Guest Editorial

RACIAL DISPARITIES IN HEALTH: TAKING IT PERSONALLY

I would like to use this space to thank the many people who worked hard to make this issue of *Public Health Reports* come to fruition, and to explain why I think it is important to critically examine the matter of racial disparities in health.

Many Thanks

A while ago, two of my colleagues, Stuart Kiken and Linda Forst, heard me give a presentation about racial health disparities in Chicago and suggested that Robert Rinsky, in his (then) new role as editor of *Public Health Reports*, might consider a manuscript from our group at the Sinai Health System on this topic. I contacted Bob, and he was most gracious and enthusiastic. A few days later, I approached him with the suggestion that an entire issue of *Public Health Reports* be devoted to health disparities. He responded by noting that this would be consistent with the journal's efforts to highlight the topic with a number of special-focus issues and individual articles. He asked me to facilitate the collection of manuscripts for this issue. It has been an honor to work on this project with Bob, who has been patient and wise throughout.

As I contacted colleagues in the field, every one, without exception, eagerly endorsed the project. I would especially like to thank three people. Nancy Krieger recommended other possible contributors, offered guidance on how to think about the overall scope of this issue, and has written an insightful commentary.[1] Jade Dell coordinated all aspects of this work from its inception, provided invaluable insights, and helped the entire project come together. David Ansell has provided critical thinking about this issue of the journal, the topic of disparities, and how best to participate in the larger discussion taking place in the literature.

We—the authors, those who helped put this issue together, Bob, and I—hope you find this collection of articles provocative and helpful. There is no way to adequately thank the contributors, all of them very busy, for finding time in their schedules to generate such high quality work.

Why Is This Issue Important?

Consider the following:

- In preparation for writing this article, I typed the words "disparities in health" into a search engine. This yielded more than 138,000 "hits," including the websites of the White House, the National Institutes of Health, and the Centers for Disease Control and Prevention, among other well-known institutions and agencies. Many of the sites outlined lofty goals and objectives. There were also wonderful flow charts and beautifully drawn diagrams.
- In many requests for proposals from federal government agencies, applicants are asked to specify up front how the proposed work would facilitate the battle against health disparities.
- Conference after conference is held under the banner of reducing (Healthy People 2000) or eliminating (Healthy People 2010) disparities.

Despite all of the attention being paid to this issue, our society (including both the public and private sectors) is failing in its stated pursuit, as is demonstrated by studies that have looked at racial health disparities over time, including seminal studies by David Williams[2,3] and Arline Geronimus and her colleagues,[4] among others. Vivid examples of a pattern of increasing racial disparities in Chicago from 1980 to 1998 may be found in the Silva et al. article in this issue.[5] Also in this issue, and very compelling, is the analysis by Levine and his colleagues suggesting that such disparities are likely to continue for many years.[6]

Sadly, progress is not being made in reducing (let alone eliminating) disparities. In fact, the trends are moving in the direction opposite to the one we are pursuing. It can not be emphasized enough that this failure does not occur in a vacuum. Rather, essential structural issues stand in the way of reducing disparities.

Structural Issues

As Cooper et al. write in this issue of *PHR*: "It is generally recognized that the health of populations is determined primarily by the structure and organization of a society, including the level of scientific knowledge and technological capacity as well as operating social values."[7] For example, there is a substantial body of knowledge that links disparities in health to disparities in wealth,[8,9] and these disparities, in turn, are expanding rapidly.[10,11] Furthermore, as Williams and Collins point out, there is growing evidence for a causal relationship between racial segregation and poor health.[12] Finally, the links between structural factors, including disparities in wealth and residential segregation, at least in the United States, are inextricably tied to the pivotal issue of racism.[13] As Cohen and Northridge note, "It is impossible to have a frank discussion of inequality . . . without confronting the continuing blight of racism head on."[14]

To summarize, the battle against racial disparities in health is: (*a*) touted widely; (*b*) long overdue; and (*c*) losing ground and predisposed to continue doing so by social forces that are propelling society in the wrong direction.

Taking It Personally

Let me try to give the statistical abstractions of racial disparities in health a human dimension by considering the notion of "excess mortality."

- In 1994–1998 in Chicago, 1,171 "excess" black infants died because the black infant mortality rate was not the same as (i.e., not as low as) the white infant mortality rate.[15] Let us think carefully about these infants. Perhaps we can envision them struggling in the neonatal intensive care unit. Perhaps we can imagine that one of our own children was in that unit and then died. Now let us imagine this scenario repeated hundreds of times every year in Chicago alone. Where is the professional outrage as this continues year after year after year? Where are the newspaper headlines? Where is the war on infant mortality? Where is the $20 billion to finance this war?
- I work at Mount Sinai Hospital in Chicago, located in one of the poorest communities in the city. This almost entirely African American community area includes about 1% of Chicago's population. In 1996–1998, this community had 103 "excess deaths" annually, calculated using the Chicago mortality rate as the reference, and 170 "excess" people died based on the rate for the US as a whole.[16] This excess mortality is reproduced many times over in locations throughout the United States.[17]

In thinking and writing about health disparities, we must not lose track of the human dimension. Think about what it means for us to look out our office windows and see some of the people who will be counted among the "excess" deaths. The opportunity to highlight the fight against racial disparities, to assemble in one place articles such as those in this journal (to reinforce those that have appeared in other journals) is very important. An opportunity is here. To let it slip away because of politeness or complicity would be a tragic failure. I cannot see how we will make progress against racial disparities unless we reveal them and proclaim their destructiveness. If the battle against disparities is being lost, let us note that.

I would suggest that one of the most important things we can do is to take the matter of disparities in health personally. If the existence of these racial disparities, indeed their growth, is a national shame, then each of us should say so. Jonathan Kozol, who writes about the role of race in the lives of children, notes the problem in finding the optimal tone for one's indignation: "You say these things for six or seven years, or fifteen years, or thirty years. . . . You say them in your writing and get slapped down by the . . . arbiters of culture . . . , who wonder why you are angrier than they are. After a time you start to feel worn out by your own words. You grow sick of being angry—sick as well of being isolated by your anger. Perhaps, in time, your narrative grows more subdued."[18]

We need to make sure that our narrative does not become subdued. It is time to respond with anger to a situation that demands anger.

In the first half of the 19th century, Black abolitionist Martin Delany asserted, "It would be duplicity to disguise the fact that the great issue, sooner or later, upon which must be disputed the world's destiny, will be the question of black and white, and every individual will be called upon for his [sic] identity with one or another" (quoted in *There Is a River: The Black Struggle for Freedom in America*[19]). Fifty years later, in 1903, W.E.B. Du Bois repeated virtually the identical sentiment: "The problem of the 20th century is the problem of the color-line."[20] Martin Luther King, Jr., said that if we do not address the challenge implied in these observations, we are all in trouble, noting that all human life is "tied together in a single garment of destiny" (quoted in *I May Not Get There with You: The True Martin Luther King, Jr.*[21]).

Through 100 years of Black struggle, from Delany to Du Bois to King, the sentiment remains the same*: the elimination of racism is essential*. White supremacy is the very bedrock upon which this country was founded; without addressing and eliminating racism, progress toward democracy, equality, and optimal health for all will not be possible.

Stimulated by dramatic racial disparities in health, literally a matter of life and death, we might pose the following questions: What will it cost to eliminate these disparities? More important, what will it cost not to do so? Can the US afford not to eliminate health disparities? Finally, for us today, what role will public health workers play in answering these questions? Opposing racism will do more than assist in the reduction and elimination of racial health disparities. As Delaney, Du Bois, King, and others have noted, the soul of the nation is at stake.

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