, education, etc.; Blas et al., 2008). Therefore, the counselor and counseling profession should have an advocacy voice to advance and improve the welfare system within the United States.

Akin to the first, legislation and regulation are areas where government can address health inequality. In particular, the government can help define roles and

responsibilities of human rights through legislation. This is important around gender, race, and ethnicity. For example, the professional counselor, through their appointed legislative body, can promote more gender equality. This can include championing for paid maternity leave and equal pay across genders. Additionally, the movement towards a living wage instead of a minimum wage is essential for promoting wellness. The professional counselor can engage in local, regional, and national movements advocating for living wage laws. Bhatia and Katz (2001) predicted the reduction of depressive symptoms with a living wage in San Francisco.

The third approach is an adequate and effective monitoring of health. The CDC has a network system in place, but in many ways it is piecemealed. These network systems vary across states and the infrastructure for some states is inadequate—such as the poorer states of Mississippi and Kentucky. This fractured healthcare system is evidenced by fragmented relationships across health care professionals, missing data for efficacious diagnosis and treatment, and duplicate services that increase healthcare costs. This maintains inequality across the states and therefore within the United States (Stange, 2009). The counselor and counseling profession would enhance these systems by actively engaging in the adoption of health monitoring systems and moving away from paper-based systems. Championing a universal health care monitoring system could decrease health care costs, increase efficiency of health care services, reduce barriers to access to care, and bring about a more just health care system (Stange, 2009). Additionally, the counseling profession can advocate for more integrated systems not only within health care, but across all systems; this includes housing, education, and social services. This would promote integrated services for an individual across multiple areas.

Other writers have advocated for action to reduce health inequalities. Marmot, Friel, Bell, Houweling, and Taylor (2008) advocated for health equity. They recognized that social gradients exist throughout the world. These social gradients are upheld by differentials in power, income, goods, and education; the greater the poverty, the steeper the social gradient and the poorer the mental health outcomes. To address this gap in health, Marmot et al. referenced The Commission on Social Determinants of Health's work to 1) improve daily life, 2) reduce the inequality across *fields/systems*, and 3) evaluate the problem and progress.

For the professional counselor and counseling profession, our work with clients attempts to improve daily lives through individual, couple, family, and group therapeutic sessions. Yet, does this address the root of mental illness or only put out the current fire? To challenge our current scope of work, the professional counselor and counseling profession need to acquire a lens that looks upstream before the individual, couple, etc. comes into our office. To do this, the professional counselor will need to engage the community and advocate for systematic changes in collaboration with others. This is at the heart of prevention and the desire to reduce and eliminate the risks before the outcome is evident.

In support of this strategy, Marmot et al. (2008) called for equity from the start. This means to look upstream and invest in the early years of life—pregnant women, infants, children, and adolescents. It is estimated that over 200 million children worldwide are not meeting their full developmental potential (WHO, 2008). This is evidenced by the social gradient in the United States and other developed and underdeveloped countries. Those parents and potential parents at the bottom of the social

gradient (those in poverty) are at greater risk for underdevelopment. For example, an infant's brain is highly sensitive to external influences—good nutrition, safe housing, and low stress environments (low crime, low violence) lead to better brain development. As all counselors know, this is evidenced by Bowlby's and others work on attachment (Brunner, 1997). An impoverished infant or child develops at a disadvantage due to the inequality inherited. Therefore, the professional counselor and counseling profession can actively engage in the development, support, and advocacy of new and existing programs that will improve a child's developmental trajectory. This includes existing programs such as WIC, SNAP, and CHIP but also developing their own programs that will improve child health across the spectrum. This directly feeds into the professional counselors' foundations of well-being and healthy lifespan development.

Additional strategies are offered by Rebecca Blank (2011) in her work, *Changing Inequality*. She devoted a chapter on recommendations for changing inequalities. She summarized her recommendations into "changes in skills; changes in key economic variables . . . changes in marital choices; and changes in redistributive policies" (p. 141). The author proposed these changes with caveats. These recommendations are primarily for those who currently exist as low-income individuals, and it does not include restructuring earnings of top income recipients, nor undoing the gender equality advances that have been made.

The skill set required for financial stability within the United States has increased over the past 30 years, as evidenced by the shift upwards of educational attainment. For example, the high school dropout rate has dropped on average 0.426 points, and skills have increased slowly over this time period (Blank, 2011). Yet the educational level for native males (those that have not migrated) has not increased; therefore, their skill level has stagnated and they are less likely to gain employment sufficient to obtain financial stability. This is in part due to immigration of a low-skilled labor force (Blank, 2011).

How does this pertain to the counseling profession? An aspect of our historical roots is in career counseling, with key aspects such as vocational guidance and the work of Frank Parsons. Moreover, the Council for Accreditation of Counseling and Related Education Programs (CACREP) standards require training in career counseling at the master's level (CACREP, 2015). With the profession's history and current training, the professional counselor is well equipped, for example, to advance the skill development of native male workers within the United States who are, as noted by Blank (2011), at a deficit for financial stability. This advancement can be conducted within the *field* of education but also through other systems such as family, work, and even leisure. Specifically, the professional counselor is able to work across systems, not only with the individual, but also the family. For example, a professional counselor could develop a targeted career services community group where the professional counselor assists community members in developing skills for employment.

The next natural conjugality between professional counselors and the suggested intervention to improve equality is increasing marriage and sustaining existing marriages in the United States. As we travel down the socioeconomic ladder, single-headed family units increase. From Blank's simulations, a 2.7% increase in marriage units in the United States will reduce the Gini coefficient, a measure of societal income inequality, from 0.43 to 0.42 (Blank, 2011). The professional counselor has an explicit position in the realm of marriage and family. As an occupation, we are primarily situated to continue our current

work of pre-marriage, marriage, and couples counseling. Through our current therapeutic work, we are in a situation to provide psychoeducation to our clients on the sustaining positive effects of marriage. Additionally, by working upstream with youth, we can modify their wellness trajectory and bring about potentially healthier, securely connected relationships such as a marital partner.

The final call to action is a safety net. This governmental safety net is especially important for those on the lower end of the socioeconomic ladder. Specifically, antipoverty programs are paramount as a safety net function in the United States. Blank (2011) noted that the United States has a higher percentage of people in poverty than other developed countries. The main reason for this is the lack of safety net infrastructure (Stange, 2009). Yet, based on her simulations (eliminating poverty completely in any family unit), there is very little change in the Gini coefficient (a change 0.42 to 0.41). The contemporary assumption is that engaging and growing governmental safety nets will effectively reduce the existing health inequality. This seems to be a questioned presupposition. The professional counselor, counselor educators, and other professionals can continue to engage and examine the effects of safety net programs for their viability towards equity. In addition to advocacy efforts to impact the policies at the macro level, professional counselors can also educate and empower their clients to be their own advocates and change agents (Conyne & Cook, 2004). Empowered clients are more likely to break the status quo and change the inequity affecting their health.

Conclusion

Health and inequity are intertwined. The nascent approach of social determinants of health that have been offered by the CDC and WHO offers a framework for advocating for change that potentially ameliorates the effects of inequality on mental health; yet it has been criticized for weak theoretical support. Applying the ecological counseling theory and Pierre Bourdieu's "Theory of Practice" allows for a robust theoretical orientation supporting the social determinants of health. Moreover, it provides the counseling profession with a theoretical lens that supports our current and future work.

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