Chapter 7
Security

Americans believe that we are all entitled to a basic level of education, economic well-being, health care, and other protections necessary to human dignity.[1] Without this security, it is impossible to access society's other rights and responsibilities, or to enjoy full opportunity. Moreover, international human rights commitments--many of which, as noted in the introduction to this report, were spearheaded by the United States--obligate our nation to ensure basic levels of health, housing, and income security for its residents. In this chapter we review threats to the security of our nation and assess our progress over time. We examine measures of income security, health and health care security, housing and food security, and physical safety.

This review shows that Americans are more secure on some measures of opportunity, such as rates of criminal victimization, than we have been in more than two decades. But for most other measures of security, national progress is stagnant or declining. Increasingly, threats to security are found in rising social and economic inequality, the eroding safety net, and unequal access to our vast resources. Moreover, these threats affect all Americans, both directly and indirectly, as our communities and public institutions are weakened by a lack of basic security. A summary of the major findings of this chapter are presented in Box 7.

Box 7: How Secure are Americans?

Major Gains in Security

- Many Americans are now more secure from criminal victimization than in past decades. The percentage of U.S. households that were victimized by crimes fell from 25 percent in 1994 to 15 percent in 2003, and homicide rates have declined by over 50 percent since 1970.
- Overall health status has steadily improved for all Americans, and life expectancy has increased to record levels for all groups.

Areas of Limited or No Progress

- Poverty is increasing again, despite declines in the 1990s: 5.4 million more Americans live in poverty today than did in 2000. In 2004 nearly 37 million people, about one in eight U.S. residents, lived in poverty. Over one-third of these individuals are children under age 18.
- Gaps in health status among racial and ethnic groups, citizenship groups, and socioeconomic groups have not narrowed much in nearly a generation. African Americans, American Indians, Alaska Natives, and Pacific Islander Americans have dramatically poorer health than the national average. The same is true for whites who live in poverty. And although women can expect to live longer than men, their longer lifespan is offset by higher rates of functional impairment and disability.

Areas Where Security Has Declined

- The number of uninsured Americans has risen steadily over the last thirty years to unprecedented levels today. More than 45 million Americans lack health insurance, and more than 87 million Americans were uninsured at any point over the last two years.
- Affordable high-quality housing is increasingly out of the grasp of working families who make less than a living wage.

- Hunger and food insecurity rose 26 percent between 1999 and 2004. Most alarming is the rise in food insecurity among children. About 20 percent of African-American and Hispanic children and more than 35 percent of low-income children live in homes that experienced periods of food insecurity during that period.

Americans generally view the United States as a land of boundless opportunity, where individuals can achieve their dreams regardless of their gender, race, nationality, family background, or the circumstances of their birth. But increasingly, Americans experience threats to opportunity arising from a lack of basic health, education, income, and other protections. These threats affect all Americans, as a lack of basic security weakens our community institutions and violates our nation's core principles and values. Moreover, these threats disproportionately affect groups who historically have been most vulnerable to exploitation and marginalization. These include women, communities of color, rural communities, immigrants, poor and working poor families, and others whose security is threatened on a daily basis.

This chapter reviews threats to the personal security of the nation's residents and assesses progress in providing a basic level of security that is necessary for opportunity. We define security of opportunity as a basic level of health, income, food security, and physical safety, below which no one should be allowed to fall if our nation remains committed to full opportunity. Specifically, we examine trends in income security (poverty, bankruptcies, and pension participation); health security (health status, health care access and quality, occupational safety, and housing); food security; physical safety (homicide, serious and violent crimes); and environmental security. Many of these same indicators are also used in domestic and international human rights reports, as they reflect the human rights community's consensus about the basic rights that are key to opportunity. Where data are available, we document national trends as well as data disaggregated by gender, race or ethnicity, immigration and citizenship status, and income or education level.

About the Data in this Chapter

The main data sources for this chapter include federal data on trends in health, poverty and economic security, food security, and criminal victimization; federal research reports published by the Bureau of Justice Statistics, the National Center for Vital Health Statistics, and other federal agencies; research published in peer-reviewed literature; and other research reports published by policy research organizations such as the Economic Policy Institute.

Where data are available, we summarize trends in measures of security over time. In addition, we review literature on the impact of selected measures on Americans' opportunities. As noted earlier in this report, there are several limitations of the data. Federal data collected prior to 1997 rarely include racial and ethnic groups other than whites, African Americans, and Hispanics. Further, these broad racial and ethnic categories often fail to adequately capture the diversity within U.S. racial and ethnic groups, which may vary considerably on the basis of immigration status or nativity,

primary language, cultural identification, and area of residence. A full assessment of opportunity should include a consideration of how opportunity varies along these dimensions. Where possible, we present subgroup information such as variations among Asian-American and Hispanic nationality groups.

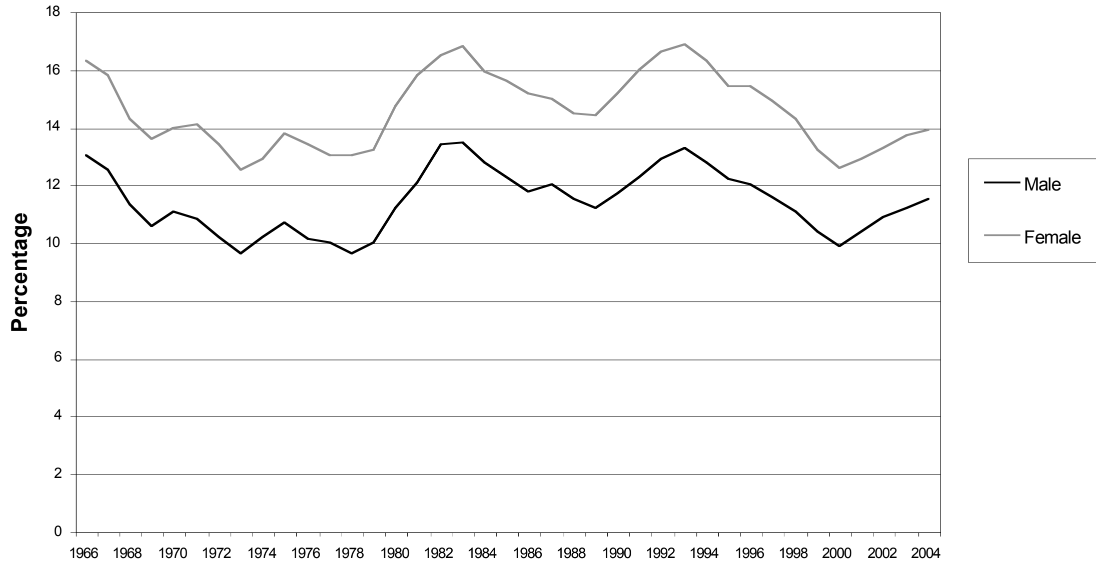
Similarly, federal data are rarely disaggregated by both race or ethnicity and measures of social class or socioeconomic status. Yet the opportunity barriers for low-income whites may differ in important ways from those of better-off whites and some minorities. We encourage future analyses to examine how opportunity indicators differ by race or ethnicity and income, as well as their interaction.

Income Security

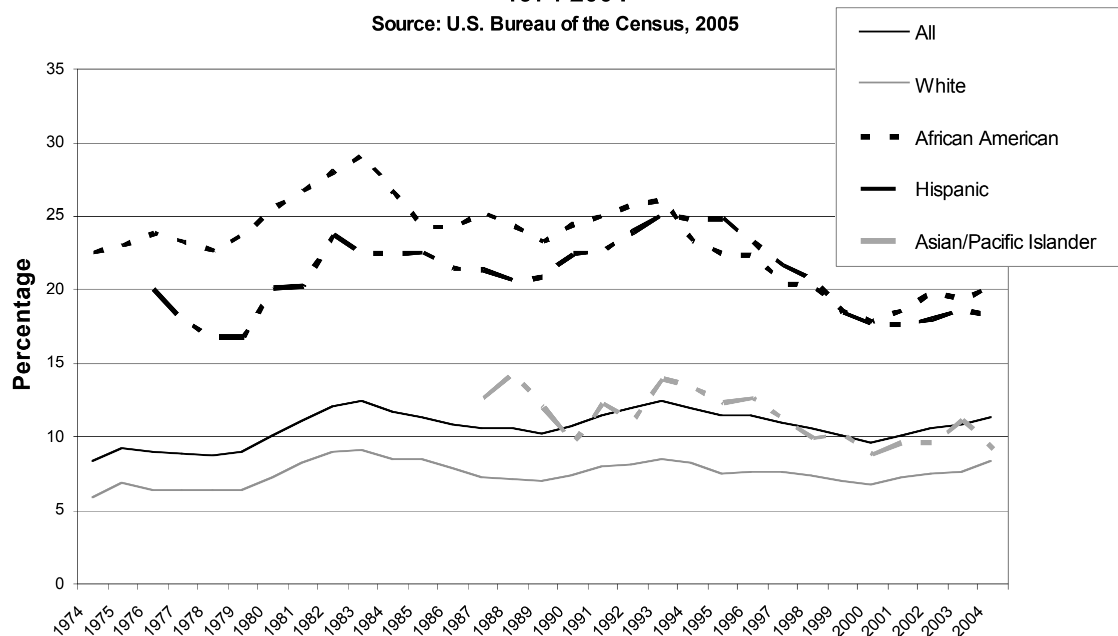
Poverty

Poverty remains a persistent threat to the security of millions of Americans. In 2004 nearly 37 million people--about one in eight U.S. residents--lived in poverty. More than one-third of these individuals are children under age 18.[2] Women, people of color, non-citizens, and people who live in urban and rural areas are disproportionately represented among the impoverished. These gaps have persisted for decades, but they narrowed after periods of progressive policies that focused on increasing economic opportunities for the working poor and creating more equitable employment practices (e.g., the Earned Income Tax Credit and federal minimum wage increases).[3] Disturbingly, however, these gaps have widened in recent years. This trend threatens to increase not only the number of Americans living in poverty, but also the economic gaps between men and women, racial and ethnic groups, new arrivals and old, and between those with higher levels of education and skills and those without them.

Gender Gaps in Poverty. The economic surge of the 1990s produced unprecedented job growth that helped to substantially reduce rates of U.S. poverty. But the gap in poverty between women and men has persisted, and overall poverty rates have since risen. Annually since 2000, between 22 percent and 27 percent more women than men have been among the ranks of the impoverished in the United States--a gap that, by and large, has not changed since 1966 (see Figure 7-1).[4] For example, the percentage of women in poverty dropped to its lowest levels in almost thirty years in 2000, with about one in eight women living in poverty, but poverty rates among men that year dropped further, to slightly under one in ten.[5]



Racial and Ethnic Differences in Poverty Rates. The prosperity of the 1990s also led to a diminution of the racial and ethnic gap in poverty rates (see Figure 7-2). In 2000 the poverty rate among African Americans and Hispanics was a little over 2.6 times greater than that for white Americans, the smallest racial and ethnic difference in poverty rates between these population groups in more than three decades. Similarly, in 2000 the poverty rate among Asian Americans and Pacific Islander Americans was one-third higher than that for whites, the smallest gap between these groups in ten years. From 2001 to 2003, however, poverty rates for all racial and ethnic groups increased more dramatically than they did for whites, widening the racial poverty gap. This gap declined slightly in 2004 for all minority groups except African Americans.[6]



Poverty among Children. Child poverty may pose the most significant barrier to opportunity for individuals, their families, and their communities. Not only are impoverished children and their families less likely to have material resources necessary for adequate nutrition, housing, and health care, they are also more likely (as detailed elsewhere in this report) to live in communities characterized by high rates of violence, instability, poor quality schools, and inadequate safety net resources.[7] Children who live in conditions of poverty face multiple barriers to full participation in the economic, cultural, and political life of the nation. They face longer odds of economic mobility, are less likely to earn a high school or college degree, more likely to experience greater health problems later in life, and more likely to have children who will likely face the same economic circumstances as they did, repeating a generational cycle of poverty.

A large body of research demonstrates the importance of basic levels of health, housing, nutrition, economic, and physical security for children's development and educational and health outcomes. For instance:

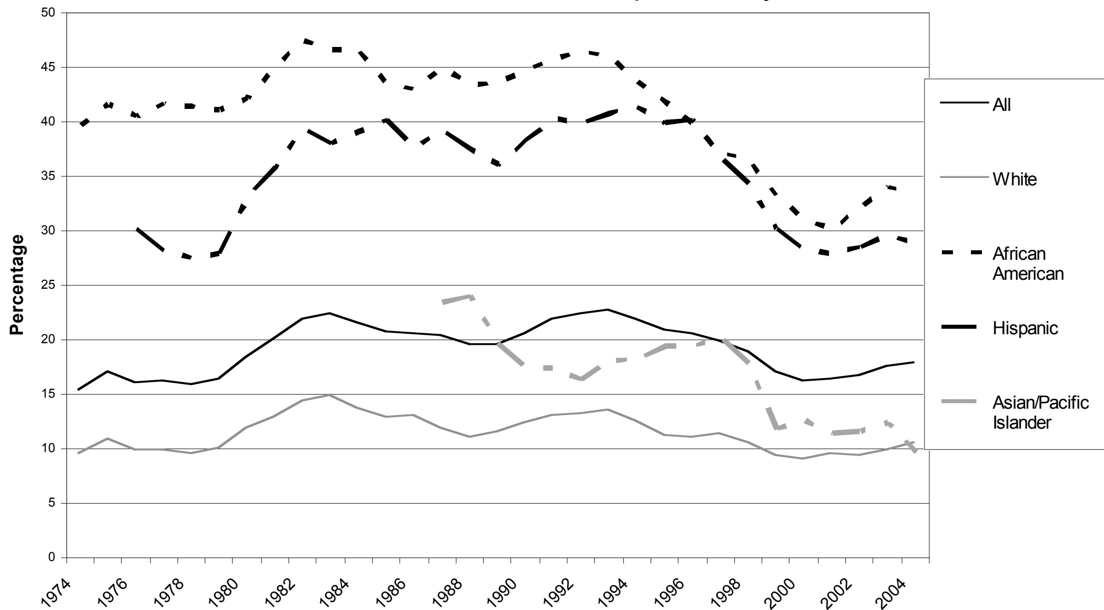
- Children who are undernourished during infant and toddler years are at greater risk for behavioral and neurological impairment, as well as cognitive delays. Similarly, undernutrition during pregnancy is associated with prematurity, low birth weight, and cognitive impairment, all of which are linked to poorer health and educational outcomes for children.[8]
- Nearly one-third of uninsured children did not receive medical care in 2003, compared to 12.5 percent of insured children; uninsured children are ten times more likely than insured children to fail to receive needed medical care.[9]

- Studies demonstrate that children who are exposed to at least one period of poverty have poorer health than children who never experience poverty. But longitudinal studies also show that children's health status has a direct, negative relationship to the *duration of poverty*. In other words, the longer children live in poverty, the poorer their health.[10]

Racial and ethnic gaps in child poverty rates reached their greatest points in 1982 and 1992, when over 45 percent of African-American and 40 percent of Hispanic children lived in poverty, relative to 13.2 percent (in 1992) and 14.4 percent (in 1982) of white children (see Figure 7-3). Similarly, Asian-American and Pacific Islander-Islander children experienced higher poverty rates than white children. In 1987 and 1998, rates of child poverty among Asian-American and Pacific Islander-American children were more than twice those of white children. These gaps declined to their lowest levels in 2000 and 2001, at the end of the economic expansion of the 1990s. Since 2001, however, overall child poverty rates have increased, as have racial and ethnic gaps in child poverty, erasing many of the gains of the 1990s.[11]

Figure 7-3. Percentage of Poor People Under Age 18 by Race or Ethnicity

Source: U.S. Bureau of the Census, Current Population Survey, 2005



Note: Data for Asian/Pacific Islander Americans is only available beginning in 1987.

Poverty and Citizenship Status. The United States has long been considered a "land of opportunity" for newcomers. Data on poverty among native-born citizens, naturalized citizens, and non-citizens suggest that opportunity varies considerably by citizenship status. In 2003 non-citizens were twice as likely as naturalized citizens to live in poverty, although this gap has narrowed significantly since 1993, when the rate of poverty among non-citizens was nearly three times that among naturalized citizens (see Figure 7-4).[12]

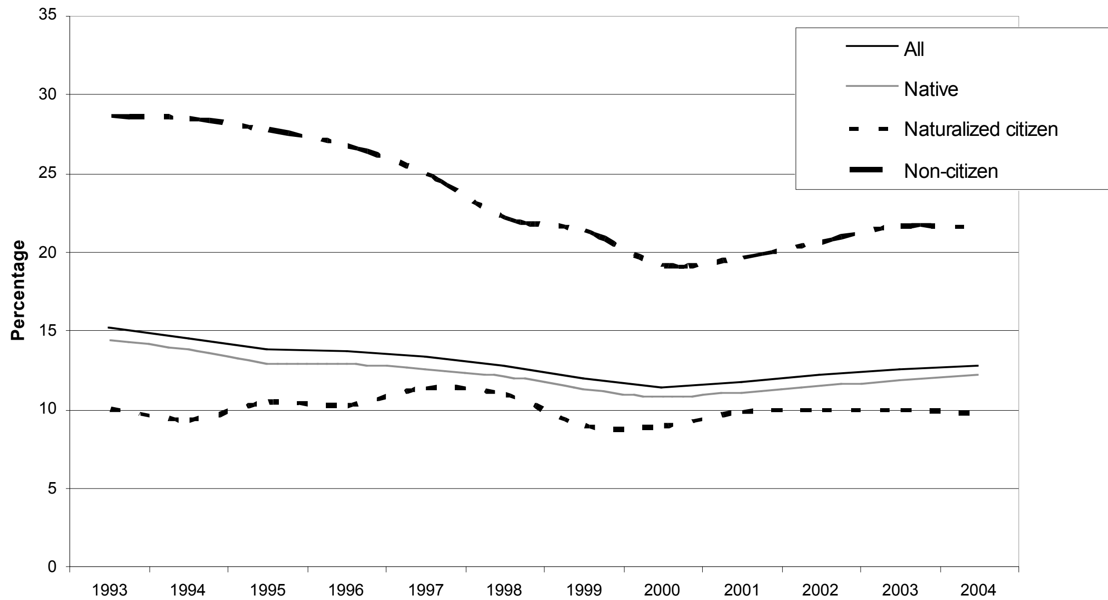
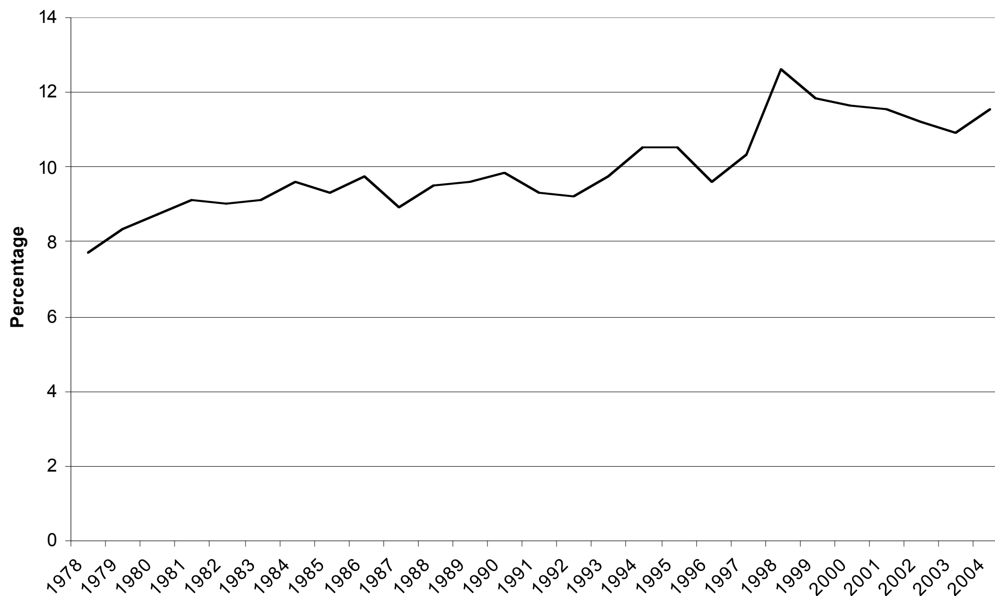


Figure 7-4. People in Poverty by Nativity, 1993-2004
Source: U.S. Bureau of the Census, Current Population Survey, 2005

Workers Living in Poverty. In 2003 more than 24 million people who worked full- or part-time lived in poverty, and over one in ten impoverished individuals worked full-time.[13] A parent who works full-time at the federal minimum wage to support a family of three makes $5,000 under the poverty line.[14] And, as depicted in Figure 7-5, the percentage of full-time workers who fall below the poverty line has increased by 42 percent since 1978. The number of these workers has more than doubled since 1978, rising from about 1.3 million to almost 2.9 million workers in 2004.[15]

Figure 7-5. Year-round, Full-time Workers as a Proportion of All Poor People, 1978-2004
Source: U.S. Bureau of the Census, Current Population Survey, 2005



Bankruptcies

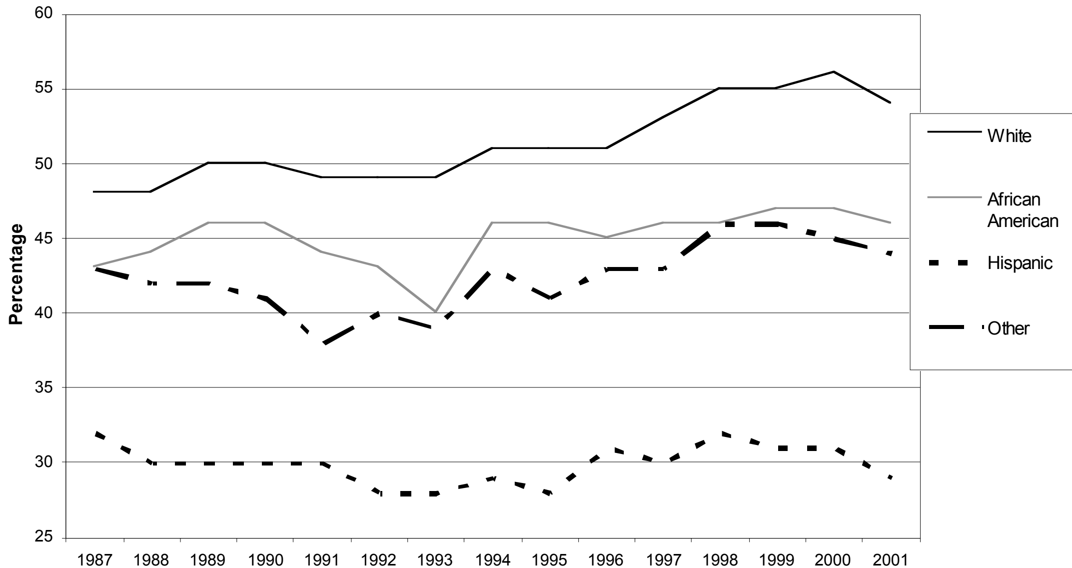
Personal bankruptcy, perhaps the most sensitive indicator of economic insecurity, has increased dramatically. More than 1.5 million people filed for bankruptcy in the United States in 2003. The rate of consumer bankruptcies more than tripled from 1980 to 2003, rising from fewer than 2 of every 1,000 adults to more than 7 of every 1,000 adults in 2003.[16] These individuals are not merely people who have amassed high consumer or credit card debt. A recent study showed that half of all bankruptcies involve unpaid medical and health care debts. Among those whose medical bills contributed to bankruptcy, average out-of-pocket costs approached $12,000, and three-quarters of these individuals possessed health insurance at the onset of illness.[17]

Pension and Retirement Security

A slightly growing number of American households can expect to retire and receive retirement income that is at least half of their current income, based on personal savings, pensions, and Social Security income. In 2001, 72 percent of households headed by someone age 47 to 64 expected to be able to retire with retirement income at least half of their current income, an increase of 2.3 percent since 1989. Yet less than half of the U.S. workforce (46 percent) is covered by employer-sponsored pensions, a decline of 4.7 percent since 1979.[18] And wide gaps in pension participation remain among demographic groups, gaps largely explained by differences in education, income, and types of employment. Women and minorities are less likely to be covered by an employer-sponsored plan.

African-American and Hispanic workers have lower levels of participation in pension plans than do whites, a gap that appears to be growing. From 1987 to 2001, pension plan participation among white wage and salary workers increased from 48 percent to 54 percent, while participation rates for African Americans increased only 3 percent during the same period, from 43 percent to 46 percent. Pension participation among Hispanics during the same period declined from 32 percent to 29 percent (see Figure 7-6).[19] These racial and ethnic gaps persist at lower- and middle-income levels, but narrow significantly between Hispanics and whites at the highest income levels. Relative to whites, African Americans have equal or higher levels of participation in employer-sponsored pension plans at upper- and middle-income levels. Pension participation is highest among public employees, and the racial and ethnic gap in pension participation is narrowest in this sector. More than two-thirds of Hispanic public employees, 70 percent of African-American public employees, and 78 percent of white public employees participated in an employer-sponsored pension plan in 2001. Conversely, the racial and ethnic gap in pension participation is greatest among employees in small- and medium-sized firms.[20]

Figure 7-6. Percentage of Wage and Salary Workers Age 21-64 Who Participated in an Employment-Based Retirement Plan by Race or Ethnicity, 1987-2001
Source: Copeland, 2003

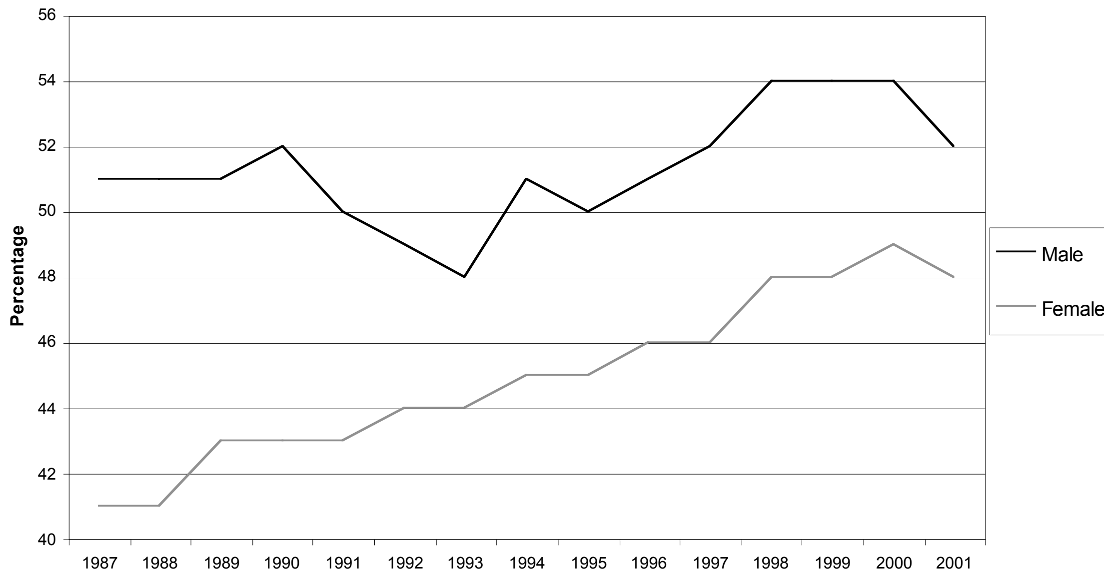


Women’s rate of participation in employer-sponsored pension plans increased more rapidly than did men’s between 1987 and 2001, from 41 percent to 48 percent. Men’s rate of participation increased just one percentage point to 52 percent (see Figure 7-7).[21] But part-time workers are less likely to be eligible for participation in employer-sponsored plans, and women are disproportionately employed as part-time workers. In 2001, 35 percent of older women reported that they worked too few hours to be eligible for employer pension plans, compared to 20 percent of older men. And older women

workers are less likely than older male workers to expect a pension from any source. Only about one-third of older men expected not to receive a pension, compared to 44 percent of older women.[22]

Figure 7-7. Percentage of Wage and Salary Workers Age 21-64 Who Participated in an Employment-Based Retirement Plan by Gender, 1987-2001

Source: Copeland, 2003



Among current retirees, the pension gap is particularly striking, reflecting the historical lack of opportunities for women and people of color to work in jobs that provide pension benefits. For example, almost half of male retirees in 2000 received a pension, compared to 30 percent of women retirees. And among those who received pensions, women's pensions were half those of men--including women's benefits received through their husbands' pensions.[23] This gap in pension income contributes to higher rates of financial insecurity among older women, particularly older women of color.

Health Security

Health Status

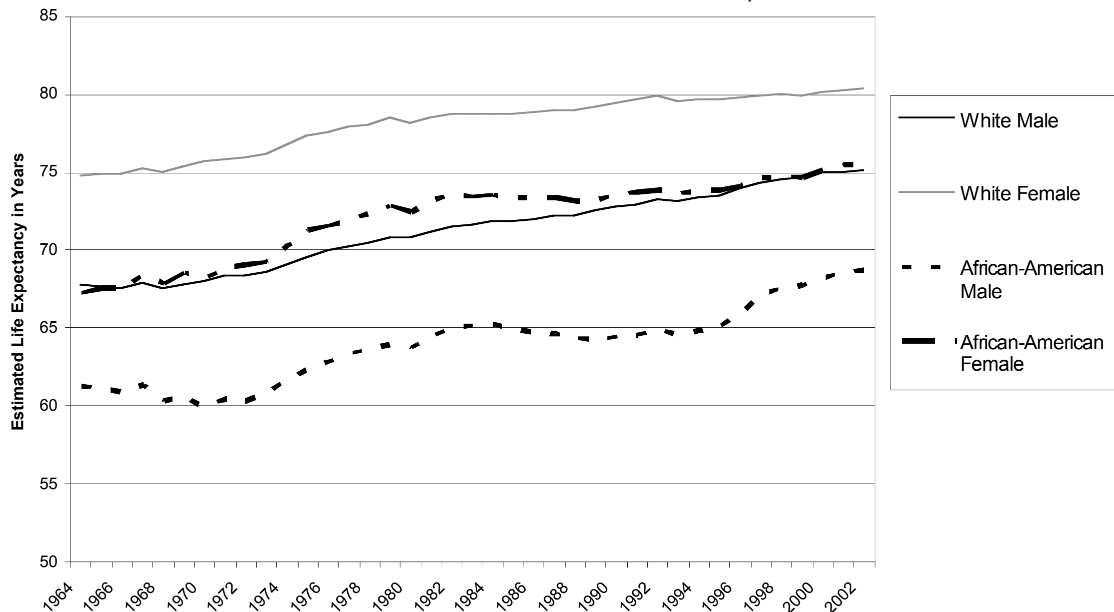
In the twenty-first century Americans are enjoying unprecedented longevity and good health. This is largely due to increases in wage and education levels, improvements in public health programs such as child immunization and smoking cessation, greater awareness of health risks and healthful behaviors, and better access to health care. But many groups experience poor health relative to national averages, and do not enjoy the same access to high-quality health care and health information as do more advantaged groups. Others who appear healthy based on national statistics may experience "hidden" health problems. For example, women live longer than men but experience greater

functional limitations and chronic health problems that can erode their quality of life.[24] These health gaps weaken our security and diminish basic human rights and opportunities that Americans cherish.

Life Expectancy. Americans can expect, on average, to live longer today than at any other point in history. White women's life expectancy has crept above 80 years, and white men's and African-American women's life expectancy is now slightly over 75 years. But African-American women continue to trail white women in life expectancy, although these trends have narrowed slightly, and African-American men continue to face lower life expectancy than other groups, as their estimated life expectancy has yet to climb above 70 years. Moreover, African-American men have experienced two periods of significant declines in life expectancy, from 1962 to 1971 and from 1984 to 1990 (see Figure 7-8). Federal data on life expectancy among other racial, ethnic, and gender groups are not available, but given the growing size of these groups, future federal vital statistics reports should include them.

Figure 7-8. Estimated Life Expectancy at Birth in Years by Race and Sex, 1964-2002

Source: Centers for Disease Control and Prevention, 2004



Mortality. Overall mortality has declined steadily in the United States over the last four decades, with the greatest declines occurring during periods when economic growth equitably benefited all income groups and when the overall population attained higher levels of education. One such period occurred shortly after World War II, when the G.I. Bill increased access to higher education for thousands of returning veterans.[25] But for some groups mortality gaps persist and in some cases are increasing, despite overall gains in mortality. African-American men, for example, died at rates that were 32 percent higher than the national average for men in 2002. This gap is 7 percent higher than the

gap in 1980 (see Figure 7-9).[26] Similarly, mortality rates among African-American females have been consistently 25 percent higher than those for women overall. And despite the national trend toward declining mortality, not all groups benefited. American Indian and Alaska Native women, for example, experienced a 19 percent increase in mortality rates from 1990 to 1999, before those rates declined in 2000 (see Figure 7-10).[27]

Figure 7-9. Death Rates for All Causes Among U.S. Males by Race and Ethnicity, Selected Years 1950-2002
Source: Centers for Disease Control and Prevention, 2005

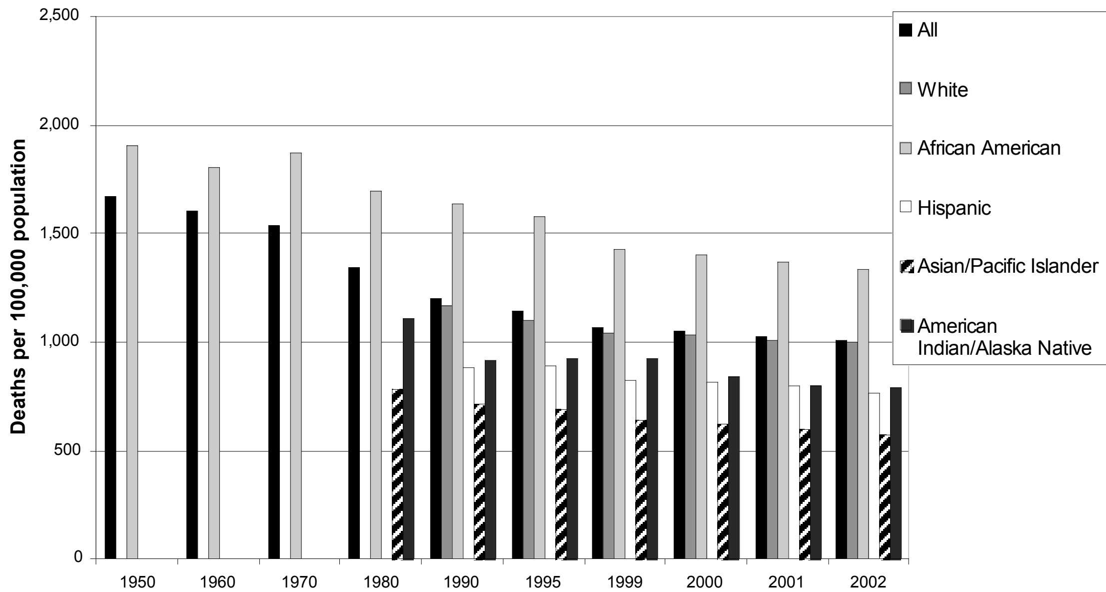
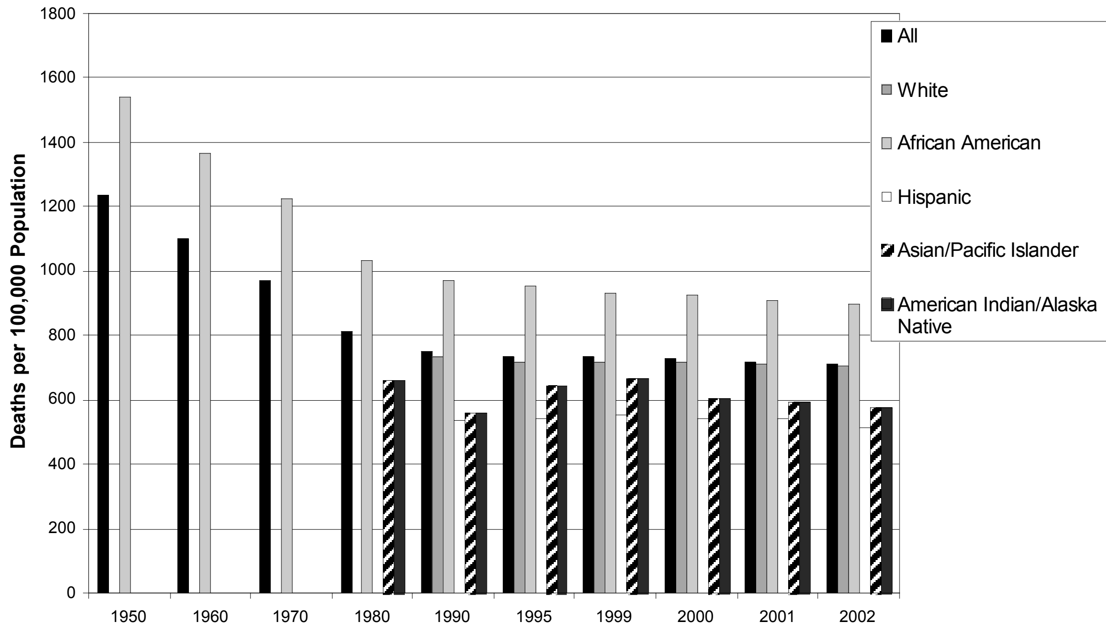


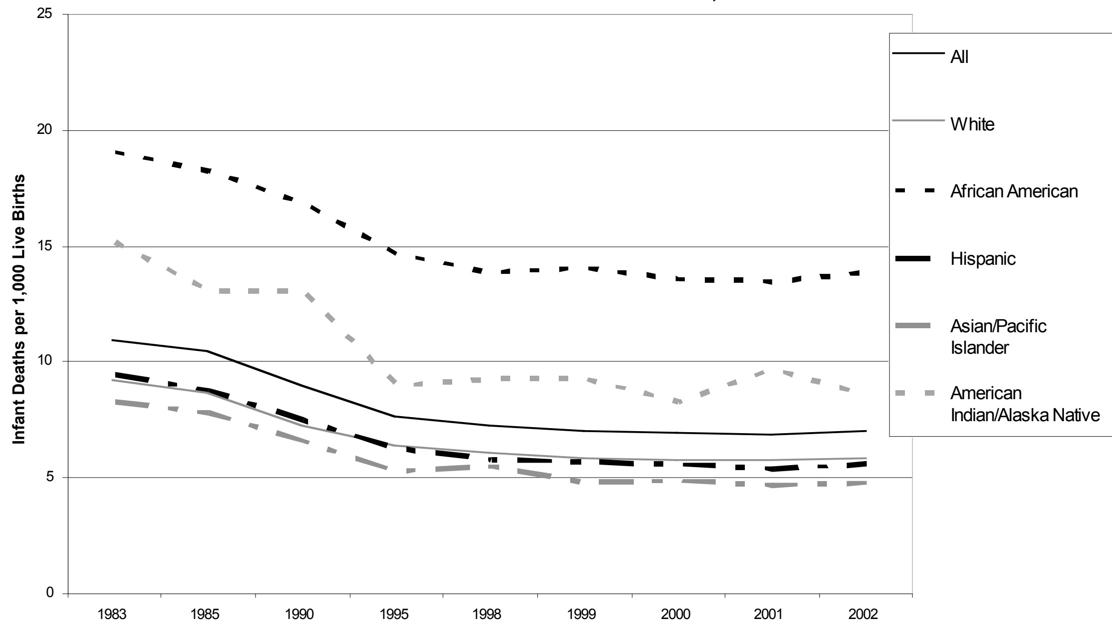
Figure 7-10. Death Rates for All Causes Among U.S. Females by Race/Ethnicity, Selected Years 1950-2002
Source: Centers for Disease Control and Prevention, 2005



Infant Mortality. Infant mortality has progressively declined in the United States, particularly during periods of economic growth that greatly reduced poverty, such as during the mid- and late-1990s. The nation has made strides in increasing access to prenatal care services and building healthier communities, but these gains still leave gaps among racial, ethnic, and socioeconomic groups (see Figure 7-11).[28] African-American and American Indian infant mortality rates, for example, remain almost two and three times higher than those for whites, respectively, and lower income groups of all races have nearly double the mortality rates of those for wealthier groups.

Figure 7-11. Rates of Infant Mortality by Race and Ethnicity, Selected Years 1983-2002

Source: National Center for Health Statistics, 2004



Physically Unhealthy Days. Today Americans are just as likely, and in some cases more likely, to feel sick for two or more weeks in a year than they were a decade ago (see Figures 7-12 and 7-13).[29] The percentage of Americans who report being physically unhealthy for 14 or more days has increased slightly for almost all racial and ethnic groups since 1993, with the sharpest increase found among Native Americans and Alaska Natives.[30] Moreover, disparities between racial and ethnic groups in physically unhealthy days has not diminished. In 2003 almost 20 percent of Native Americans reported two weeks or more of unhealthy days, almost twice the rate of their white counterparts.

Similarly, almost 30 percent more women than men report two or more weeks of physically unhealthy days in a year, the same difference observed in 2003 as in 1993. This rate, however, is trending upward for both men and women (see Figure 7-13), suggesting that the gender gap in physically unhealthy days is not likely to diminish in the near future.[31]

Figure 7-12. Percentage of Respondents with 14 or More Unhealthy Days by Gender, 1993-2003
Source: Centers for Disease Control and Prevention, 2005

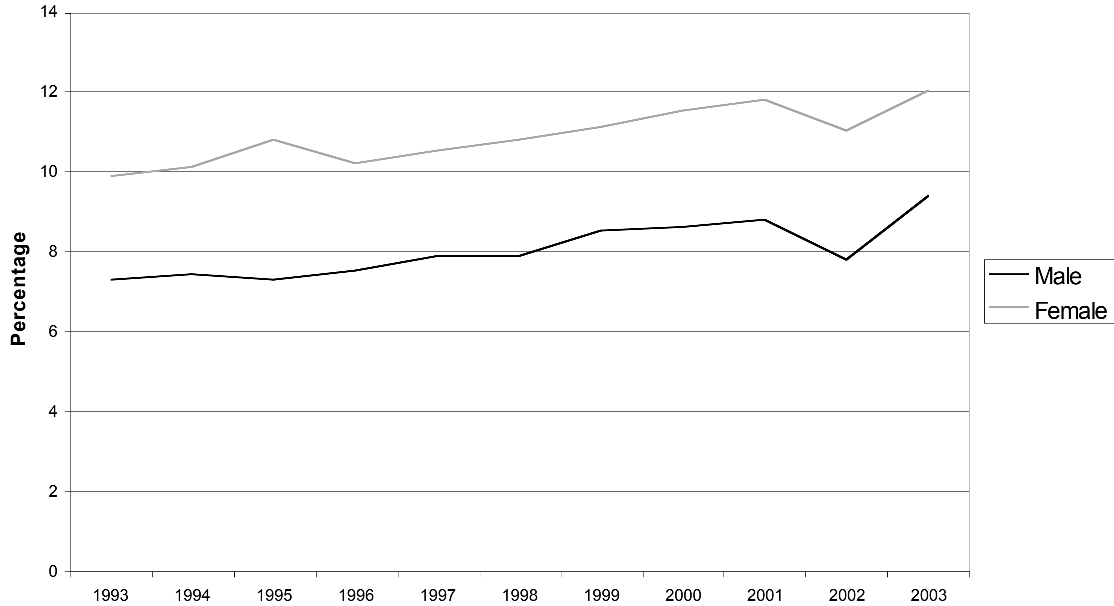
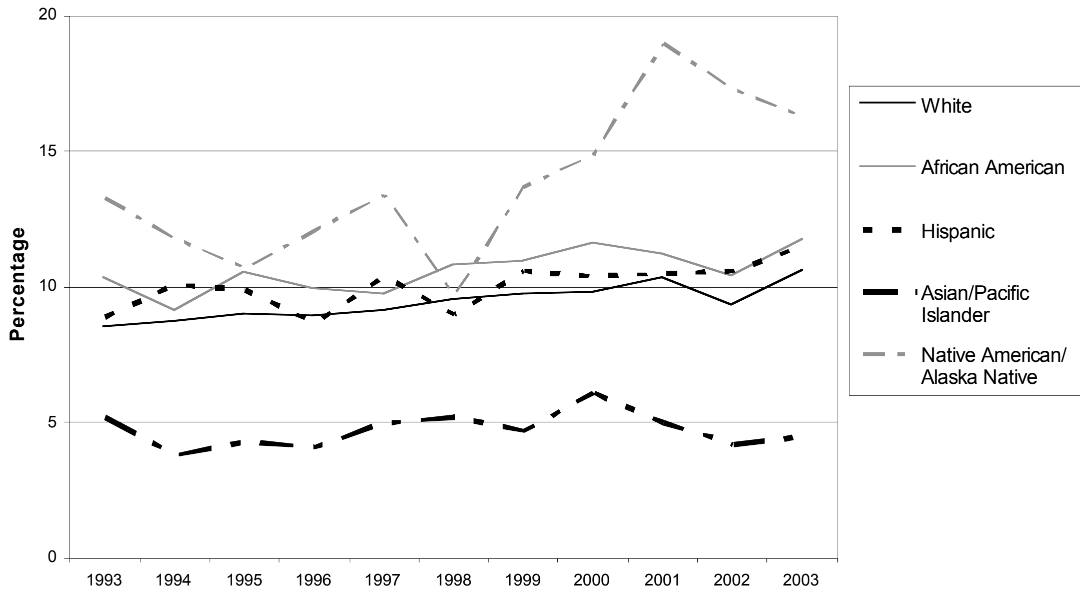


Figure 7-13. Percentage of Respondents with 14 or More Physically Unhealthy Days by Race and Ethnicity, 1993-2003
Source: Centers for Disease Control and Prevention, 2005



Health Care Access and Quality

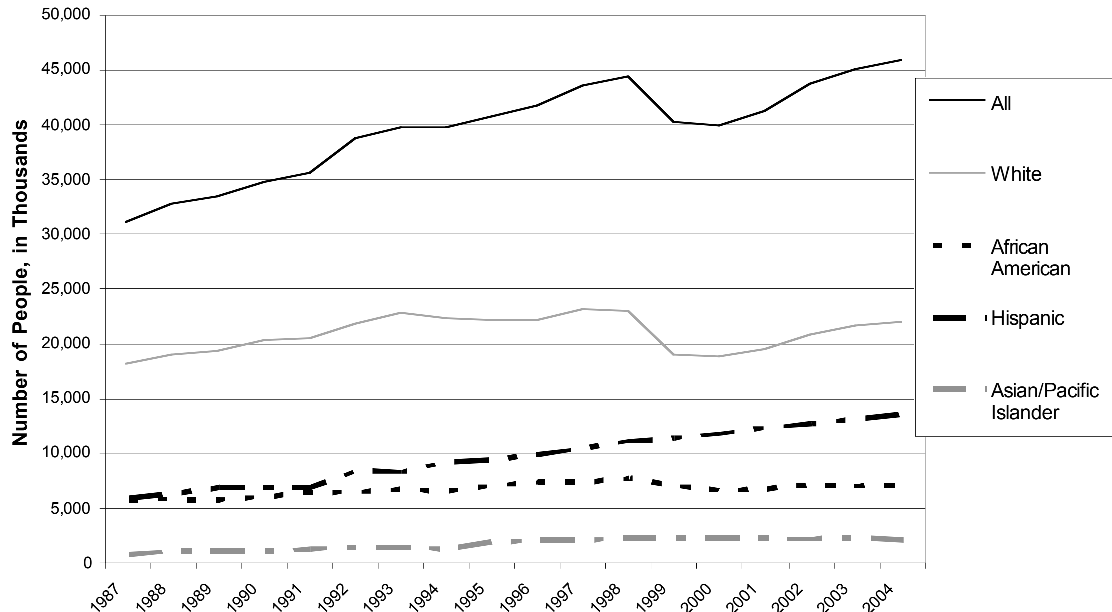
Access to Health Insurance. More than 45 million Americans lack health insurance, and more than 80 million Americans lacked health insurance for all or part of the last two years.[32] A lack of health insurance creates staggering costs, in human and economic terms, for the uninsured, for the insured, and for entire communities and their institutions. People who lack health insurance are less likely to receive preventive health services, thereby increasing their risk for preventable chronic and infectious diseases. Fewer hospitals and health systems can afford to provide indigent care, and the health care that the uninsured may receive is often of poor quality. The Institute of Medicine estimates that the aggregate annual cost of poorer health and shortened life spans attributable to uninsurance is between $65 billion and $130 billion.[33] Nearly 80 million insured and uninsured Americans have experienced difficulty paying medical bills and/or have accrued debt related to medical care costs. More importantly, two-thirds of people who experience problems with medical bills or debt go without needed care because of cost--a rate three times that for people without medical care-related financial problems.[34] A report by Families USA finds that in 2005 premium costs for private employer-provided family health insurance coverage rose by $922 due to the cost of caring for the uninsured, while premiums for individual coverage cost an extra $341 for the same reason.[35]

Trends in the Number of Uninsured Individuals. The number of uninsured Americans currently stands at an all-time high, although it briefly had trended downward in the late 1990s before increasing at a rapid rate (Figure 7-14).[36] The number of whites who were uninsured declined by 20 percent between 1997 and 1999, while the number of uninsured among other racial and ethnic groups increased steadily. The number of uninsured Hispanics more than doubled between 1987 and 2004, largely due to new immigrants, who were less likely to receive health insurance through an employer.

Perhaps more significantly, the percentage of U.S. families who receive health insurance coverage for the entire family has also declined, and an increasing number of families are relying on public sources of health insurance such as Medicaid or the State Child Health Insurance Program to provide coverage. This is the case even though one or more other family members may continue to receive employer-sponsored health insurance, and it is particularly true among families of color who work. Between 1999 and 2002, the proportion of Hispanic and African-American children covered by Medicaid living in a family where at least one member had employer-provided health insurance increased by 11.3 percent and 8.8 percent, respectively.[37] State and federal sources are therefore increasingly subsidizing health insurance for families who work.

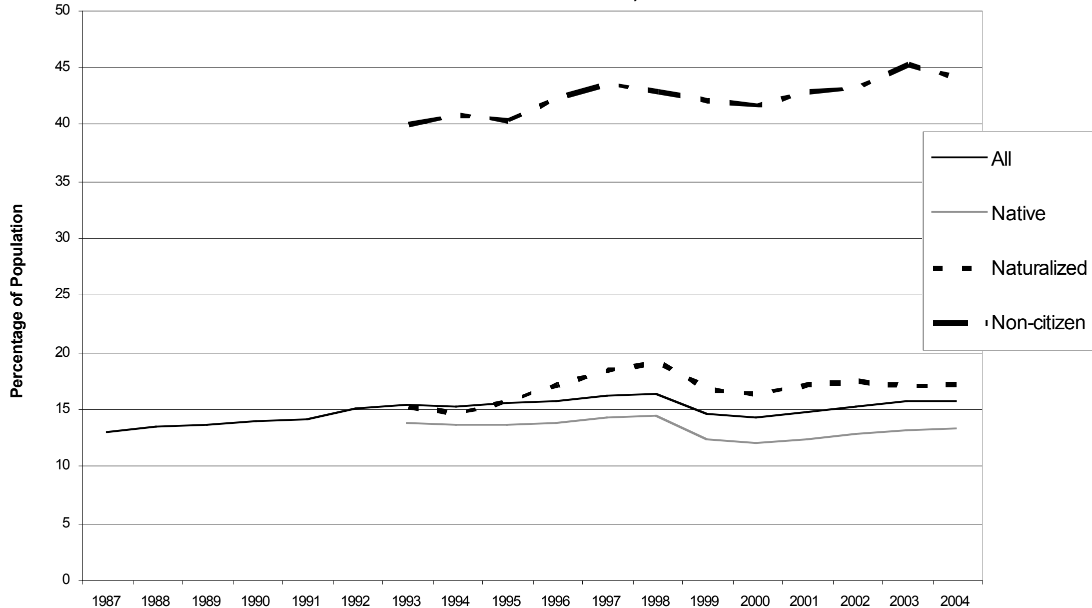
Figure 7-14. Uninsured People in America by Race and Ethnicity, 1987-2004

Source: U.S. Bureau of the Census, 2005



Racial and ethnic minority and immigrant communities are disproportionately uninsured. For example:

- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.[38] And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.[39]
- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured. The uninsurance rate among immigrants increased dramatically in the late 1990s, following the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the Act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals. Between 1998 and 2003 they accounted for 86 percent of that growth.[40]
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993 (see Figure 7-15).



Regular Source of Health Care. Having a regular source of health care--a local physician, clinic, or health center--is important, particularly for individuals who are at risk for illness or injury. When patients are able see a health care provider consistently, they are better able to build trusting relationships, ask questions, and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.[41] The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who have low incomes are more likely to report not having a regular source of health care.[42] This problem poses serious risks for personal health security, as well as for the health of communities as a whole.

Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing. Causes include the poor distribution of health care resources across communities, insufficient funding of public and safety-net health systems, and a dearth of culturally appropriate health care in some communities.[43]

African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. But these gaps have increased since 2000. Over 42 percent of Hispanic poor and 37 percent of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30 percent and 18 percent, respectively, since 1995 and 1996. During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went

largely unchanged. But these groups were up to 75 percent more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002. And the percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15 percent decline over the same period in the ranks of white poor individuals who lacked a regular source of health care.[44]

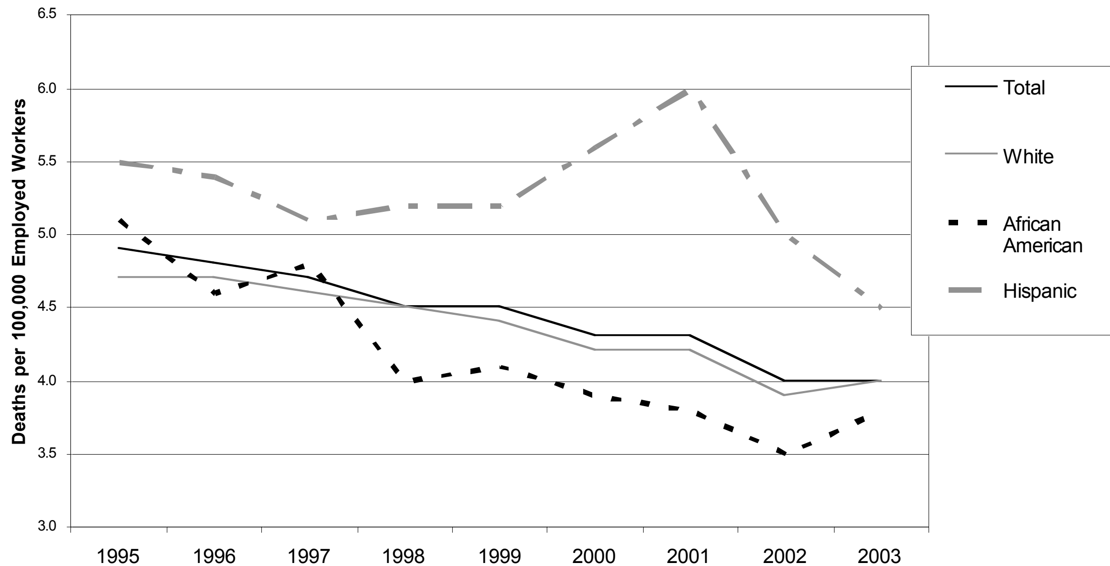
Reproductive Health Care. Publicly funded family planning clinics are an important means of expanding access to affordable sexual and reproductive health care in the United States. The Alan Guttmacher Institute estimates that more than 34 million U.S. women needed contraceptive services in 2002, nearly half of whom needed public services because of low income and/or other barriers to receipt of contraceptive care. Of these, only about 6.7 million women, or four in ten, were served in publicly funded clinics.[45] These clinics have experienced only a 2 percent increase in clients since 1994, despite modest growth in the number of publicly funded family planning clinics providing contraceptive services to eligible women.[46] Public expenditures on contraceptives services totaled $1.26 billion in 2001, almost completely reversing declines in public funding in the 1980s (adjusted for 2001 dollars).[47] Funding for public family planning services is severely threatened, however, by pending state and federal cuts in Medicaid programs; more than eight in ten family planning agencies receive Medicaid funding for contraceptive services. And in many states capacity is well behind need. Since 1980, thirty states have reduced their spending on contraceptive services.[48] In the last decade, a large number of states experienced a decline in met need or an increase in women in need living in counties without a publicly funded clinic.[49]

Occupational Safety

Many people of color, immigrants, and low-income families tackle some of the most dangerous jobs in America. They do so as a means of providing for their families and as a way to attain better, safer work ahead. But historically these groups have also faced higher rates of occupational injury and death, making the workplace a disproportionate threat to their security. Although overall rates of occupational injury and death have declined--the result of improved workplace health and safety policies enacted in the 1990s--Hispanics remain at greater risk for work-related death, as depicted in Figure 7-16.[50] Hispanic workers face a 28 percent greater risk of workplace-related death than do whites, and they are at 42 percent greater risk than are African Americans.

Figure 7-16. Occupational Injury Death Rates by Race and Ethnicity, 1995-2003

Source: National Center for Health Statistics, 2005



Housing

Safe, affordable, quality housing is another important dimension of security, yet adequate housing is increasingly difficult for even average wage earners to afford.

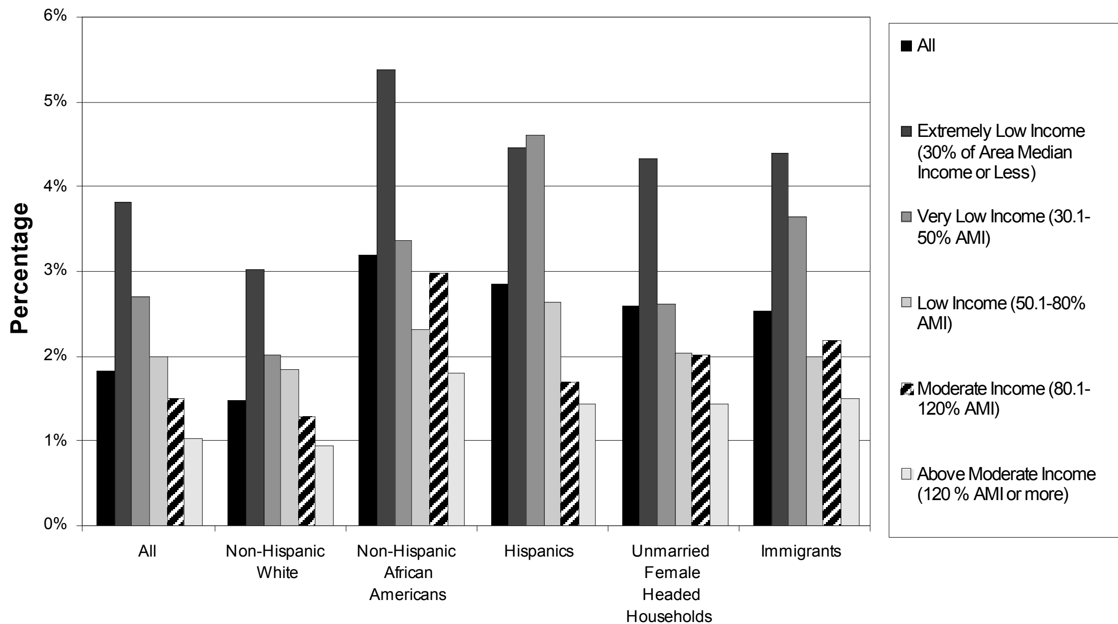
Federal standards define affordable housing as housing costs that do not exceed 30 percent of family income. Today, many families pay far more than this proportion of income for housing. According to the National Low Income Housing Coalition, U.S. workers must earn an average hourly wage of $15.37 to afford the rental costs of a two-bedroom unit, yet the national hourly wage average is about $14, and more than one-quarter of the population earns less than $10 an hour.[51] For families earning extremely low incomes--less than 30 percent of the median income in an area--the situation is even more dire:

- On average, families with extremely low incomes can afford to rent a two-bedroom house at fair market price in only nine U.S. counties, and in only four counties in the nation can a person working full-time at the minimum wage afford even a one-bedroom apartment.[52]
- Of the 4.4 million “working poor” households in the United States, nearly 60 percent pay more than half of their incomes for housing or live in dilapidated conditions. Nearly three in five of these households have children.[53]
- Working families that pay more than half of their incomes for housing are more likely than other working families to have trouble paying household bills, to lack health insurance, and to experience food insecurity.[54]

For groups such as female heads of households and families of color, affording a home is particularly difficult because of lower incomes and fewer mortgage lending options. Unmarried women are more likely than men of all age groups to spend more than half of their monthly income on housing. This is particularly true among women age 35 to 44, who are twice as likely as men to experience severe housing cost burdens.[55] One-quarter of the nation's single mothers spend more than half of their income on housing, compared to one in ten households headed by single fathers.[56] And, as discussed in the chapter on *Mobility*, rates of subprime home mortgage lending--characterized by higher interest rates and fees--are increasingly concentrated in low-income and predominantly minority communities, leading to rising default rates. From 1993 to 2001, for example, rates of subprime home lending increased severalfold in low-income and predominantly minority communities.[57]

Some groups also face a greater likelihood of living in severely inadequate housing, defined by the Census Bureau as housing that has deficiencies in any of five problem areas, such as lacking hot water, heat, or electricity, or having significant upkeep problems. Low-income, unmarried female-headed, immigrant, and minority households experience a greater percentage of severely inadequate housing than higher income and white households. But gaps in rates of severely inadequate housing among racial/ethnic minorities, immigrants, and whites persist at all income levels, including households above moderate income (see Figure 7-17).[58]

Figure 7-17. Percentage of Households with Severely Inadequate Housing, by Race, Ethnicity, and Income Level, 2003
Source: Poverty and Race Research Action Council, 2005



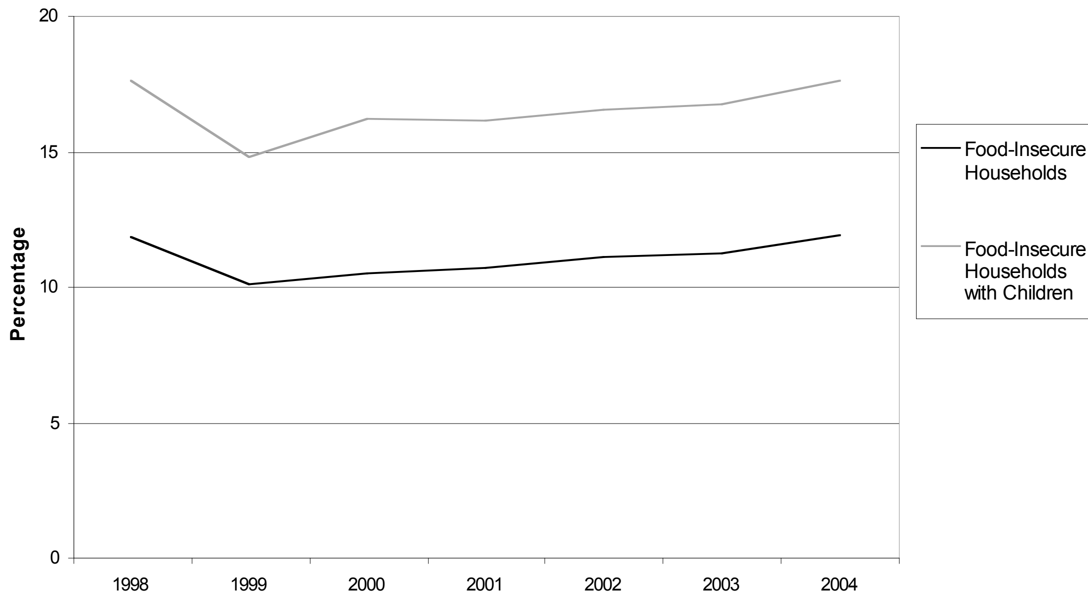
Food Security

Having an inadequate supply of food and nutritional resources can greatly hamper opportunity, particularly among young children, whose early physical and cognitive development depends on access to nutritious food.[59] Households characterized by food insecurity, according to the U.S. Department of Agriculture, are those that experienced uncertainty about adequately feeding all members of the family or were unable to acquire enough food because of a lack of funds or other resources at some time during the last year. These households avoid having one or more family member go hungry because they are able to participate in a federal food assistance program, receive emergency food from a community food pantry, “stretch” meals, eat less varied diets, and/or adopt other coping mechanisms.[60] But some households experience periods when one or more family member is hungry. In 2003 nearly 4 million families experienced food insecurity with hunger, the fourth straight year in which the number of families experiencing hunger increased.[61]

Federal data on rates of food insecurity are available only from the mid-1990s, and a change of methodology only allows a comparison of these rates from 1998 to the present. The percentage of families experiencing food insecurity has increased since 1999, but this percentage is below the rate of households reporting food insecurity at the first measurement point in 1998. Households with children are more likely to experience food insecurity than those without children. In 2003 nearly 17 percent of all U.S. households experienced food insecurity, while slightly over 11 percent of households without children experienced food insecurity (see Figure 7-18).[62]

Figure 7-18. Rates of Food Insecurity by Household

Source: Economic Research Service, USDA, 2004



Physical Safety

Rates of homicide and other serious crimes are sensitive indicators of personal security. Overall rates of violent and serious crimes have declined over the last decade, coinciding with the economic boom of the 1990s and continuing through 2003.[63] Homicide rates have declined dramatically since the 1970s.[64] Some communities, however, continue to experience high rates of violence. Communities with high rates of concentrated poverty, joblessness, dislocation, and minimal political power--more often than not, poor urban communities of color--continue to experience higher rates of serious crime and criminal victimization than do their white and higher income counterparts. Geographic, cultural, and linguistic isolation experienced by other marginalized racial and ethnic minority groups can contribute to insecurity from violence. And violence against women continues to be underreported and inadequately addressed by criminal justice policy and practice.

Homicide

Racial and ethnic disparities in female homicide rates have declined dramatically over the last thirty-five years. As shown in Figure 7-19, in 1990 African-American women were five times more likely than white, non-Hispanic women to be murdered. In 2002 this ratio declined to 3.6. Over this same time period, American-Indian or Alaska-Native women were usually twice as likely as white women to be homicide victims.[65]

For men, the racial gap in mortality due to homicide has been more persistent. In 1990 African-American men were more than eleven times more likely than white men to be killed; in 2002, this ratio declined to just under ten-to-one (Figure 7-20). Among Latino and white males, the homicide gap was about five-to-one in 1990; in 2002 Latino men were three times more likely than white men to die by homicide. And Asian-American and Pacific Islander-Americans have been consistently more likely than white men to die by homicide since 1990.[66]

Figure 7-19. Female Death Rates From Homicide by Race and Ethnicity, Selected Years 1950-2002
Source: Fox and Zawitz, 2004

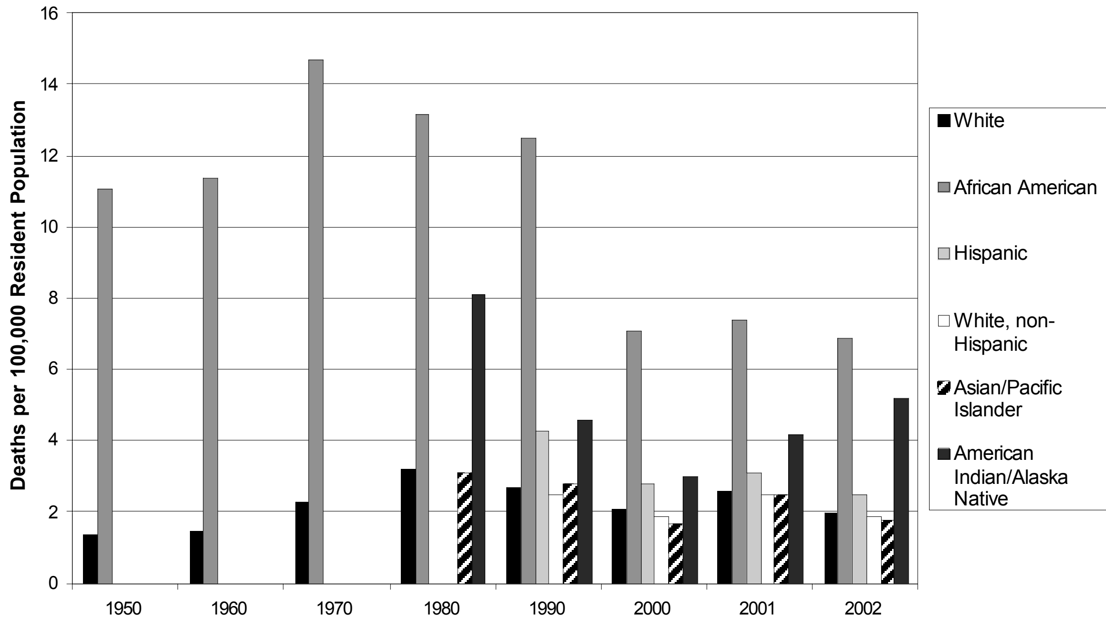
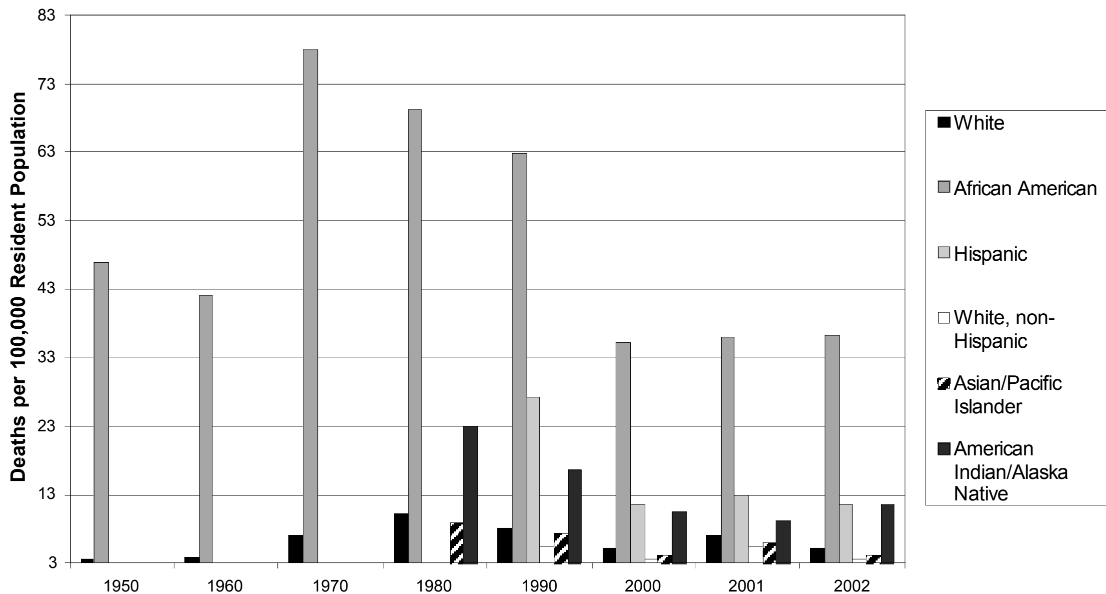


Figure 7-20. Male Death Rates From Homicide by Race and Ethnicity, Selected Years 1950-2002
Source: Fox and Zawitz, 2004



Violent Victimization

The downward trend in rates of violent victimization, which includes crimes such as rape, sexual assault, robbery, and aggravated assault, has been steady for both men and women

and for all racial and ethnic groups. Rates of violent victimization are now less than half what they were in 1993, when the Department of Justice's National Crime Victimization Survey (NCVS) was redesigned.[67] Since 1995 the NCVS sample has also declined as a result of the escalating costs of data collection. The declining crime rate, combined with sample reductions, has led to a diminished federal capacity to track victimization rates among racial and ethnic groups other than whites, African Americans, and Hispanics. Trends in victimization rates, as assessed by the NCVS, are presented in Figures 7-21 and 7-22.

Figure 7-21. Rate of Violent Victimization per 1,000 Persons Age 12 or Older by Gender, 1993-2003

Source: Bureau of Justice Statistics, U.S. Department of Justice, 2004

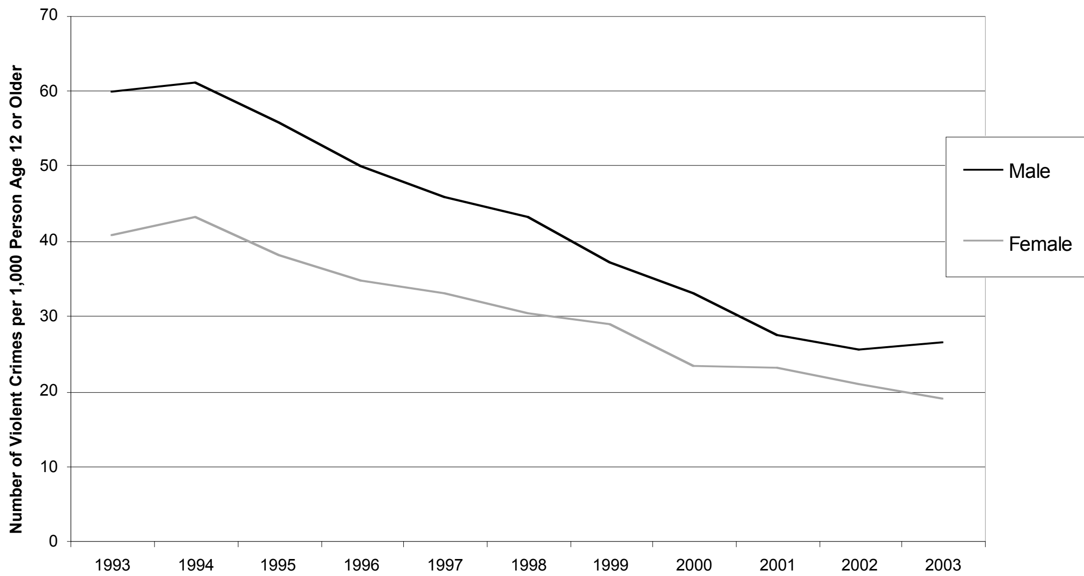
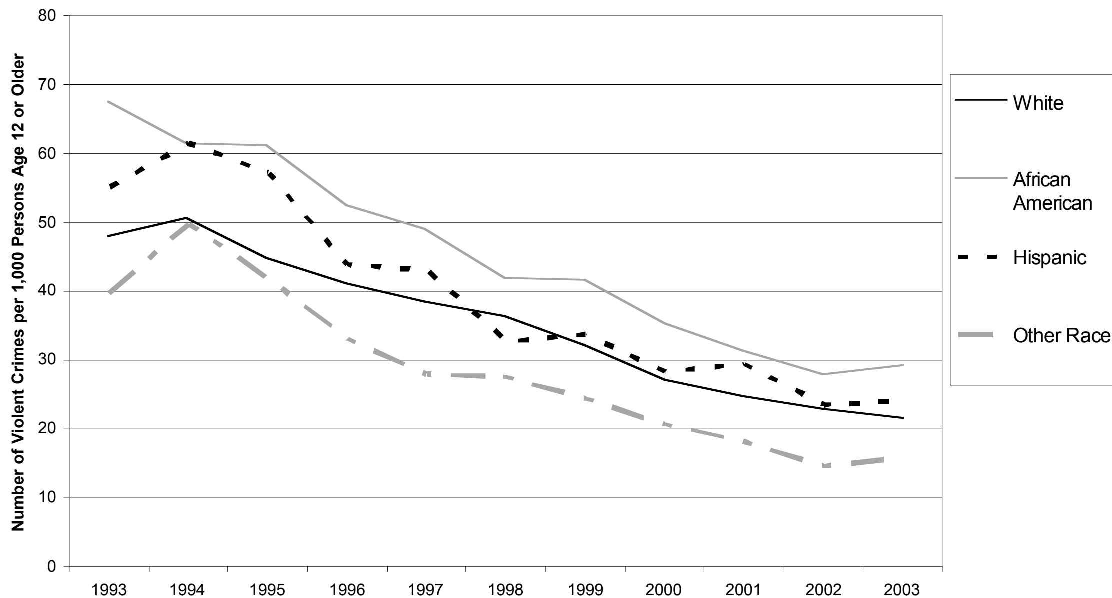


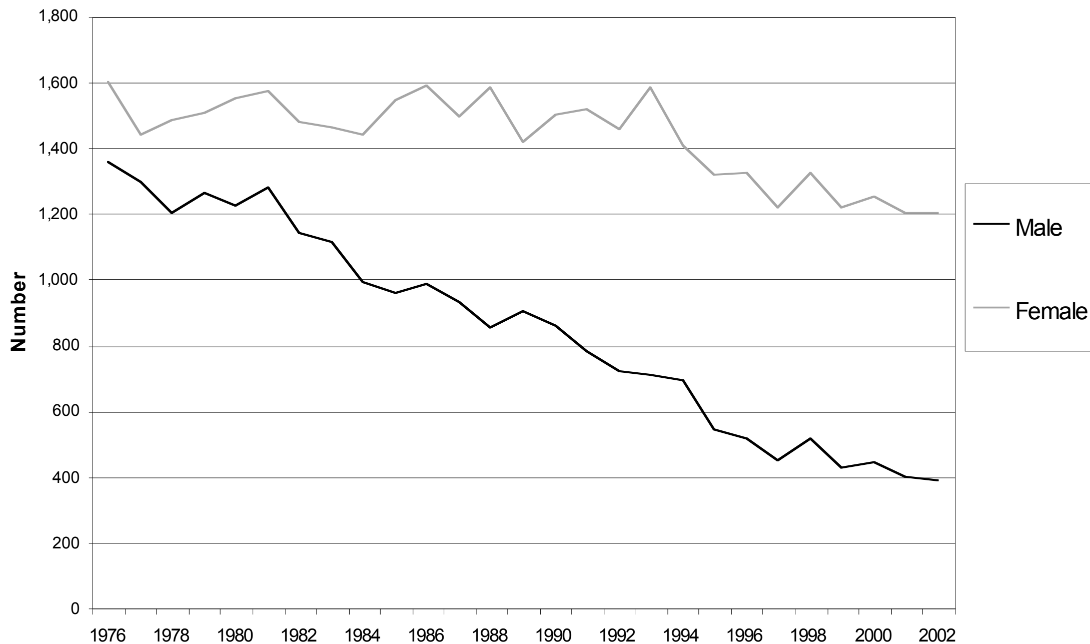
Figure 7-22. Rate of Violent Victimization per 1,000 Persons Age 12 or Older by Race/Ethnicity, 1993-2003
Source: Bureau of Justice Statistics, U.S. Department of Justice, 2004



Intimate Partner Violence

Intimate partner violence (IPV) is pervasive, affecting more than 32 million Americans each year. Almost one-quarter of women and 7.6 percent of men in the Justice Department's National Violence Against Women survey reported that they had been raped or physically assaulted by a spouse, co-habiting partner, or date at some point in their lifetime.[68] Victims of IPV, however, are overwhelmingly women (85 percent). Domestic violence is the largest single cause of injury to women age 15 to 44 in the United States, constituting 20 percent of nonfatal violence against women in 2001.[69] Almost 5.3 million incidents of IPV occur each year among U.S. women age 18 and older.[70] An estimated 1.5 million women annually are victims of rape or sexual assault by a domestic partner. Many are repeatedly assaulted, resulting in about 4.8 million intimate partner assaults per year.[71] Women living in poverty, as well as American Indian/Alaskan Native, African-American, and Hispanic women are disproportionately at risk.[72]

Trends suggest that although rates of IPV are declining in some measures, women remain at risk for victimization. For example, the number of women who are victims of domestic homicide was more than three times higher than that for men in 2002. This gap is considerably larger than in 1976, when the female/male IPV-related homicide ratio was only about 1.2 (see Figure 7-23).[73] One-third of all homicides among women are the result of intimate partner violence, a proportion that has not changed substantially over the last three decades.[74]



Environmental Security

Environmental insecurity occurs when communities disproportionately bear the burden of man-made environmental degradation, toxins in the built environment, and other environmental health hazards. These environmental insults include "physical, chemical, and biological pollution of the air, water, soil and biota."[75] The most common environmental hazards include lead, hazardous waste sites, and air pollution. Environmental risks harm residents of the communities that harbor them--directly in the form of health risks and indirectly in their effects on community property values, the tax base, and business climate.

These problems disproportionately affect American Indians and African Americans, poor communities, and communities in the South.[76] Several studies demonstrate the greater prevalence of environmental degradation in marginalized communities, as well as their health effects. But no single study has systematically collected national data on the prevalence of environmental hazards and the demographic composition of the communities that unwillingly host them. It is therefore not possible to assess the nation's progress in addressing this threat to personal security. Nonetheless, environmental inequity remains an important civil and human rights problem that poses a large barrier to opportunity.[77]

Environmental risks arise from many sources. Municipal landfills, incinerators, hazardous waste treatment plants, and industrial waste storage and disposal facilities are some features of the built environment that contribute to environmental risks. Other

factors include elements of the transportation infrastructure such as those associated with placement of highways and bus depots near residences.[78] Substandard housing also can contribute to environmental risks through residents' exposure to lead and asbestos, vermin infestation, and other health risks. And occupational hazards such as those faced by migrant workers who are exposed to known carcinogens in pesticides and herbicides or unsafe work conditions in illegal "sweatshops" remain widespread.[79]

Evidence of environmental inequity is consistent across several large studies, but such studies have been limited. In 1983 the U.S. General Accounting Office found that three out of four off-site commercial hazardous waste landfills in the southeastern United States were situated in predominantly African-American communities. The United Church of Christ's 1987 study found that three in five African Americans and Hispanics lived in communities with abandoned waste sites. And in 2000, more than half of low-income public housing units were located within a mile of factories that produce toxic emissions.[80]

The impact of environmental hazards on health has been widely documented. A 1998 U.S. Department of Health and Human Services study found that poor children in urban and rural regions are more likely to have blood lead levels that far exceed federal standards.[81] African-American and Hispanic children suffer from higher rates of both lead exposure and asthma induced by air pollution. And the Environmental Protection Agency estimated that pesticide exposure causes between 10,000 and 20,000 illnesses a year among farm workers, and countless thousands of illnesses later in life.[82]

How Can We Ensure Security for All in the United States?

A range of opportunity policies can enhance the security of our nation and its residents. The description of policy initiatives below is not meant to be comprehensive; rather, it provides examples of policies that can enhance security in many of the domains described above.

Poverty and Income Insecurity

Problems of poverty and income insecurity can be reduced by expanding a range of existing living wage, job training, child care, education, and temporary financial assistance programs; by developing programs that help lower income families to save and to acquire assets and financial skills; and by addressing structural inequality that allows poverty to persist and fester. Ways to reduce structural inequality include promoting mixed-income housing, encouraging regional planning to address inequality between urban and suburban jurisdictions, and supporting public transportation programs that reliably and efficiently help people who live in areas of high unemployment to commute to areas of high job growth and opportunity.

Expand Living Wage Laws. Living wage ordinances help to ensure that full-time minimum wage earners (70 percent of whom are adults) can support their families. Living wage laws have been enacted in more than seventy localities, ensuring that city or

county governments will not contract with businesses that pay workers wages less than what would be needed to live above poverty levels, given local economic conditions. Living wage standards range from a low of $6.25 an hour in Milwaukee, Wisconsin, to a high of $12 an hour in Santa Cruz, California.[83]

Increase the Federal Minimum Wage. An increase in the federal minimum wage to $7.25 per hour would raise the wages of 7.3 million workers, and an additional 8.2 million workers would likely receive pay increases as a result of "spillover" effects. Such a hike would increase the real value of the minimum wage, which currently is about one-third of the average hourly wage, the minimum wage's lowest value since 1949. Women and workers of color would reap the most benefit from a minimum wage increase, as would families with children. Low-wage workers who support families with children contribute to half of family earnings, on average, and 36 percent of workers who would be affected by a minimum wage increase to $7.25 contribute 100 percent of their family's earnings.[84]

Help Low-Income Families Develop Assets. Policies that help poor and low-income families to develop long-term assets like savings accounts, homeownership equity, and savings for college education are gaining bipartisan support. These strategies shift the emphasis of poverty reduction strategies from solely providing cash assistance to helping poor and low-income families acquire resources necessary to achieve greater financial security. Several states are successfully experimenting with approaches that encourage asset development. These approaches include creating Individual Development Accounts (IDAs) and state-level earned income tax credits, increasing homeownership programs, reducing or eliminating asset limits for public benefit programs, and implementing antipredatory lending measures. Evidence suggests that many of these strategies yield broader social and economic benefits, including increased educational attainment among children, greater levels of civic participation, and better health outcomes.[85] IDAs--matched savings accounts for low-income households--have been found to increase the likelihood that the poor will develop savings and assets, but they do not necessarily increase beneficiaries' net worth.[86] Nonetheless, when implemented with policies that protect the poor from predatory lending and improve beneficiaries' knowledge of personal financial management, such strategies are promising means to allow low-income families to gain financial security.

Address Geographic Influences on Poverty. One of the greatest structural obstacles to reducing poverty is geography. Impoverished families often live in communities where a large percentage of other residents are also impoverished or subsist on low incomes. This geographic isolation increases the likelihood that poor families will live in substandard housing, face barriers to attaining job opportunities and commuting to communities where jobs are available, and have few options to access high-quality education. The federal Moving To Opportunity (MTO) demonstration program provides low-income families living in high-poverty neighborhoods with the option of relocating to mixed-income neighborhoods. A rigorous evaluation of the MTO program found that MTO yielded broad opportunity benefits for families that moved to mixed-income neighborhoods, including significant positive impacts on personal safety, housing quality,

adult mental health and obesity, teenage girls' mental health, school dropout rates, delinquency, and risky behavior.[87]

Health Insecurity

Health inequality and insecurity must be tackled by state and federal efforts to develop a universally accessible, comprehensive, and equitable health care system. The United States is the last modern, industrialized nation without a universal health care program. Health insurance coverage is primarily provided by employers, but as benefit costs rise employers are declining to offer coverage or are purchasing plans that require greater employer cost sharing. Health insurance coverage is increasingly unequal, disproportionately hurting those who need health care the most--racial and ethnic minorities, children, and lower income families. Less than half of low-wage workers have employer-provided health insurance from their own employer or a family member's employer, and female low wage workers are half as likely as male low-wage workers to receive health insurance from their employer.[88]

Federal programs such as Medicare, which is much more efficient than private plans because of its low administrative costs, should be expanded to include uninsured individuals. The ultimate goal would be to create a "Medicare for all" single-payer program that efficiently and equitably insures all Americans. Because Medicare is a federal program, subject to the Civil Rights Act of 1964 (particularly Title VI, which prohibits discrimination on the basis of race, ethnicity, language status, and other factors), it contains mechanisms of accountability that can be expanded and enhanced to ensure that inequitable health care is addressed.

Food Insecurity

Food insecurity should be eliminated by expanding existing state and federal food assistance programs such as food stamps and school lunch programs. The Food Stamp Program, for example, has successfully assisted millions of families that face food insecurity. The program currently feeds 17 million food stamp recipients, but benefits provide an average of 78 cents per meal, and program participation has declined 22 percent since 1996, in part due to tightened eligibility requirements. Yet an estimated 43 percent of those eligible for the program do not participate. Other federal programs such as the Women, Infants and Children (WIC) Program and school feeding programs provide for about 7.2 million pregnant low-income women and their infants and children each month. The National School Lunch Program serves more than 27 million meals daily.[89] A recent study found that children who benefit from federal safety net programs such as food stamps, WIC, and Temporary Assistance to Needy Families have better health status, less food insecurity, and show less evidence of undernutrition than comparable children who are not enrolled in these programs.[90] Expanding program eligibility, easing the enrollment process, and expanding outreach activities to enroll eligible families will help to ensure that avoidable health, education, and behavioral problems linked to poor nutrition and food insecurity among children will be avoided.

Moreover, local, state and federal governments should ensure that all communities have access to high-quality, low-cost nutritious foods by creating incentives for major grocery chains and other commercial food vendors to set up stores in areas with few such resources. High-poverty urban and rural communities are less likely than higher income areas to have full-service grocery stores or supermarkets, and are more often served by smaller, independent stores that do not or cannot offer high-quality, low-cost foods, particularly fresh produce. Residents of low-income communities are more likely to face transportation barriers that restrict their access to low-cost, high-quality foods that are more commonly available in supermarkets.[91] Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. For example, the city of Rochester, New York, which experienced an 80 percent decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the Community Development Block Grant program, and other sources) to attract a major supermarket chain to open stores in the city. This move provided jobs, greater economic growth, and improved access to healthful, low-cost foods for urban residents.[92] More recently, Pennsylvania awarded a $500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia, part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access to supermarkets.[93]

Personal Security and Safety

Protection against crime and violence should be enhanced by adopting proven criminal justice policies that focus on prevention and do not rely solely on incarceration as an “after-the-fact” approach to deterring crime. Community policing, substance abuse prevention and treatment, and other crime prevention programs have proved effective in reducing low-level criminal activity before it escalates. Fundamentally, however, rates of crime and violence are linked to broader opportunity problems within some communities, such as high unemployment rates, insufficient job training, and community dislocation. To the extent that crime and violence reflect a lack of opportunity, many of the other opportunity policies described here and elsewhere are likely to contribute to a decline in crime rates.

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[1] These values are reflected in a range of state and federal programs such as Social Security, Medicare, Medicaid, Temporary Aid for Needy Families, federal housing assistance, and other social and economic security programs. Funding for some of these programs has eroded in recent years, despite high levels of public support. For example, 88 percent of respondents in a recent survey stated that Social Security is “very important,” as did 83 percent of respondents when asked about Medicare, 74 percent of respondents when asked about Medicaid, and 74 percent of respondents when asked about federal aid to public schools. See the Kaiser Family Foundation’s *National Survey on the Public’s Views About Medicaid*, June 2005, www.kff.org (15 July 2005).

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