As a basis for health planning, data were collected from a sample of the population of Oakland, Calif. Whites and Negroes in the part of Oakland designated as a poverty area were compared with people of the same race and income level living elsewhere in the city. Comparisons on a number of health, economic and social items are presented here.

POVERTY AREA UNDER THE MICROSCOPE

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To carry out its mission, a health department must know the composition of the population it serves, where health problems exist, and in what combinations. Of particular concern are the poorer sections of the city, which absorb a large proportion of the services provided by health and other agencies. To gain some insight into a depressed area, the Human Population Laboratory of the California Department of Public Health included in its demographic description of Alameda County[1] separate data on the part of Oakland designated as a "poverty area" for purposes of the federal antipoverty program.

The contrasts shown between the poverty area and the remainder of Oakland are sharp: The poverty-area population includes far higher proportions of Negroes, of unemployed, of persons in low-skill occupations, and, of course, of low-income families. This not unexpected finding leaves a number of unanswered questions. Do people in the poverty area exhibit such high rates of physical and social impairment simply because so many of them are poor? Or because many of them are Negroes? Or does residence in the poverty area in itself have a debilitating effect?

Because answers to these questions are important for effective health department planning, the laboratory undertook an intensive analysis of the relevant data from its study. This paper compares persons of different races and income groups on a number of health, economic, and social items, both within each section—poverty and nonpoverty—and between the two areas. For example, whites in the poverty area are compared with Negroes in the area, as well as with whites elsewhere in Oakland. Persons of various income levels are compared within each area, and each income level in the poverty area is compared with the same level outside. White persons of inadequate income are compared with Negroes of inadequate income in the same area, as well as with whites of inadequate income living in the other area, and so on.

Conclusions from this analysis, while directly applicable only to the Oakland population, should provide clues for the organization and content of health services generally. In particular, the indication of a relationship between residence in a poverty area and individual malfunctioning should give further impetus to the present tendency to provide com-

prehensive health and other social services in poverty areas. Such a relationship also suggests the need for far-reaching environmental changes to make these services effective.

Description of the Study

The data reported here are based on an area probability sample of adult residents of Oakland, California. The city is situated on the east shore of San Francisco Bay and has a population of close to 400,000 people. The sample for this report comprises 908 adults in the poverty area and 1,672 in the remainder of the city.

The boundaries dividing the so-called poverty area from the rest of the city were based primarily on unemployment rates for men, as reported in the 1960 Census. The poverty area consists of a set of contiguous census tracts with 1960 male unemployment rates of 9 per cent or higher. As of 1965, about one-third of the residents of Oakland lived in this area, including a majority of its Negroes.

The focus of the present report derives from an unsought by-product of the way that the poverty area was defined. The poverty area includes those sections of Oakland generally conceded to be the most depressed, and it includes a majority of the city's poor people; nevertheless, most of the residents of the poverty area do not have poverty-level incomes. Indeed, fewer than one-third of the adults living in the poverty area have "inadequate" family incomes, and almost half of all Oakland residents with "inadequate" family incomes live outside the poverty area.*

While the incongruity between poverty-area residence and nonpoverty-level income may be troublesome for administrators of antipoverty funds, it offered the Human Population Laboratory a valuable opportunity to compare poverty area residents with nonresidents at the same income level—adequate as well as inadequate. Since race is generally associated with both area of residence and level of income, white and Negro residents of the poverty and nonpoverty areas were also compared. These comparisons involve the rates of sickness, economic deprivation, and social instability found among members of the sample in the poverty area and elsewhere in the city. The indicators of sickness include reported health problems, negative self-evaluations of health, and insufficient use of health care resources. Deprivation is defined by indicators of financial insecurity and limited occupational skills. Social instablity refers to marital disruption and general dissatisfaction.

The data herein indicate that these problems are reported more frequently by poverty area residents than by nonpoverty area residents, by people with inadequate incomes than by people with adequate incomes, and by Negroes than by whites. The data also shed light on the following questions:

Are poverty area residents more likely to report these problems, regardless of their race and income?

Are Negroes and whites living in the poverty area equally likely to report these problems, or are Negroes in the area more comparable to those outside it?

Are poverty area residents with adequate incomes as likely to report these problems as those with inadequate incomes, or are they more comparable to persons of the same income level outside the area?

To what extent are poverty area residence, inadequate income, and being a Negro cumulative in their effect on rates of sickness, economic deprivation, and social instability?

We shall present our findings in the following way: First, we shall describe the poverty and nonpoverty areas in demographic terms. Second, we shall compare residents of the poverty area with residents of the nonpoverty area on

* See Figure 1 for definition of "inadequate" income. Roughly, it is equivalent to less than $4,000 annual income for a family of four. The distribution of adults of various income levels in the two areas is shown in Table 4.

Table 1—Home ownership, type of dwelling, crowding and other household characteristics in the poverty and nonpoverty areas

Household characteristics	Poverty area	Nonpoverty area
Total Households	600	1,106
	Per cent	
Do not own home	65*	44
Multiple dwelling	63*	42
Crowded (1.01 or more persons per room)	12*	4
Head and children but no spouse (with or without other adults)	14*	6
	Average	
Mean number of persons in household	2.8	2.6
Mean number of persons in household working	1.0	1.1
Median number of years in present house	3.1	3.3

* Difference significant at the level of ≤ 0.05 (t-test).

the frequency with which they report sickness, deprivation, and social instability. Third, we shall subdivide the poverty and nonpoverty area residents according to family income and compare them on the same indicators, and then make the same comparison between poverty and nonpoverty area residents subdivided according to race. Finally, we shall examine the effect of residence, income, and race simultaneously taken into account.

Poverty and Nonpoverty Areas of Oakland

Demographic Description

Households in the poverty area of Oakland are compared with households in the nonpoverty area in Table 1. The two areas differ little in size of household, number of wage earners or length of residence in the present home, but far higher proportions of poverty area households are in multiple rather than single dwellings and are occupied by renters rather than owners, by one-parent families, and by persons living in crowded conditions.

Table 2 shows that the race distributions in the two areas are very different ($\chi^2=795.47$, df$=2$). The poverty area has a large Negro population, while the remainder of the city is predominantly white.

As shown in Table 2, the over-all adult age distributions in the two areas are quite similar ($\chi^2=0.728$, df$=3$). But whites and Negroes differ sharply in both areas. Far higher proportions of whites are 65 and older (Table 3).

Since age is associated with some of the variables under study, in particular with health variables, we corrected our raw data by the indirect method of age adjusting.[2] The age-adjusted indexes for whites and Negroes were then compared within each area, applying standard statistical technics.

On indicators of economic deprivation and social instability, age adjustment

Table 2—Distribution of age and race among residents of the poverty and nonpoverty areas

	Poverty area	Nonpoverty area
Total Adults*	908	1,672
	Per cent	
Age		
Less than 30 years	20	19
30–44	26	28
45–64	37	35
65 and over	17	18
Race		
White	37	88
Negro	58	8
Oriental and others	5	4

* Persons 20 years and older plus persons 16-19 who have ever been married.

Table 3—Age distribution of poverty and nonpoverty area adult residents by race

Age	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
Total Adults*	332	526	1,468	135
	Per cent			
Under 30 years	20	20	20	15
30–44	18	31	26	53
45–64	35	39	35	28
65 and over	27	10	19	4

* The 119 "Orientals and others" in the sample are *excluded* from this and all subsequent tables subdivided by race. They are included in Tables 4 through 11.

did not affect our conclusions substantially. On health problems, however, it eliminated some of the significant differences between whites and Negroes (see Tables 9, 12, and 17, notes).

We have already mentioned the distinction between poverty-area residence and poverty-level income. Various federal, state, and private agencies have set up criteria for defining poverty-level income. We drew on these criteria for our definition, which involves a combination of family income and family size. Figure 1 shows how income levels for various sizes of family were grouped in three categories: "inadequate," "marginal," and "adequate."

A sharp cleavage in income exists between the two areas ($\chi^2=162.62$, df=2). Three adults out of ten in the poverty area subsist on inadequate incomes —over twice as high a proportion as in the remainder of Oakland (Table 4).

Sickness, Deprivation, and Social Instability

In addition to the data on sickness, deprivation and social instability collected by the Human Population Laboratory in 1965, corroborative data were gathered by Oakland city agencies[3] in 1964. According to the Alameda County Welfare Department, 85 per cent of Oakland's general assistance recipients, 79 per cent of those receiving aid to families with dependent children, 79 per cent of those receiving aid to the disabled, 63 per cent of the blind needing help, 53 per cent of senior citizens requiring welfare assistance, and 46 per cent of the aged in need of medical aid were residents of the poverty area. The Oakland Police Department reported that 65 per cent of the police work load was absorbed by the poverty area.

Figure 1—Graphic presentation of derivation of inadequate, marginal and adequate income groupings

Family income	Persons in household			
	1 or 2	3 or 4	5 or 6	7 or more
Less than $3,000	I*	I	I	I
$3,000–$3,999	M†			
$4,000–$4,999		M	M	
$5,000–$5,999	A‡			M
$6,000–$6,999		A	A	
$7,000–$7,999				A
$8,000 and over				

* I=Inadequate family income.
† M=Marginal family income.
‡ A=Adequate family income.

Table 4—Family income level by poverty and nonpoverty area

Family income	Poverty area	Nonpoverty area
Total Adults*	805	1,592
	Per cent	
Inadequate	30	12
Marginal	23	16
Adequate	46	72

* Persons who gave insufficient information about income are excluded from this table.

Table 5—Indicators of sickness among residents of the poverty and nonpoverty areas

	Poverty area	Nonpoverty area
	Per cent	
Reported Health Problems		
Some disability	16*	10
1 or more chronic conditions	46*	38
1 or more impairments	12	10
1 or more symptoms	64	62
Low Evaluation of Health		
Report health "fair" or "poor"	34*	18
"Seriously bothered" by some condition, impairment or symptom	25*	17
Less energy than most people their age	34*	25

* Difference significant at the level of ≤ 0.05 (t-test).

These proportions all exceed the 41 per cent of Oakland's population living in the poverty area in 1960, according to the U.S. Census. (Our data indicate that only 32 per cent of the noninstitutional population lived in the poverty area in 1965. The decline since 1960 is probably due to the reduced number of available dwellings in the poverty area during extensive redevelopment, and condemnation of housing for rapid transit and freeway construction.) It is clear that a disproportionate amount of the demand for community services comes from the poverty area.

Table 5 presents some health characteristics of the people in the Human Population Laboratory study. Poverty area residents are more likely than others to report disabilities and chronic conditions, and 34 per cent consider their health only "fair" or "poor," compared with 18 per cent of those living elsewhere in Oakland.*

Since there is more sickness in the poverty area, one might expect its residents to use health facilities more often, but this is not the case. Similar proportions in the two areas report medical checkups, doctor visits, and having a regular physician. Poverty area residents are far less likely to report insurance coverage† and dental checkups (Table 6).

That poverty-area residents suffer

* The health problems reported by poverty-area residents are both more numerous and of a more serious nature, according to data from a Human Population Laboratory report on "Health in Alameda County 1965," now in preparation.

† At the time of the survey—spring and summer 1965—health insurance related to self, employer, or similar provision of coverage. Currently, Medicare and Medi-Cal fill the gap in many cases.

Table 6—Indicators of deficient health care among residents of the poverty and nonpoverty areas

	Poverty area	Nonpoverty area
	Per cent	
Health Care Deficiency		
No health insurance	33*	14
No dental checkup in more than 2 years	48*	24
No medical checkup in more than 2 years	31	30
No doctor visits in past 12 months	29	30
No regular physician	26	22

* Difference significant at the level of ≤ 0.05 (t-test).

Table 7—Indicators of deprivation among residents of the poverty and nonpoverty areas

	Poverty area	Nonpoverty area
	Per cent	
Financial Insecurity		
Unemployed	11*	3
Receive unemployment disability or welfare payments	22*	7
Limited Occupational Skills		
Service workers or laborers		
Men	36*	9
Women	42*	11
Eighth grade or less education	38*	17

* Difference significant at the level of ≤ 0.05 (t-test).

relatively severe economic deprivation is indicated not only by their lower income (Table 4) but also by higher rates of unemployment and dependence on community support, lower-status occupations and lack of educational qualifications for betters jobs (Table 7).

Poverty area residents are also more likely to experience social and psychological maladjustment than persons living elsewhere in Oakland. Far more of them report marital difficulties, general unhappiness, and particularly that sense of rootlessness known as anomy,*[4] (Table 8).

Income Comparisons in the Two Areas

We have demonstrated that residents of the poverty area are less healthy, less well-off economically, and socially less stable than people in the nonpoverty area. We have also shown that income distributions in the two populations are markedly different. We turn now to comparisons involving both residence and income, to see how persons of different income levels in the two sections fare.

Sickness and Health Care

The data in this section are organized to emphasize differences *within* areas. Here our analysis demonstrates the role of income within each area. For example, Table 9 shows that in the poverty area, the lower the income, the higher the proportion who report sickness and evaluate their health negatively. On most items, this is also true in the nonpoverty area.

Differences *between* areas are also of interest, though in most cases they are smaller than the differences between income groups. Poverty area residents are more likely to report "fair" or "poor" health, regardless of income, and those with inadequate incomes are also more likely to report less energy than most people their age.

Questions about health care yield a

Table 8—Indicators of marital instability and general dissatisfaction among residents of the poverty and nonpoverty areas

	Poverty area	Nonpoverty area
	Per cent	
Marital Instability		
Separated or divorced	18*	9
2 or more marriages	29*	21
Marriage is unhappy or only somewhat happy	30*	17
General Dissatisfaction		
"Not too happy" these days	16*	10
High "anomy" score	38*	20

* Difference significant at the level of ≤ 0.05 (t-test).

* We used the nine-item "anomy" scale developed by Herbert McClosky, and others. It consists of questions such as the following (Agree or Disagree): "People were better off in the old days when everyone knew just how he was expected to act," "I often feel that many things our parents stood for are just going to ruin before our very eyes," "With everything so uncertain these days, it almost seems as though anything could happen," and so on. A score of from 6 to 9 is "high."

Table 9—Indicators of sickness by residence and family income level

	Poverty area			Nonpoverty area		
	Income level					
	Inadequate	Marginal	Adequate	Inadequate	Marginal	Adequate
	Per cent					
Reported Health Problems						
Some disability	27*	15	8	20*	10	7
1 or more chronic conditions	54*	49†	39	52‡	39	35
1 or more impairments	18*	10	8	16‡	11	8
1 or more symptoms	74*†	68	56	66	63	62
Self-Evaluation of Health						
Report health "fair" or "poor"	46*†	33†	25†	27*	21	15
"Seriously bothered" by some condition, impairment or symptom	38*	22	16	29*	20	14
Less energy than most of same age	47*†	32	27	25	26	25

* Within-area differences significant at the level of ≤ 0.05 (F-test).
† Between-area difference for the indicated income group significant at the level of ≤ 0.05 (t-test).
‡ The age-adjusting procedure applied to Negroes and whites was also applied to the three income groups in each area. In the nonpoverty area, this made differences among the income groups nonsignificant on chronic conditions and impairments. On all other items, age adjustment did not change the original findings.

mixed picture, as shown in Table 10. Within the poverty area, income level has relatively little influence on the utilization of health facilities; health care programs may be reaching their target here. Outside the poverty area, however, persons with inadequate incomes make least use of health insurance and medical and dental checkups, and they are least likely to have a regular physician. Dental checkups and health insurance are less common in the poverty area, but these are the only health-care items that distinguish poverty area residents from nonresidents at the same income level.

Social Instability

By and large, the less adequate the income, the more common are reports of marital and social instability. But residence also plays an important role. In

Table 10—Indicators of deficient health care by residence and family income level

	Poverty area			Nonpoverty area		
	Income level					
	Inadequate	Marginal	Adequate	Inadequate	Marginal	Adequate
	Per cent					
Health Care Deficiency						
No health insurance	56*†	24	18†	39*	14	8
No dental checkup in more than 2 years	54†	46†	46†	36*	30	22
No medical checkup in more than 2 years	37	28	31	41*	32	28
No doctor visits in past 12 months	30	26	29	34	30	29
No regular physician	27	25	25	32*	24	19

* Within-area differences significant at the level of ≤ 0.05 (F-test).
† Between-area difference for the indicated income group significant at the level of ≤ 0.05 (t-test).

Table 11—Indicators of social instability by residence and family income level

	Poverty area			Nonpoverty area		
	Income level					
	Inadequate	Marginal	Adequate	Inadequate	Marginal	Adequate
	Per cent					
Marital Instability						
Separated or divorced	26*†	17	10	16*	12	7
2 or more marriages	33*†	36†	23	23	22	20
Marriage unhappy or only somewhat happy	39*	31	25†	25*	25	16
General Dissatisfaction						
"Not too happy" these days	21*†	13	12	12	11	9
High "anomy" score	40	36†	37†	30*	25	18

* Within-area differences significant at the level of ≤ 0.05 (F-test).
† Between-area difference for the indicated income group significant at the level of ≤ 0.05 (t-test).

particular, "anomy," or alienation, is pervasive in the poverty area at all income levels; elsewhere, it decreases with more adequate income. Poverty area residents are more likely than others, at the same income level, to report marital separation or divorce, but only those with adequate incomes are much more likely to consider their marriages unhappy (Table 11).

In sum, income is not the single key to health and happiness; on a number of issues, it does not overcome the influence of depressed surroundings. The most striking examples are the subjective health ratings and the "anomy" scores: In both cases, the differences between poverty area residents and others exceed the differences among income groups within either area.

Race Comparisons in the Two Areas

As we have shown, the two sections of Oakland studied here differ widely in racial composition: the poverty area

Table 12—Indicators of sickness by residence and race

	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
	Per cent			
Health Problems Reported				
Some disability	18†	16	10‡	5
1 or more chronic conditions	48†	45†	39‡	32
1 or more impairments	16†‡	10†	10*	1
1 or more symptoms	68	62†	64*	50
Low Evaluation of Health				
Report health "fair" or "poor"	32†	36†	18	22
"Seriously bothered" by some condition, impairment, or symptom	25†	25†	17	12
Less energy than most of same age	33	35†	26*	20

* Within-area difference significant at the level of ≤ 0.05 (t-test).
† Between-area difference for the indicated race significant at the level of ≤ 0.05 (t-test).
‡ The differences between whites and Negroes, on impairment in the poverty area and on disability and chronic conditions in the nonpoverty area, become nonsignificant after age adjustment. On the other hand, the difference between whites and Negroes in the poverty area reporting themselves in fair or poor health becomes statistically significant after age adjustment.

Table 13—Indicators of deficient health care by residence and race

	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
	Per cent			
Health Care Deficiencies				
No health insurance	27*†	36†	13	18
No dental checkup in more than 2 years	40*†	51†	22*	41
No medical checkup in more than 2 years	40*†	26	30*	22
No doctor visits in past 12 months	32	26	30	25
No regular physician	24	26	22	20

* Within-area difference significant at the level of ≤ 0.05 (t-test).
† Between-area difference for the indicated race significant at the level of ≤ 0.05 (t-test).

has a biracial character (37 per cent white), and the remainder of the city is largely (88 per cent) white. We turn now to the question of whether race accounts for the differences between the two sections in the rates of sickness, deprivation, and social instability.

Sickness and Health Care

Compared with other members of the same race living elsewhere, both Negroes and whites in the poverty area are more likely to report health problems and to evaluate their health and energy negatively. The few Negroes who live outside the area, however, are apparently less susceptible to health problems than the comparable white population; this is partly because they are younger (see Table 3), and perhaps partly because the most fit are the most likely to have moved out of the poverty area (Table 12).

Poverty area residents of both races are less likely than people outside to have health insurance or to use medical and dental services (Table 13). Within each area, Negroes are less likely than whites to have had a dental checkup, but more likely to have had a medical checkup.

Deprivation

White and Negro income distributions are very similar within the poverty area ($\chi^2=1.8$, 2 df), but whites and Negroes are significantly different with respect to income in the nonpoverty area ($\chi^2=10.6$, 2 df).

The difference between races is somewhat obscured in Table 14, for outside the poverty area more than two-thirds of both whites and Negroes are classified as having "adequate" income. This is an open-ended category, however, including small families with incomes of $5,000 and above, and all families with incomes of $8,000 and over. Thus, it includes people in the top-income brackets, and these are mainly whites.

In income, education, unemployment, and dependence on community assistance, whites and Negroes in the poverty area are practically indistinguishable from each other, and far worse off than persons of either race outside the area (Tables 14, 15). But Negroes inside and

Table 14—Family income level by residence and race

	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
	Per cent			
Inadequate	31	28	12	12
Marginal	24	23	16	19
Adequate	45	49	72	69

Table 15—Indicators of deprivation by residence and race

	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
	Per cent			
Financial Insecurity				
Unemployed	12†	10†	3	3
Receive unemployment, disability or welfare payments	21†	24†	6	8
Limited Occupational Skills				
Service workers or laborers				
Men	20*†	43	6*	32
Women	13*	52	7*	46
Eighth grade or less education	40†	38†	16	21

* Within-area difference significant at the level of ≤ 0.05 (t-test).
† Between-area difference for the indicated race significant at the level of ≤ 0.05 (t-test).

outside the poverty area are much more likely than whites to be in "service" or unskilled jobs; this is the only economic item where the pattern of Negro-white similarity within areas does not hold.

Social Instability

In both areas, Negroes are more likely than whites to have or have had problems of marital adjustment. The proportion of Negroes who are separated or divorced is higher in the poverty area than outside, and for both races unhappiness and alienation are much more widespread in the poverty area than elsewhere in Oakland (Table 16).

In sum, whites and Negroes living in the Oakland poverty area share economic, social, and psychological burdens in far greater measure than their counterparts elsewhere in the city. Negroes in both areas have lower-status jobs than whites, report more marital disruption, and are more likely to neglect certain aspects of health care, but on all other indicators of financial deprivation, social instability, and poor health,

Table 16—Indicators of social instability by residence and race

	Poverty area		Nonpoverty area	
	White	Negro	White	Negro
	Per cent			
Marital Instability				
Separated or divorced	13*	23†	9	10
2 or more marriages	26	33	20*	32
Marriage is unhappy or only somewhat happy	22*	35	16*	31
General Dissatisfaction				
"Not too happy" these days	14†	17†	10	8
High anomy score	32*†	42†	20	23

* Within-area difference significant at the level of ≤ 0.05 (t-test).
† Between-area difference for the indicated race significant at the level of ≤ 0.05 (t-test).

they resemble their white co-residents more than they do other Negroes.

Residence, Income and Race

In our search for insight into the poverty area syndrome, we have examined three factors in pairs—residence and race, residence and income. We have thus achieved an overview of the relation between residence and our indicators of sickness, economic deprivation, and social stability, as well as an assessment of the way race and income affect this relationship, but we have not answered the question of how whites and Negroes of different income levels fare inside and outside the poverty area. To answer this question, we analyzed residence, race and income in combination, as shown in Table 17. Here, we dichotomized income level, combining people with marginal and adequate income into one group, called "adequate," to be compared with the "inadequate" income group. (This procedure yields eight groups, but the small number of low-income Negroes outside the poverty area forced us to omit them from our analysis.)

The major findings from this analysis, as far as indicators of sickness, deprivation, and social instability are concerned, are as follows:

1. Although they are much younger than comparable whites (only 19 per cent are 65 and over, versus 43 per cent), Negroes living in the poverty area on an adequate income are much like these whites in the frequency with which they report sickness, and in education. The Negroes are worse off in terms of marital problems and are more likely to be in low-status occupations, but these two low-income groups in the poverty area resemble each other far more than either resembles its high-income racial counterpart in the area.

2. Similarly, Negroes with adequate income in both areas are as healthy or healthier than whites with adequate income in the same area, but they are more likely to be in "service" or unskilled jobs and to report unhappy or broken marriages.

3. High-income Negroes enjoy better health and use health-care facilities more regularly than low-income whites in the same area, and they are also better educated. Both advantages may well be a function of youthfulness, however, for virtually none of these Negroes is 65 or over, compared with 43 per cent of low-income whites in the poverty area and 53 per cent of those outside.

4. Low-income whites outside the poverty area tend to be better off than those inside, particularly on self-evaluation of health, use of health facilities, and dependence on welfare.

5. High-income Negroes outside the poverty area are definitely better off than those inside, particularly in education, occupational status, and "anomy." They tend to report better health, but they are equally prone to unhappy marriages and general unhappiness.

6. High-income whites outside the poverty area are similarly better off than those inside, particularly in health care, dependence on community support, education, occupational status, and "anomy."

Summary

Our study of the interaction between income, race, and residence on the one hand, and indicators of sickness, deprivation, and social instability on the other, leads to certain conclusions:

Looking at income and residence alone, we find that people with more adequate incomes have better health and health care, better jobs, more education, and more stable marriages; but even at the same income level, poverty-area residents have more problems than those outside. In particular, large proportions of poverty-area residents at all income

Table 17—Sickness, health care deficiencies, deprivation and social instability by residence, race and income level

	Poverty area				Nonpoverty area			
	Negro		White		Negro		White	
	Income level							
	Inadequate	Adequate[1]	Inadequate	Adequate[1]	Inadequate	Adequate[1]	Inadequate	Adequate[1]
Number of Persons	129	325	94	208	16[a]	114	165	1,230
	Per cent							
Indicators of Sickness								
Reported health problems								
Some disability	29*	9	29*	12	—	5	24*	8
1 or more chronic conditions	57*	41	57	44	—	31	56*†	37
1 or more impairments	15*	6	23*†	12	—	1	18*†	9
1 or more symptoms	77*	56	77	64	—	52	70	63
Self-evaluation of health								
Rate health "fair" or "poor"	51*	28	44*	27	—	19	29*	16
"Seriously bothered" by some condition, impairment, or symptom	40*	18	42*	17	—	11	32*	15
Less energy than most of same age	48*	29	49*	27	—	19	25	26
Health Care Deficiencies								
No health insurance	63*	19	49*	18	—	12	39*	8
No dental checkup in more than 2 years	54	49	50*	37	—	39	32*	21
No medical checkup in more than 2 years	28	25	50*	36	—	20	41*	28
No doctor visits in past 12 months	29	24	29	33	—	22	33	29
No regular physician	24	25	28	23	—	14	28*	20
Indicators of Deprivation								
Financial insecurity								
Unemployed	17	7	31*	9	—	3	6*†	3
Receive unemployment, disability or welfare payments	40*	12	32*	14	—	7	15*	5
Limited occupational skills								
Service workers or laborers	58*	43	15	18	—	34	23*†	5
Eighth grade or less education	47*†	33	47	36	—	21	38*	12
Indicators of Social Instability								
Marital instability								
Separated or divorced	33*	14	20*	11	—	5	15*	8
2 or more marriages	38	31	29	24	—	35	26	20
Marriage is unhappy or only somewhat happy	50	32	33*†	19	—	29	27*	15
General dissatisfaction								
"Not too happy" these days	23	13	20*	10	—	8	13*†	9
High "anomy" score	45	40	39	30	—	22	32*†	19
Age								
65 and over	19*	4	43*	21	—	4	53*	14

[1] Includes persons with marginal income.
[a] Cases too few for analysis.
* Differences between income groups within race in each area significant at the level of ≤ 0.05 (t-test).
† These differences between income groups within area and race became nonsignificant after age adjustment. On the other hand, the differences in unemployment, marital and general happiness between Negroes with adequate and inadequate income in the poverty area became significant after age adjustment.

levels display a sense of isolation or "anomy."

Looking at race and residence alone, we find that Negroes and whites in the poverty area are very much alike, and members of each race are far worse off than their counterparts outside the poverty area.

Analysis of the three factors together shows that in each area high-income whites resemble high-income Negroes more than they do low-income whites. Similarly, low-income Negroes are more like low-income whites than they are like high-income Negroes. Persons of each race, at a given income level outside the poverty area, are consistently better off than their counterparts inside the area. A major exception to all racial comparisons is that regardless of income or residence, Negroes are more likely than whites to be in low-status occupations and to have unstable marriages.

Thus, our study demonstrates once again that low income and minority race are handicaps. In addition, we have found that residence in a defined "poverty area" is in itself a major disadvantage.

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