relevant to improved health. Only with the incorporation of such a socially expanded data base will we begin to develop an elucidation and understanding of nonmedical factors that we know will influence and improve health, and thus increase our ability to design programs, policies, and education. The government will ultimately be the centralized depository of this health care data base, thus, de facto, creating a National Institute of Social Health, which I believe is necessary.

Recognition of the importance and identification of nonmedical factors on health status has been painfully slow; it continues to be controversial. Yet, with the publication of "Toward a Social Policy of Health" in the *New England Journal of Medicine*, and Pincus and Callahan's article in *Advances*, as well as the publications of others, progress is occurring. Perhaps by the next generation, when this vision of a health care system is realized, the political environment will be sufficiently capable of responding to the vital information that will be generated and motivated to expand its view to a social policy for health. Only then will good health be potentiated through modification of advice and behavior that has been based on specific psychosocioeconomic and mind-body factors and those unforeseen causal relationships we have yet to identify through health care data base analysis.

REFERENCES

Pincus T & Callahan L. 1995. "What Explains the Association Between Socioeconomic Status and Health: Primarily Access to Medical Care or Mind-Body Variables?" *Advances: The Journal of Mind-Body Health.* 11(1):4-36.

Hurowitz JC. 1993. "Toward a Social Policy for Health." *New England Journal of Medicine.* 329:130-3.

You Can't Get There From Here: Understanding the Association Between Socioeconomic Status and Health Requires Going Upstream

George A. Kaplan

George A. Kaplan, Ph.D., is chief of the Human Population Laboratory in the California Department of Health Services.

Pincus and Callahan are to be congratulated for reminding the readers of *Advances* about the fundamental importance of socioeconomic factors in health and illness. After all, "mind-body" advocates, as well as the medical establishment, have, for the most part, ignored these most powerful determinants of people's health.

As a social epidemiologist who has troubled over understanding the relationship between social class and health for some time, I find there is much to agree with in this article. Starting with the oft-quoted and provocative quote from Virchow on the salutogenic importance of changes in social conditions, the authors describe some of the mountains of evidence that illustrate the role of social class in the etiology and progression of a wide-ranging set of diseases. The scope of this evidence, which they are only able to hint at (see, for example, Haan, Kaplan & Syme 1989), should constitute a major challenge to understanding the forces involved in health. They then go on to develop a set of reasonable recommendations for medical research, medical education, and medical care reform.

While there are many areas in their discussion that I agree with, there is one statement which, to me, seems absolutely wrong. Unfortunately, it refers to half of the major thesis of their contribution. They propose that "associations between socioeconomic status and health are based primarily on mind-body factors that importantly affect health." As their title puts it, these mind-body factors "explain" the association between socioeconomic status and health. Perhaps I don't understand what they mean by "mind-body factors," but I assume, based on the rest of the text, that they include behavioral, psychological, and cognitive variables. There are several reasons why I think their thesis is incorrect.

As they are discussed, these behavioral, psychological, and cognitive variables are presented as properties of individuals. While it is true that individuals behave, feel, and think, the fundamental fact is that these behaviors, feelings, and cognitions are differentially distributed across socioeconomic groups. For example, in Pincus and Callahan's table showing the educational level and clinical status of a series of patients with rheumatoid arthritis, we see that patients with lower education are more likely to have higher scores on learned helplessness, and lower levels of sense of coherence and optimism. In another sample, we have similarly shown that those with lower incomes are more likely to be cynically distrustful, depressed, and hopeless, and to have lower self-esteem and sense of coherence (Kaplan 1995). The fact that these "individual" factors are socially patterned suggests that they are better seen as properties of the group or of environments shared by a group than as properties of the individual. While some

One statement by Pincus and Callahan seems to me absolutely wrong—their proposition that "associations between socioeconomic status and health are based primarily on mind-body factors that importantly affect health."

might argue that these factors lead to different levels of education and income, similar patterns are seen if we examine behavioral factors such as smoking. Yet few would argue that an individual's smoking behavior results in one being in a particular socioeconomic position!

Thus, it is important to ask why these mind-body factors are differentially clustered socioeconomically. A reasonable hypothesis is that the lives of people at different socioeconomic levels expose them to very different environments, challenges, opportunities for mastery, and resources. Is it really surprising that being poor might lead to higher levels of depression and cynical distrust, and lower levels of optimism and sense of coherence? Or doesn't it seem very much the case that the experience of coping with a flat tire varies enormously by social class?

Focusing on "mind-body factors" as the causes of socioeconomic differential in health leads, by necessity, to a position that focuses on what's happening downstream without understanding the antecedent, upstream factors, which help to understand why people who are poorer are less optimistic or have lower self-efficacy. What would happen if we were able to take everyone who was pessimistic, had low self-efficacy, and was cynically distrustful, and magically make them optimistic, self-efficacious, and trusting? While it just *might* improve their health, it would do relatively little for the many, who because of their place in life were becoming pessimistic, passive, and distrustful.

What's more, an approach that focuses on mind-body variables and ignores the world, ignores the powerful macroeconomic factors and social factors which shape individual lives. Such an approach cannot be very informative. It's a little like trying to reconstruct the reasons for the massive changes in smoking behavior as the sum of individual decisions without reference to environmental restrictions, changes in taxation policy, and other large-scale forces.

From this perspective, it is unlikely that the strictly biomedical approach will be able to explain socioeconomic gradients in health, and it is equally unlikely that the mind-body approach will succeed. Can we really expect a mind-body approach that is not grounded in the real world to do any better? On the other hand, an approach that examines a wide range of economic and socioenvironmental factors and how they influence individual behavioral, psychological, and cognitive trajectories could greatly expand our understanding of the role of socioeconomic factors in health and disease. In this sense, studies of socioeconomic factors and health represent a prototype for the challenge of understanding the interaction between the environment, mind, body and health.

REFERENCES

Haan MN, Kaplan GA & Syme SL. 1989. "Socioeconomic Status and Health: Old Observations and New Thoughts." In Bunker JP, Comby DF, Kehrer BH (eds.). *Pathways to Health: The Role of Social Factors.* Menlo Park, CA: H.J. Kaiser Family Foundation.

Kaplan G. 1995. "Where Do Shared Pathways Lead? Some Reflections on a Research Agenda." *Psychosom. Med.* In Press.

Community-Oriented Primary Care Provides a Framework for Studying Psychosocial Factors and Health

Shiraz I. Mishra and Howard Waitzkin

Shiraz I. Mishra, M.D., Ph.D., and Howard Waitzkin, M.D., Ph.D. are at the University of California, Irvine, Center for Health Policy and Research and Department of Medicine. Additionally, Mishra is in the School of Social Ecology, and Waitzkin is in the School of Social Science.

Pincus and Callahan have put forth the intriguing hypothesis that associations between socioeconomic status and health are based primarily on mind-body activities that importantly affect health and that socioeconomic status is more of a surrogate marker for behavioral, psychological, and cognitive variables than for demographic conditions and access to medical care (Pincus & Callahan 1995). Furthermore, they argue that for advances to occur in health and well-being, there must be a shift from the current medical care model with its emphasis on the medical profession, curative medicine, and technology to a health care model that incorporates the contributions of individuals.

The premise of the hypothesis may be true, and the ensuing debate on the importance of mind-body variables in explaining the association between socioeconomic status and health will be fruitful. It is helpful, however, to broaden