THE HEALTHY WEALTHY AND ROBIN HOOD

Tom Kinney

August 31, 2003

Bulletin Insert: There is a story…that the French police were chasing a criminal who fled into a building in Paris. Their first thought was that they would surround the building. But then they realized that the building was so large, and had so many exits, that they didn't have enough policemen on the scene to do that. So they surrounded the building next door, which was smaller and had fewer exits.

Much of the academic research in the social sciences follows exactly this pattern of reasoning.

Often we don't have information on the variables that matter, so we surround other variables, using statistics that the Census Bureau, or the Congressional Budget Office, or someone else supplied us. Last year, for example, both the media and the politicians seized upon statistics, which showed that blacks received less prenatal care, and had higher infant mortality rates, than whites. The obvious answer was more government spending on prenatal care. Yet the very same study showed that Mexican-Americans received even less prenatal care than blacks and had slightly LOWER infant mortality rates than whites.

Prenatal care was the building next door.

Thomas Sewell, Sept 1992
Sr. Fellow, Hoover Institute
(Mr. Sewell is an African-American)

"One bitter lesson of the 20th Century welfare state is that a bureaucracy has an apparently infinite capacity to absorb extra money without producing additional output."

James Pinkerton
"Atlantic Monthly" Jan/Feb 2003

OPENING WORDS –

The shamans, the witch doctors, the medicine men, the wizards of ancient cultures, some of which have survived the onslaught of modernization, focused on a variety of ills that threatened their constituency. Some of those ills related to the body that threatened comfort at best, and threatened life at the worst. Some of the ills were more of the mind and drew incantations, inhalants, brews, and poultices accompanied by occasional directives that said, essentially, "Get your show together, Dude". And some of these ills were of the spirit that required purging of the devils, inviting in of the angels, or other such manifestations that leave few tracks, few god tracks as we've discussed before.

Today, in what is now Our country, the medicine men of when it used to be Their country are hard to find, let alone a witch doctor, wizard, or shaman or two. Our wizards are biophysics inventors. Our doctors have dropped the witch preface. And our medicine men are pharmaceutical researchers. And our shamans? I don't know. Psychiatrists,

priests, ministers or maybe just everybody's Dutch Uncle with a willing and sympathetic ear.

We spend a lot of wampum on this stuff. Let's see how we're doin'.

The United States spends about $4000 per person each year for health care, by far more than any other nation. Most of this is spent through reasonably efficient HMO's, or somewhat less efficient private insurance plans, or through three or more layers of bureaucracy by Medicare / Medicaid at a highly questionable level of efficiency. With this exceptional level of spending, one might logically presume the U.S. ranks as number one in most, if not all, measures of a healthy population.

Well, we don't. Just to quote a few: In infant mortality, that is number of deaths per live births, we lose almost double the number of babies as does Finland. We rank 25th in that category. In life expectancy at birth, Japan beats our men by 4 years. We rank 25th again, five down from Cuba, if you are willing to believe Castro's numbers. Our women rank 19th in the life expectancy standings. Specific statistics by particular cause of death are generally supportive of these rankings.

What happened? Why does our country rank number one in spending and realize less? The National Policy Association, NPA, and the Academy for Health Services Research and Human Policy takes a shot at the answer in their "Income, Socioeconomic Status & Health: Exploring Relationships", which is in our UUFR library here. I'll use some of their words with some of mine supplemented by words and thoughts from other sources with hopes that a little plagiarism here and there won't wholly destroy your vision of yours truly.

The NPA chose various authors to write each chapter that led NPA to conclude the problem is socioeconomic inequality – more popularly the gap between rich and poor, a frequent UU theme. That shorthand gap statement is a bit misleading because, as we've discussed before, the gap between absolute starvation threatened, mud shack dirt poor will hopefully always continue to increase as the standard of living continues to improve. One can go no lower than starvation without surviving until every last dirt hut is gone – not likely soon – that's relatively fixed. Thus betterment of the average increases the gap. But we need to look at this economic inequality in a different way to get in tune with NPA's work. And that is, what percent of the national GDP and/or national wealth resides with the top 10% vs. the bottom 10% of the population – or any other upper or lower same percentage of the people. The ideal communist state would have everyone's income and wealth be the same. Some socialists believe it should be a perfectly symmetric relationship with the middle 50% with half the nation's wealth and income and the upper and lower 25% deviate equally from the norm – maybe 10%, 20%, whatever. However, a free market meritocracy, that is a system that, in general, rewards the most unique talents, initiatives, hard workers, and risk takers based on market forces, will be asymmetric where the most innovative or successfully manipulative will garner a significantly higher percentage of the wealth with a broad middle class sharing a good chunk of the remainder. Under-developed countries are a whole different ball game when it comes to poor health and just plan poor issues – that's a discussion for another time. *We'll leave it at things are getting much, much better. The UN writes in 1997 "Few people realize the great advances already made (in the increasing wealth of all peoples). In the past 50 years poverty has fallen more than in the previous 500 years."*

In 1950, approximately 50% were poor worldwide. By 1987, it had dropped to 28.7 % and, by 1998, 24% and it is continuing to drop according to the World Bank. We need factual uplifting data every once in awhile showing how well we're doing lest we become depressed by the "Sky-is-Falling" crowd.

NPA points to the health records of Japan, Sweden, and other countries where the gap between the rich and the poor is much less. When one analyzes this data, a definite and important correlation between economic inequality and population health appears. NPA ignores characteristics of population homogeneity. While strong in Sweden, it is a passion in Japan. Most of us know the Japanese passion for purity where immigration is not an option. Unless you are a Hawaiian-American Sumo champion who happens to have darker skin and a playful cant to his eyes. Our lack of homogeneity and exceptionally high immigration rate lends us health challenges including bamboo and mud hut births that prejudices that person's health for a lifetime. Let's consider NPA's analysis, being cognizant of that homogeneity issue is in the wings.

Their premise is, if we could greatly reduce the economic inequality in our country we could do wonders for the health of our people. When we compare the gap between rich and poor as it varies from state to state, we find this premise is supported by the data. Life expectancy is higher in more income equal states such as Utah and New Hampshire, and lower in less equal in states such as New York, Mississippi, and Louisiana. One might quickly be willing to follow Robin Hood by confiscating wealth from the rich and giving to the poor. After all, both compassion and practicality come together in a wish for a healthy and strong populace.

First, NPA's authors report the issue is NOT access to health care. Analysis by the Center for Disease Control studies conclude only 10% of today's premature mortality can be attributed to inadequacies of health care. This makes some sense as the great gains in life expectancies from 1900 on came early in the century, before widespread introduction and application of medical treatments kicked in. Sanitation, food preparation, nutrition, and a generally more health knowledge and conciousness gave us the biggest boost. Ten percent is a pretty small and surprising statistic when one reflexes on the furor over Universal Health Care.

What is the breakdown of the other 90% that impacts premature mortality in the lower socioeconomic group? The CDC says 50% of premature mortality can be attributed to health behavior and lifestyle, 20% to environmental exposure (meaning what we would consider normal safe, clean, and health homes and communities – not to be confused with the "Love Canal" type issues), and 20% is genetic.

Social and economic inequality yield bad health in America, speculates the NPA, because major behavioral risk factors such as smoking, high alcohol use, sedentary lifestyle, and high fat diets for key diseases show the same correlation with socioeconomic status as does the general health outcomes. A reinforcing example is that the more educated, more affluent were quicker to pick up on the dangers of smoking and take action. Smoking persists among those lower in the economic hierarchy and is now apparent in the demographics today's lung cancer data compared to the 1970's and 1980's. One wag defined poverty as the lack of skill in the sense of inability to make good decisions to improve one's circumstances.

Further NPA states it is more likely the lower one's socioeconomic status is, the higher the everyday stress environment. Now don't poo poo this in relation to executive

stress. This stress can be from the lack of physical safety in living conditions, discriminatory practices, or failure to achieve the materialistic "needs" of life as established by spouse, children, friends, or TV now found in the most meager of American homes. This latter may be called the "expectation factor" or "I want it NOW" syndrome. The broadly available "get it now" credit cards compound the stress for those with weak discipline and little grasp of economic reality as they waste substantial purchasing power on interest payments. Stress related health problems are much higher in those of low socioeconomic status. And high stress alone is known to be a determining factor in overall health and stamina.

Early childhood care, including infant care within the first few months, is being better understood as an important factor in **lifetime** health. Volunteer baby-huggers are now encouraged by some hospitals just to stop by and hold or stroke those little preemies that lack parental attention. Doctors say it works! Poor parenting skills and less active involvement with children correlate with both poor lifetime health and low social economic status.

Finally, NPA reports it can be shown that those with a support network enjoy better health and improved recovery from health problems than those with no family, friends, or group affiliations. Those relationships are notably fewer and weaker among those lower on the socioeconomic scale.

For a quick look on the increasing economic gap, America's industrial economy provided the base for much of worker wealth and health. What happened over the last few decades that caused many skilled and un-skilled families to slip in earning power and socioeconomic status? Two of the many factors are deterioration of the family cohesiveness that some blame on the social attitudes and programs of the '60's and, second, is the economic shift of population centers. The first has been amply debated and we won't go into governmental fostered dependency here. Second, the perspective on the economic shift is summarized by David Friedman's writings published in early 2003:

"As early as 1969, New York City adopted a plan that explicitly called for the systematic displacement of the city's…industrial base by a subsidized…office economy. Over the next three decades this policy stripped 600,000 well-paying manufacturing jobs from what was once America's largest and most diverse production center, replacing them with a small number of professional positions at one extreme and many more low-paying service jobs at the other. Others followed suit…Seattle, Portland, Boston, San Francisco. The drive to transform our cities seems in part to reflect an almost aesthetic or cultural distaste for blue-collar work among our political, economic, and media leaders. The technology boom of the 1990's masked the 1990's increasing reliance of the economy on government and consumer spending – a big reason why public deficits and private debt are ballooning."

"The average production-sector job creates three times as many additional employment opportunities as the average service job. Given that more than 60% of U.S. workers lack college degrees, and that manufacturing disproportionately employs the non-college educated and pays wages roughly 20% higher than other sectors, it is not surprising to find that as manufacturing declines, economic inequality rises."

Friedman continues, "In the 10 years, 1993-2002, the U.S. economy created barely more jobs than in the previous 10 years when the working age population was smaller. Revised data shows our productivity growth since 1995 was only half as strong

as the initial numbers showed. Even these gains may turn out to be more superficial than they now appear. And, beginning in 1998, America has shed another 11% of her relatively well-paying manufacturing jobs.

A return to policies promoting maximizing the diversity of the economy would generate the widest range of employment opportunities for all our citizens and help to fill the income gap.

If you doubt that, cruise through Wal-mart checking countries of origin of their stock as I have. Consider the low paid clerks you see versus the manufacturing jobs you don't see that made those products. Then consider the attitudes toward establishing a 100-acre plastic injection molding plant in our community with its accompanying aesthetics, noise, traffic, phenolic smells, and infrastructure requirements necessary to make it quality and price competitive. We jointly and individually make these decisions and a societal price is to be paid.

Remember the CDC reported source of the health problem was 50% health behavior and lifestyle and 20% environmental exposure, essentially living conditions, and 20% genetic as the cause of premature mortality. Assuming we can't attack the 20% genetic issue at this point, that means health behavior and healthy environment is almost 90% of the correctable problem with a remaining 10% being access to health care. So why not focus on healthy behavior including motivating people to create a more healthy home environment?

Here's a quote from NPA's report. "It's unreasonable to expect people to alter their (behavior and) lifestyle when numerous social, cultural, and physical environmental forces conspire against such change." Let me read that again. """" Does that make sense to you? Would you make an effort to alter your health behavior and/or living environment if it meant that half the babies dying today in America would live? Would you make an effort to alter your health behavior and/or environment if it meant four additional years of happy and productive life? Would you take such action if you knew it would greatly reduce your chances of suffering one or more debilitating diseases? The people in the early part of the 20th century sure did and produced monumental gains. Those people learned healthy behavior in issues of cleanliness, food preparation and diet, healthy home environment, maintaining wells and sewage disposal systems and household animal and pest control, just to name a few.

What better way to alter health behavior patterns than to increase the care and loving of children? Treating others with respect, empathy, and support. Sharing ways to progress down this path of life that lends meaning and comfort. Considering your own body as a gift of nature, an awe-inspiring temple of the gods if you wish, that deserves both care and respect – not drugs and abuse. Developing a sense of values that raises relationships above possessions, that raises contributions to community above the age of your car, that recognizes your children are your most valued legacy – and maybe your only meaningful one. Being a part of something beyond yourself – extended family, community, church, or other purposeful fellowship groups. All of these guide and change our behavior. How does that healthy message get to those who need a healthy boost? Sounds more like churchy stuff to me – morals, lifestyle, values and all. *Why not be Robin Hood and steal all these ideas and understandings from the rich and not quite so rich and give all that to the poor?*

Interfaith's SAIF Water group is doing just that on wells and sewage disposal. Could it be that the churchy philosophy of our society upon which our founding fathers depended to provide moral standards and behavioral guidance has slipped a bit and should have more a part in the "fix"? And that doesn't mean just working with the poor.

Yes, there are two destinations to this discussion. One could be how do we influence others within our community who are at health risk to reduce that risk. And, if we expect people to address behavior that compromises their health future based on the analysis discussed, they will. And just maybe we can do with a bit of reminder ourselves.

While we teach others the wisdom of living within their means, can we ourselves learn how much is enough and be happy with that? While we help others to adore and hug their children, can we teach ourselves the importance of cherishing and hugging each other? While we encourage others to build support networks, be attentive to family, and engage others through group involvements, can we devote the time and energy to do the same? While we alert others to the health risks related to excessive consumption and absence of exercise, can we listen to ourselves and tune our own habits to reduce risk?

While we help others see the wisdom of expending their funds wisely with emphasis on home ownership or other assets of stable value, can we resist the frivolity and ego-enhancing spending where our excess funds could accomplish more worthy goals? Ray Boshara in the "$6000 Solution" quotes African-American households have 54 cents of income and 12 cents in wealth for every dollar of typical white households. Hispanics had 62 cents of income and only 4 cents of wealth. We can do little things to help. A fella named Burke, owner of an old truck and nothing else, began working side by side with me on and off about 13 years ago. As working friends, we talked a lot about life. For example, he and I hit a cord on the smoking issue when together we worked out that he would have had $40,000 in cash or wealth at this point in his life if he had not spent it on cigarettes, plus a little grass on the side. My need for Burke's help ended about four years back, but he keeps in touch. Last I heard he owns a house in Kilmarnock, mortgage paid off, and a "country home" in Mollusk. Although a hard working girlfriend to become his wife in October certainly helped as did a small inheritance, Burke's view of the long term impact of his spending habits and how he uses his extra time and carpentry skills to improve his living environment have made a difference. Tonya, his oldest of his two daughters, is now in college in North Carolina. Burke's income is improving but, as important, so is his health and his wealth.

So what did I get out of this latest batch of reading?

Health behavior and living conditions are 90% of the modifiable health care determinates with 10% being access to health care. Whereas our support of the Northern Neck Free Health Clinic does an excellent job in addressing the 10% part of the premature mortality statistic, the 90% side of the issue, health behavior modification, needs proportionately a lot more weight. *Where's Robin Hood and his band of merry…people…when you need him?*

If the mores, morals, and behavior patterns of the community are influenced by the social and religious groups, peer pressure, and other influences on the individuals, that may mean UUFR is included among those who can make a difference to the health of our community. Or may share some obligation to try. For don't we believe we have a responsibility for each other?

The value of a supportive network of friends to a healthy, long and productive life is yet another contribution UUFR can make to its people. We should be mindful of that as we remain aware of needs of our members, especially those more reserved and those new found. And what better place to invest our time and fortune,

Like with our remarkably successful Northern Neck Free Health Clinic providing medical access to the working poor, those of us involved in its beginnings believed solutions lie here, in our own communities. Not in Richmond. Not in Washington. So, as individuals, lets make good things happen. And maybe do a little of the same as…a band of merry men – and women.