SOC XXXX

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Analytic Memo #4

This memo revolves around the discussion of health inequality and its relation to structural racism within the United States. Utilizing structural functionalism proposed mainly by Herbert Spencer and undergirded by Emile Durkheim's theories (Gomez-Diago; Pope), this memo explains how health inequality is not only shaped by disparaging access to and eligibility for quality healthcare resources but also influenced by other domains of society, including social institutions and policies that reinforce and perpetuate the health inequalities endured by people of low socioeconomic status and racial/ethnic background.

In the United States, health inequality has long been a pronounced social issue that poses detrimental effects to the well-being of the marginalized population and exemplifies the structural racism as well as classism. To put things into perspective, research has found that the richest Americans have a life span 10 years more than that of the poorest Americans (Dickman et al.). This, alongside the evidence that socioeconomic status is one of the primary predictors of healthcare resources access (Williams et al.), suggest that health inequality is something that is shaped by class. However, when we closely examine the racial/ethnic background of those of low socioeconomic status, it becomes quite clear that health inequality is not only a class issue but also one of race.

Specifically, data from the U.S. Bureau of Labor Statistics (2022) indicates that minority groups including Hispanics and African Americans constitute majority of low socioeconomic status group. Not only that, minority groups in and of themselves have poorer health status

compared to the Whites (Baciu et al.). It is certainly the case that such health disparities stem from individual factors including poorer health literacy, lifestyle, inability or unwillingness to access quality medical resources and undergo regular medical checkups, but it is also essential for us to realize the larger, structural factors that contribute to shaping the health inequality.

These structural factors include discriminatory practices within healthcare settings, insurance policies that render certain populations ineligible for or unable to afford quality healthcare services, financial practices that disable minority groups' social mobility, and higher concentration of tobacco and liquor stores in minority neighborhood, and unequal distribution of healthcare services in certain communities.

Firstly, medical professionals can carry out discriminatory practices toward minority patients or sometimes base their diagnosis and treatment on the notion such as that African genes predispose people to certain illnesses (Hamed et al.). Besdes, insurance policies largely favor those of better jobs, thus higher pension and better employer-sponsored health insurance allowing for better services, while disadvantaging blue-collar workers whose predicament is compounded by their need to put in physical labor, live in drafty, crowded hosing conditions, and commute, which became quite obvious during the COVID-19 (Leigh and Chakalov; Sohn). Moreover, financial practice including redlining deny minority individuals' access to financial services that can equip them with social mobility (Lynch et al.). Lastly, minority neighborhood is replete with alcohol stores and poor quality healthcare services (Gaskin et al.; Theall et al.). Together, these factors conjointly shape a reality of

multiple jeopardy in which the health welfare of the minority and/or low income populations is undermined.

To explain such a phenomenon, structural functionalism can come in as a great fit because of the multiple-jeopardy nature of this issue. Structural functionalism sets forth that society is composed of various interconnected parts that co-contribute to maintaining the status quo or stability and solidarity. Importantly, such is done in a way that can potentially benefit the groups or people who made up the rules and established these different social components in the first place. Now, given the fact that multiple domains of society conjointly shape and compound the predicament of minority, low income individuals of poorer health status, structural functionalism is perfect in explaining this.

Discriminatory practices in healthcare settings are essentially a component functioned by the healthcare system. Financial practices such as redlining are actions done by the financial sector. Insurance policies are designed by a branch of the government. So on and so forth. Each of these sectors or components are the interconnected parts that serve to maintain the status quo that disadvantages one group while benefiting the rulers. Another rationale for choosing this theory is that some low-income, minority individuals represent the family sector/component, and their self-damaging behaviors (e.g., substance abuse, criminal offense, etc.) also play a role in shaping the poorer health status. Importantly, when we delve deeper to examine the semantic controversies of the central component of functionalism, which is solidarity and stability, it becomes clear that these two can also refer to the inherent hierarchies and inequity in society. Therefore, the choice of this theory is a strong one.

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