

## **Social Structure and the Health Status of Black Males**

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Four days after Martin Luther King's birthday, this year, a report appeared in the *New England Journal of Medicine* that highlighted the seriousness of the crisis in terms of the health status of black males (McCord and Freeman 1990). This study calculated mortality rates for African Americans in the central Harlem health district of New York City, and compared them to those of whites. Between the ages of 25-44 black males in Harlem are 6 times more likely to die than white males in the U.S. Cardiovascular disease, cirrhosis of the liver, homicide and cancer are the main causes of the excess deaths. Moreover, the life expectancy of adult males in Harlem is lower than that of males in Bangladesh. Bangladesh is categorized by the World Bank as one of the poorest countries in the World.

This study also profiled the socioeconomic conditions in Harlem. The median family income in Harlem in 1980 was \$6,497. That compares with \$16,818 for New York City; \$21,023 for the U.S. and \$12,674 for all African Americans in the U.S. Harlem is 96% black and 41% of the population lives below the poverty line. The population of Harlem declined from 233,000 in 1960 to 121,905 in 1980. During this same period the death rate from homicide increased by almost 400 percent.

Today, I would like to give an overview of some of the critical health issues facing black men. I would particularly like to emphasize that the health problems confronting the African American community cannot be separated from the socioeconomic conditions in the black community. Disease is rooted in social structure. I will illustrate this relationship by discussing socioeconomic differences in health status, the role of medicine as a determinant of health status, race differences in high blood pressure, and the social distribution of health behaviors.

### **State of Black Health**

The Secretary's Task Force on Black and Minority Health reported that there are nearly 60,000 excess deaths among blacks every year (U.S. Department of Health and Human Services [DHHS] 1985). That is, there are 60,000 deaths among blacks each year that would not occur if blacks experienced the same death rates as whites. Now, the death rates for whites are not necessarily an ideal standard of comparison; there are thousands of avoidable deaths among whites. At the same time, this comparative data provides one way of highlighting the health

problems of the black population. Compared to whites, black males are 1.4 times more likely to die of cancer; and two times more likely to die of cerebrovascular disease (stroke and heart disease), diabetes and cirrhosis of the liver. Black males under age 45 have rates of death from tuberculosis that are 17 times greater than that of whites; hypertension 10 times, homicide 7 times, and anemias 6 times greater.

In terms of mental health, blacks are disproportionately exposed to social conditions considered to be important antecedents of psychiatric disorder but blacks do not have higher rates of mental illness than whites. The latest and best evidence comes from the National Institute of Mental Health's Epidemiologic Catchment Area Program (ECA) studies. The ECA program involved assessing rates of mental disorder in 5 sites across the country using criteria based on the Diagnostic and Statistical Manual III (DSM-III). In addition to sampling large community populations, the ECA program also sampled persons residing in institutional settings such as correctional facilities and nursing homes. In the community 14% of black males had a psychiatric disorder compared to 13% of white males. Twenty-seven percent of black males in institutions had a psychiatric disorder compared to 26 percent of white males. Blacks historically have had lower suicide rates than whites. Recently, there has been an increase in suicide rates for black males but the age patterning of suicide varies across race (Griffith and Bell 1989). For white males the highest suicide rates are for those over age 65; for black males suicide peaks in the 25-34 age group. The increase in suicide among young black males probably reflects the growing sense of hopelessness that characterizes their opportunities in this society.

The overall evidence on black mental health clearly indicates that there are important resources and strengths in the black community that is protecting the community from the onslaught of pathogenic stressors. One of these important and neglected resources is probably the black church and renewed research attention should be given to the possible health promoting functions of religious involvement.

### **Socioeconomic Status and Health**

It is important that we recognize that the high rates of disease and death in the African American community is part of a larger pattern. Low socioeconomic status is a powerful and pervasive predictor of a broad range of health outcomes (see Williams 1990 for a recent review). Our earliest records indicate that poor people had lower life expectancy and more health problems than the wealthy. This relationship has not changed over time. Despite general improvements in health status, broad based social and economic change, and advances in health care technology and the delivery of medical services, there has

The health problems of black males are thus part of a larger, fairly universal phenomenon in which poverty is associated with increased rates of disease and death. This general trend may be exacerbated among African Americans because of their exposure to both poverty and discrimination.

### **Medical care**

Inadequate access to medical care is one of the sources of the racial disparity in health status. Recent national data indicate that African Americans are less likely than whites to have health insurance, to have a regular source of care and more likely to be dependent on emergency room and hospital clinics (Blendon et al. 1989). Blacks are also more likely than whites to be dissatisfied with the medical care received. It is frequently assumed that simply improving access to medical care will eliminate disparities in health. The available evidence suggests, though, that the attention given to medical care is disproportionate to its importance as a determinant of health status.

Medical care can explain no more than ten percent of the variation in health status (U.S. Department of Health, Education and Welfare [DHEW] 1979). Some studies find that increased access to medical care is either unrelated to health or leads to a deterioration of health status (Diehr, Richardson, Shortell and LoGerfo 1979; Newhouse and Friedlander 1980). Even those studies that find a positive impact for physician services, note that the effect of medical care is small when compared to that of non-medical variables (Williams 1975, Hadley 1982). Hadley (1982) notes for example that a reduction in cigarette consumption would do more to improve health than an increase in medical expenditure.

As surprising as these findings may seem they are consistent with the evidence from other researchers that, to a large degree, medical care is not an important determinant of health status (McKeown 1979; Powles 1973). It has been demonstrated, for example, that improvements in health status in the last 150 years, in both the U.S. and the U.K., have been due more to improvements in the standard of living and the environment (water supply and sanitation) than to personal medical care (McKeown 1979; McKinlay and McKinlay 1977). These researchers indicate that most of the decline in the infectious diseases (that were the leading causes of death in the 19th and early 20th centuries) occurred before the advent of effective medical treatment for those illnesses. Medical economists have similarly noted that non-medical variables are more important determinants of health status than medical care. Specifically, greater reductions in morbidity and mortality are possible through additional expenditures on formal education than through additional expenditures on medical care (Auster,

been no narrowing of the SES differential over time. A review of mortality data from England, France and the United States concluded that there has been no change in the excess mortality of poverty populations in any of these countries since the Second World War (Behm and Vallin 1982).

The case of England and Wales is especially instructive. It was expected that the combination of post-war economic growth and the introduction of the National Health Service would eventually lead to the elimination of the SES gradient in health status. In contrast, recent data reveal that SES differences in England and Wales are widening (Hollingsworth 1981; Wilkinson 1986). Moreover, differential recruitment of immigrants into the lower SES groups in the U.K. does not account for these findings (Marmot and McDowall 1986). Instead, while health status has improved for all groups in Britain, the higher SES groups have experienced greater improvement than their less prosperous peers.

This persistence of SES differentials in health outcomes is not limited to the U.S., England and France; SES differences in health status are a fairly universal phenomenon. Recent reviews of this literature reveal that SES differences in mortality exist in Norway, Sweden, Denmark, Finland, Germany, the Netherlands, Australia, New Zealand, Canada, Japan and several Third World countries (Marmot, Kogevinas and Elston 1987; Haan and Kaplan 1986; Department of Health and Social Security [DHSS] 1980).

The power of SES as a determinant of adverse changes in health status is also illustrated by the secular trends that have been observed in the social distribution of certain diseases. That is, in the history of particular diseases, even when an illness was initially more prevalent among the higher SES groups, over time it becomes more prevalent among the less affluent. Coronary heart disease (CHD) is an example of this phenomenon. During the 1950s, the prevalence of CHD and CHD risk factors was positively associated with social status (Taylor 1967). As these risk factors (serum cholesterol, smoking, blood pressure and a sedentary lifestyle) became more pervasive throughout the society, the relationship between social status and CHD changed from a positive to an inverse gradient (Morgenstern 1980). AIDS is an instructive recent example. Most of the initial AIDS patients were white, middle class, homosexual or bi-sexual males. Currently, the incidence of this disease among black and Hispanic homosexual males is two to three times higher than among whites; for heterosexual males (the majority of new cases), the rate is 20 times higher among blacks and Hispanics than among whites (Peterson and Marin 1988).

Levenson and Saracheck 1969; Fuchs 1979). The earlier noted continuing occurrence of SES differences in health status in the countries of Western Europe, where inequalities in access to medical care have been virtually eliminated, is also consistent with a limited contribution of medical care to health status.

Studies of the recent decline in mortality from coronary heart disease lend strong support to this argument. Goldman and Cook (1984), for example, analyzed the decline in ischemic heart disease between 1968 and 1976. They found that changes in lifestyle saved more lives in the period studied than all medical interventions combined. They estimated that while reductions in cholesterol and cigarette smoking were responsible for 54 percent of the decline in heart disease mortality, medical interventions (coronary care units, pre-hospital resuscitation and care, coronary artery bypass surgery, medical treatment of clinical heart disease and the treatment of hypertension) were responsible for only 40 percent.

Although differences in medical care resources will not explain differentials in disease, and medical care is less important than generally assumed, equality of access to medical care is still an important and desirable goal and is crucial to arresting further deterioration of the health status of African Americans. There are several ways in which medical care can be crucial to promoting health and preventing disease. Preventive medical care, throughout the life cycle but especially during infancy and childhood, is critical in preventing illness. Similarly, adequate prenatal care can play a role in preventing infant mortality and other adverse pregnancy outcomes (Nersesian 1988). Finally, early intervention in the course of a disease and medical management of chronic illness can affect both survival rates and the quality of life. Blacks with cancer and AIDS, for example, have shorter survival times than whites (Haan and Kaplan 1986; Primm 1987). This is probably due to race differences in the quality of care including later diagnosis and treatment of these diseases in blacks.

It also appears that medical care has a larger impact on the health status of lower SES groups than on their higher SES peers. For disadvantaged groups faced with multiple vulnerabilities, medical care may be the only health protective resource. In contrast, in groups that enjoy many social and environmental resources, the additional contribution of medical care may be negligible. Thus, prenatal care, while critical to a poor mother with multiple risk factors for adverse pregnancy outcomes, has little positive effect on a middle class mother in favorable social circumstances (Nersesian 1988). The medical treatment of hypertension is also more effective in blacks than whites (DHHS 1985). Similarly, Hadley (1982) indicates that additional

medical care will lead to larger reductions in mortality rates for blacks than for whites. Thus, we must continue to improve health care delivery in the black community. At the same time, we must recognize that more health care alone will not solve the health problems in Black America.

### **Race and Blood Pressure**

The problem of hypertension provides a particularly potent illustration of the social origins of illness. High blood pressure is one of the most serious health problems in the black community. Hypertension is the major risk factor for cerebrovascular disease (stroke), and a major risk factor for coronary heart disease and kidney disease--three diseases that are important contributors to the excess morbidity and mortality in the black population. Heart disease is the most common cause of death among blacks and occurs more frequently among blacks than among whites (Cooper and Simmons 1985). Mortality rates from stroke and end-stage renal disease are 3 to 17 times higher for blacks than whites (Check 1986; U.S. Department of Health and Human Services [DHHS] 1985).

Epidemiologic studies have long observed that blacks have higher average levels of blood pressure than whites and are twice as likely as whites to have hypertension (Stamler, Stamler and Pullman 1967). National studies indicate that there is an age patterning to the race differences in high blood pressure. Blood pressure levels increase with age for both blacks and whites. However, up through adolescence there is no racial disparity in blood pressure. It is during early adulthood that blood pressure increases more dramatically in blacks than whites, so that racial differences are clearly apparent by age 25 (U.S. Department of Health, Education and Welfare 1977).

Genetic and physiologic explanations alone are unlikely to explain race differences in blood pressure. Unlike the U.S., where blood pressure levels increase with age for both blacks and whites, numerous societies exist where blood pressure levels remain stable over the life course (James 1987). Thus, genetic explanations appear unlikely to explain why the race difference in blood pressure becomes evident only in adulthood. Blood pressure levels of African people in West Africa are lower than those of blacks in the U.S. (Gillum 1979). However, when black populations in Africa and other traditional populations in third world countries move from their original communities to large urban centers, there is a rise in blood pressure (James 1987). It appears then, that to the extent that genetic and physiological differences exist, they are likely to operate by interacting with other environmental variables to affect blood pressure levels.

**Stress and Social Conditions.** The finding of a positive association between urbanization/westernization and blood pressure levels clearly suggests an important role for environmental stress in hypertension. Animal studies reveal that experimentally induced stress can cause chronic elevations in blood pressure (Brody et al. 1987). This stress-induced hypertension occurs most frequently when experimental animals have a predisposition to high blood pressure. Studies of human populations have not uniformly employed the same level of methodologic rigor as the animal experiments, but the overall weight of the evidence from these studies clearly implicates stress as at least a precipitating agent in hypertension.

Studies of occupational groups characterized by high levels of stress (such as air traffic controllers, and urban bus drivers) indicates that these groups have higher levels of blood pressure than other comparable groups (Brody et al. 1987; Krantz et al. 1987). Other studies reveal that blood pressure increases in factory workers when they lose their jobs (Kasl and Cobb 1970). Attempts have also been made to identify the specific characteristics of working environments that are predictive of increased hypertensive risk. A review of this literature indicates that the working conditions strongly associated with a high risk of hypertension are high job demands combined with low control (Krantz et al. 1987). The U.S. occupations identified as falling into this category include clerks, laborers, and assembly line workers. All of these occupations are those in which African Americans, in particular, and persons from the lower socioeconomic groups more generally, are likely to be overrepresented.

The work of Harburg and colleagues (Harburg, Enfurt, Chape, Hauenstein, Schull and Shork 1973a,b) provides striking evidence that stress in the social environment is positively associated with blood pressure and can explain a substantial part of the race differences in hypertension. These researchers characterized census tracts in Detroit as either high or low in stress. High stress areas were defined by high levels of economic deprivation (low median income and years of formal education), residential instability, marital instability and crime. Low stress census tracts had the converse conditions. The study found that persons living in high stress areas had higher levels of blood pressure than persons in low stress areas. This association was stronger among blacks than whites. However, the blood pressure levels of black males in low stress areas did not differ from those of white low stress males. Other studies reveal that there is a positive association between blood pressure and specific stressors in residential environments, such as industrial noise, airport noise, traffic noise and overcrowding (Krantz et al. 1987).

Harburg and colleagues (1973b) also assessed the association between blood pressure levels and emotional response to being unfairly treated in two hypothetical situations. Holding anger in or feeling guilty about displaying anger were both positively related to blood pressure. Suppressed hostility (the combination of keeping anger in and feeling guilty if anger is expressed) was positively associated with hypertension among both black and white males. Moreover, coping patterns appeared to be constrained by the social environment. Men in high stress areas reported higher levels of suppressed hostility and greater use of keeping anger in than men in low stress areas (Harburg et al. 1973b). It is likely that persons who live and work under conditions of acute social and economic deprivation would be exposed to more anger-arousing social situations.

Research by William Dressler has documented an association between thwarted aspirations and high blood pressure. Dressler (1982) found a positive association between blood pressure and the active pursuit of material success among persons who lacked the economic resources to attain it. The classic studies of John Henryism and blood pressure by James and colleagues (James, Hartnett and Kalsbeek 1983; James, Strogatz, Wing and Ramsey 1987) provide further evidence that thwarted aspirations may play an important role in the high rates of hypertension in the African American population. John Henry was a strong but uneducated steel driver in a black American folktale who died of exhaustion immediately after conquering a mechanical steel drill. A high score on the John Henryism scale reflects an active orientation to cope with stress. In a sample of black men, James et al. (1983) found the highest blood pressures among men who scored high on the John Henryism scale but lacked the social and economic resources (had not completed high school) to facilitate their determined efforts to succeed. Subsequent research in a larger sample found that among African Americans who scored high on the John Henryism scale, persons of low SES were three times as likely to be hypertensive as their higher SES peers (James et al. 1987).

Interestingly, John Henryism was unrelated to the blood pressure of whites (James et al. 1987). This finding may reflect the different socioeconomic circumstances of these two racial groups, the absence of whites at the extremes of the SES distribution in this study, and/or the differential impact of stress. The available evidence suggests that existence in the lower SES groups may be more stressful for blacks than for whites. For a given level of education blacks receive less income than whites (DHHS 1986), and in employment settings, even after controlling for job experience and education, blacks are more likely than whites to be exposed to occupational hazards and carcinogens (Robinson 1984). Lower SES blacks also experience higher rates of

some stressors (such as unemployment) than lower SES whites and exposure to both poverty and discrimination may be particularly productive of stress (Williams 1990). Other recent experimental evidence indicates that stress may have more adverse effects on African Americans than whites (Light et al. 1987).

Blood pressures are very labile and vary according to an individual's level of activity, emotional state, and stress. It appears that chronic exposure to adverse working and living conditions are a critical determinant of the chronic elevations of blood pressure levels that are common in the African American population. Health behaviors, such as the excessive intake of alcohol, sodium, dietary fat and inadequate physical activity are also determinants of high blood pressure (Williams forthcoming).

### **Health Behavior**

Health behaviors further illustrate how the health problems of black males are embedded in the social, economic, and political structures of society. Health behaviors, such as smoking and alcohol use, appear to be central determinants of health status. The U.S. Surgeon General, for example, has indicated that almost half of U.S. mortality is attributable to unhealthy behavior or lifestyle (U.S. Department of Health, Education and Welfare 1979). In comparison, 20 percent is due to environmental factors, 20 percent to genetic factors, and 10 percent to inadequate medical care. It has been estimated that the health status improvements possible through increases in healthy behaviors exceed those that would be achieved if an overnight cure were found for heart disease or cancer (Olshansky 1985).

Moreover, health behaviors are primary determinants of the heavy burden of disease in the black population. Blacks smoke more than whites and are more likely to abuse alcohol than whites. The recent report on Black and Minority Health identified six causes of death that are responsible for 80 percent of the 60,000 annual excess deaths in the black population (U.S. Department of Health and Human Services [DHHS] 1985). Table 1 indicates that cigarette smoking and/or alcohol abuse is a risk factor for five of the six causes of death. Thus, the two most serious drug problems in the U.S. are cigarettes and alcohol. Last year crack and cocaine were responsible for 5,000 deaths. In contrast, smoking caused 390,000. That is the equivalent of three fully loaded jumbo jets crashing every day and everyone on board dying! Alcohol directly causes 100,000 deaths and plays a role in an additional 100,000. Smoking and alcohol are thus responsible for the largest and most accepted ongoing mass slaughter in the modern world.

**Table 1**  
**The Leading Causes of Death for Blacks**  
**and Their Associated Risk Factors**

<b>CAUSES OF DEATH</b>	<b>RISK FACTORS</b>
Cardiovascular Disease	Smoking, high blood pressure, elevated serum cholesterol, obesity, diabetes, lack of exercise.
Cancers	Smoking, alcohol, solar radiation, worksite hazards, environmental contaminants, diet, infectious agents.
Homicide, Suicide, and Unintentional Injuries	Alcohol or drug misuse, stress, handgun availability.
Diabetes	Obesity.
Infant Mortality	Low birth weight, maternal smoking, nutrition, stress, trimester of first care, age, marital status.
Cirrhosis of Liver	Alcohol.

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**Source: DHHS 1985 (Vol. II)**

Higher rates of smoking and alcohol abuse among blacks represents a dramatic historic shift in the social distribution of these behaviors. In the 1930s lung cancer death rates for blacks were half that of whites, and up through the 1950s smoking rates for blacks were lower than for whites (Cooper and Simmons 1985). Similarly, if we use death rates for cirrhosis of the liver as an indicator of alcohol use, higher levels of alcohol abuse among blacks than whites are also a relatively recent phenomenon. Up through 1955 age adjusted mortality rates for cirrhosis of the liver were higher for whites than for blacks (DHHS 1985:Vol. VII). Accordingly, efforts to understand and address the health problems of the black population must come to grips with the social structures and processes that facilitate the initiation and maintenance of particular health behaviors.

Most current discussions of health behaviors view them as matters of personal choice. Smoking and alcohol use are treated as if they were autonomous, psychologically oriented factors that are unrelated to working and living conditions and independent of the broader social and political order. John Knowles (1977:58) a former president of the Rockefeller Foundation, typifies this approach with his assertion that we are "born healthy and made sick as a result of personal misbehavior." He argues that individuals are ultimately responsible for their own health and health problems and are under a "moral obligation" to preserve health because one individual's ill-chosen health practices can become another's "shackle in taxes and insurance premiums." Some sociologists have also relied implicitly or explicitly on variants of this psychologically-based "blaming-the-victim" ideology to account for the positive association between health enhancing practices and social status. For example, Mechanic and Cleary (1980:813) indicate that "poor health behavior is part of a lifestyle or orientation reflecting a poor ability to anticipate problems, mobilize to meet them, and cope actively."

In contrast, the evidence clearly indicates that the social distribution of health behavior is dependent on cooperative efforts by the state and powerful economic interests. The very existence of the alcohol and tobacco industries, the price and availability of their products, and thus their profitability are due to specific state action or inaction on their behalf. The financial resources that the alcohol and tobacco industries control have led to a symbiotic relationship with the state and has provided them with the necessary power to coopt other influential actors that would otherwise attempt to mobilize the state to act against them.

The dependence of the state on tobacco and alcohol revenues explains in part why these products are legal in the United States. Tobacco, for example, is exempted by law and administrative decision from the purview of the Consumer Products Safety Commission, the Food and Drug Administration and other federal regulatory agencies (Warner, Ernster, Holbrook, Lewit, Pertschuk, Steinfeld, Tye, and Whelan 1986). If the same standards applied to other products controlled by these agencies were applied to tobacco, it would be banned as a consumer product. Yet although tobacco is harmful when used as intended and remains the nation's most important source of preventable deaths, it escapes federal regulation.

In the case of alcohol, the link between legality and tax revenues is even more transparent. Prohibition (1919-1933) was a success from a public health viewpoint. Alcohol consumption decreased by one-third to one-half, and there was a marked decline in the incidence of cirrhosis of the liver, alcoholic psychoses, and arrests for drunkenness (Burnham

1968; Aaron and Musto 1981). However, prohibition was repealed during the Depression, in part to raise badly needed federal revenues. The federal excise taxes on alcohol remain unchanged until 1951 when they were raised to assist in the financing of the Korean War (Bunce et al. 1981).

Both industries have been very active (and successful) in lobbying against tax increases (Bunce et al. 1981). As a result of this considerable influence exerted over the legislative agenda on tax increases, federal excise taxes on alcoholic beverages and cigarettes (based on a fixed-rate per unit rather than a percentage tax) were not raised since 1951 and 1952, respectively, until the Reagan administration increased them during the recession of the early 1980s [Cowan and Mosher 1985; Fritschler 1989]. This falling rate of taxation led to a decline in the real price of tobacco and alcohol beverages. Given that both tobacco and alcohol consumption are very responsive to price increases (Davis 1987; Cook 1983), the government's failure to let taxes keep up with inflation has been an important mechanism not only to keep these products profitable but also to maintain, if not increase, consumption levels.

Tobacco has the highest dollar yield per acre of any crop grown in the U.S. This distinction is due in large part to a price support program operated by the U.S. Department of Agriculture. The marketing and quota rules of this program protect growers from price instability, and keeps the prices of tobacco up by holding the lid on tobacco production. Although some have noted that the actual costs of the program to the government is small, the operation of the program clearly indicates the state's priorities in the contradiction between profit and safety. The Federal government spends four times as much on the administrative expenses of the program than it does on the Office of Smoking and Health, the federal agency dedicated to educating the public on the risks of smoking (Marwick 1984).

There are more retail outlets for alcoholic beverages in black and poor neighborhoods than in more affluent areas (Rabow and Watts 1984). This has not occurred by chance. Government policies control the availability of alcohol. Retail outlets for alcoholic beverages are licensed in every state and there is a positive association between availability and consumption.

**Building Alliances.** The alcohol and tobacco interests are also able to wield power over legislative agendas because of their ability to build coalitions with potential adversaries. Groups that may have sought government action against these industries are coopted by substantial contributions of monies and assistance from the tobacco and alcohol producers. For example, the alcohol industry provided financial and technical support to Mothers Against Drunk Drivers and Students

Against Drunk Drivers when these organizations were formed (Mosher and Jernigan 1989). In 1987, state legislative associations received a quarter million dollars from tobacco companies, and Phillip Morris and RJR Nabisco provided over \$4.3 million to black, Hispanic, labor and women's groups (Levin 1988). These groups included the black, Hispanic, and Women's Congressional caucuses, the National Urban League and the United Negro College Fund. Similarly, during 1985-1986 alcohol industry political action committees donated \$1.2 million dollars to key legislative leaders and members of Congress and provided an equivalent amount of financial support to state legislators in California (Mosher and Jernigan 1989). Religious organizations have also received generous contributions from tobacco companies. And the outpouring of gratitude from the religious community serves to enhance the image of the tobacco industry. The National Conference of Christians and Jews, Catholic Charities, the Anti-Defamation League of B'nai B'rith, among others, have all sponsored dinners to pay tribute to tobacco company executives (Blum and Fitzgerald 1985).

The result of these contributions has been a reluctance of these groups to make formal statements against these industries or on the health effects of smoking and alcohol use. Moreover, some companies (such as Adolph Coors Co. which agreed to invest \$625 million over five years in black and Hispanic areas) explicitly tie continued economic support to increased consumption of the companies' products (Hacker et al. 1987). These industries do not always win but they have been very successful in derailing hostile legislative action. In Congress during the 1985-1986 year, none of the 160 bills that would have restricted the tobacco industry passed and only one was passed in the following year (Levin 1988).

**Social Conditions.** The need to use alcohol and tobacco is rooted in social structure. Social and economic deprivation create adverse working and living conditions from which people attempt to escape. That is, tobacco and alcohol are mood-altering agents frequently employed to provide relief from the personal suffering that is induced by large scale social structures. Cigarette smoking and alcohol use are socially approved ways to deal with stressful working and living conditions (Berkman 1982). Both the distribution of stress, in occupational, residential and family environments, and the resources to cope with it vary with social status (Williams and House forthcoming). The disadvantaged face more stressors and have fewer options for dealing with them. There is need for greater recognition that social structures create these stressful living conditions and working environments and shape the nature of the adaptive response of social groups.

Scientific research on the reasons why people smoke indicates that people smoke to reduce as distress, anger, fear, and nervous tension (Benfari, Ockene and McIntyre 1982). Stark (1982) has noted that smoking behavior increases in women when they enter the labor force, and in high school graduates who are unable to find work. Data from a longitudinal study of occupational stress reveal that cigarette smoking increases during periods of high stress (Conway, Ward, Vickers and Rahe 1981). It is also instructive that very high rates of smoking have been noted in stressful institutional situations. Prevalence rates in the military are 47 percent, with even higher rates (80% to 85%) in prison populations (Davis 1987). Cigarette smoking appears to be a potent strategy that can break up the drudgery of people's lives and bring diversion and, at least, temporary relief from the chronic irritations and hassles people face. Blair (1979) explains that given that the nicotine high lasts 20-30 minutes, smoking provides the ideal solution for tedious, boring jobs. They not only help pace out a day -- on the production line, in the typing pool, behind the lunch counter or waiting in a welfare line -- but they give you a steady flow of small rewards to keep on trucking. No wonder, according to the U.S. Department of Agriculture, cigarettes are the first luxury item poor people buy (Blair 1979).

Similarly, alcoholic beverages are used for emotional self-regulation. Feelings of powerlessness and helplessness have been identified as critical determinants of substance abuse (Schinke et al. 1988). Alcoholics routinely indicate that drinking helps them to relax and reduce tension (Horwitz et al. 1987). The relationship between perceptions of control and drinking behavior has been clearly demonstrated in the work of Seeman and his colleagues (Seeman, Seeman and Budros 1988; Seeman and Anderson 1983). In a study of the drinking habits of working and lower-middle-class men, these researchers have demonstrated that an individual's sense of powerlessness is positively related to drinking frequency, drinking quantity, and drinking problems. Moreover, stressful life experiences were positively related to increases in both powerlessness and drinking problems.

Other data reveal that the sale of alcoholic beverages increase during economic recessions and periods of increasing unemployment (Singer 1986). Thus, the social and economic stress created by large scale social processes appear to be a critical determinant of alcohol consumption. It is also instructive to note that since colonial times alcohol has been used as a labor control device (Singer 1986). Alcohol and tobacco use may thus have important **social** consequences beyond their effects on health status. The use of drugs, legal or illegal, to deal with problems may encourage people to suffer rather than resist.

## CONCLUSION

McCord and Freeman (1990) in their study of excess mortality in Harlem indicated that poor black communities with extremely high mortality rates should be designated as disaster areas, so that they would be recipients of a major new political and economic commitment to eliminate the underlying socioeconomic causes. I concur. The Bush administration is currently committed to investing billions of dollars to rebuild the economies of Panama and Nicaragua. This is entirely appropriate given our role in creating the current crises those countries face. Similarly, the socioeconomic realities that confront black males were created by large scale economic and political interests. We also need to make a major commitment to improving the economic situation and thus the health status of African Americans.

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