

Letter from America: Unequal treatment, unequal incomes, and race

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It is often said that America, unlike Britain, is a classless society, but that stratification by class in Britain often maps into stratification by race in America. The link between immigration and race that is so important in Britain holds in the United States for Hispanics and for recent immigrant groups from Asia, but is largely absent for African Americans, many of whose ancestors were brought to America in chains. Black Americans experience a wide range of disadvantages relative to whites and the disparity in incomes contributes to overall income inequality. Median earnings for black men are 20 percent lower than median earnings for white men, and while nearly 30 percent of white men are managers or professionals, only 18 percent of black men are such. In the latest poverty statistics, 24.3 of blacks are in poverty, as opposed to 10.5 percent of whites. The median net worth of white households is approximately ten times that of black households. Test scores for reading and mathematics are substantially lower for blacks than for whites. A quarter of births to white women take place out of wedlock, while more than two-thirds of black children are born to unmarried women. Blacks are six times more likely than whites to be murdered, and seven times more likely to be murderers. In 1997, nine percent of the black population was "under some kind of correctional supervision" (the phrase comes from the Department of Justice), compared with two percent of the white population, and less still for other races.

None of these racial inequalities seems to inspire the same degree of discomfort as differences in health between blacks and whites. Life expectancy at birth is 6.4 years less for black than white men, and 4.7 years less for black women. (For comparison, at the end of the century, differences in life-expectancy between Social Classes I and V in Britain were 7.4 years for men, and 5.7 years for women.) Many who are tolerant of economic inequalities find these health differences to be unacceptable. For example, the Bush administration, which has hardly made reduction in economic inequalities a priority, has (sometimes reluctantly) made minority health a focus of research within the Department of Health and Human Services (HHS) and the National Institutes of Health. The health and human services administration notes on its website that "African Americans, American Indian/Alaska Native, Asian and Pacific Islander, and Hispanic citizens suffer poorer health and higher rates of premature death than the majority population. They are often burdened disproportionately by cardiovascular disease, lupus, diabetes, cardiovascular diseases, HIV/AIDS, end-stage renal disease, and certain cancers." (This statement is at best misleading; although the data are disputed in various ways, Hispanics typically have lower mortality, not only than African Americans, but also than whites. Asian immigrants have the highest life-expectancy of any racial or ethnic group. As we shall see, the inaccuracy is no accident.) HHS has set up a national center on minority health and health disparities whose mission "is to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities." The most widely accepted story is that a substantial portion (although certainly not all) of the health differences between blacks and whites comes from differences in health-care, a view that was documented in the 2003 report, *Unequal treatment*, prepared by a distinguished panel of the Institutes of Medicine of the US National Academies of Sciences. According to the report, physicians, who are largely white, discriminate against minorities, either through outright racism, or through statistical discrimination based on the different patterns of disease among patients in the different groups, a process that *Unequal treatment* refers to as "bias, stereotyping, and uncertainty." The report notes that blacks are less likely to receive (desirable) preventative care, or coronary artery by-pass grafts, while they are more likely than whites to experience such (hugely undesirable) treatments such as lower-limb amputation or double bilateral orchiectomy (don't even ask.)

An apparently unrelated finding is that across cities of the United States, income inequality (for example, as measured by the gini coefficient) is positively correlated with mortality rates. The effect is substantial: the probability of dying at any age increases by about 5 percent moving from a low (gini 0.35) to a high (gini 0.45) city. This finding has attracted attention among those who think of income inequality as a form of social pollution that is a direct hazard to health. The correlation is spurious, but the story behind it is an interesting one that brings us back to racial differences in health. In cities where there is a large African American population, white incomes are higher, and black incomes lower, which carries through to higher income inequality in the city. Predominantly black cities are unequal income cities. Once we condition on the fraction

black, there is no correlation between mortality rates and income inequality. But why should people (both black and white) die younger just because they live in cities with substantial black populations? Recent work has helped resolve the city puzzle, and casts light on why blacks have worse health outcomes than whites. Because blacks and whites are so residentially segregated, and because people seek physicians and hospitals in their own communities, there are essentially different sets of physicians and hospitals for blacks and for whites. A group led by Peter Bach at Sloan-Kettering Cancer Center, publishing in the *New England Journal of Medicine* in August this year, finds that eighty percent of doctor visits by black patients are made to less than a quarter of doctors who, in turn, rarely see white patients. Work by Jonathan Skinner and colleagues at Dartmouth documents the fine geographical structure of healthcare, and shows that both whites and blacks do worse in hospitals that treat more blacks. These findings hold for Medicare patients, whose age entitles them to close to free treatment at the point of care. The Sloan-Kettering study shows that the doctors who predominantly treat blacks are less wellqualified and are less likely to have access to the resources needed for advanced treatment. On the positive side, these results mean that it is unlikely that discrimination by white physicians can play much of a role in black-white health differences; there is just not enough overlap of patients within doctors to do much harm, even if they are all racial stereotypers, and even if health care is an important cause of differences in health. Such a result is consistent with the fact, noted above, that Hispanics and several other ethnic minorities have longer lifeexpectancy than whites. (Creating the false impression that everyone has worse health than whites is an important part of the “white doctors stereotyping” argument, and is extremely unhelpful for thinking about policy responses.) Both studies undermine the case that is being made in some quarters for a “matched” health-care system, in which patients are treated by doctors of the same racial or ethnic group. On the negative side, it is clear that the US has a health care system that is run on something close to apartheid lines, with separate but unequal facilities for blacks and whites. The racial segregation of American cities supports this arrangement, so that areas where the population is largely black are served by less sophisticated health care, less well-trained physicians, and less well-funded hospitals. These poorer facilities hurt the health of everyone who lives in those areas, white and black alike. Income inequality across cities is not the fundamental determinant of health, but simply an indicator of deeper processes of racial segregation and inequality in America.

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