Health Policy and Ethics Forum

The Color Line: Race Matters in the Elimination of Health Disparities

Stephen B. Thomas, PhD

Herein lie buried many things which if read with patience may show the strange meaning of being black here at the dawning of the Twentieth Century. This meaning is not without interest to you . . . for the problem of the Twentieth Century is the problem of the color line . . . the relation of the darker to the lighter races of men in Asia and Africa, in America and the islands of the sea.

W. E. B. Du Bois,
The Souls of Black Folk (1903)

The "color line" is not fixed but ripples through time, finding expression at distinct stages of our development as a nation. As the meaning of race has changed over time, its burdens and privileges have shifted among population groups. At one time in our history, for instance, the Irish and Italians were considered "non-White," along with other immigrants who were not descendants of the early Anglo-Saxon Protestant settlers.

In this issue of the Journal, Gerald Oppenheimer traces the color line through the course of American history.[1] He demonstrates how the original language of White racial differences began with the anxious response of early Americans to waves of immigration, beginning in the 1840s when the Irish (or Celts) entered US ports, followed by nationals from Central, Southern, and Eastern Europe. Over time, the descendants of these "White ethnic groups" became the monolithic Caucasian race, the majority population, superior in all respects to the Black people of African descent.[1]

Race Matters

Oppenheimer attempts to reconcile the biological fact that we are all members of one human race with the daily reality that we are not all treated with the same degree of human dignity. One consequence of this persistent discrimination is an unequal burden of illness and premature death experienced by racial and ethnic minority populations. The focus of his discussion is on the Institute of Medicine (IOM) report *The Unequal Burden of Cancer: An Assessment of NIH Research and Programs for Ethnic Minorities and the Medically Underserved*.[2] More specifically, Oppenheimer's narrative addresses Recommendation 2-4:

> The [IOM] committee recommends an emphasis on ethnic groups rather than on race in NIH's cancer surveillance and other population research. This implies a conceptual shift away from the emphasis on fundamental biological differences among "racial" groups to an appreciation of the range of cultural and behavioral attitudes, beliefs, lifestyle patterns, diet, environmental living conditions, and other factors that may affect cancer risk.[2(p19)]

According to the IOM, human biodiversity cannot be adequately summarized according to the broad, presumably discrete categories assumed by a racial taxonomy. Furthermore, "racial" groups, as defined by the Office of Management and Budget (American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, or White, and 1 of 2 ethnic groups, Hispanic or non-Hispanic) are not discernible on the basis of genetic information.

Cooper and others argue that we should abandon the concept of race for the purpose of surveillance and instead use ethnicity as the appropriate classification schema for public health research and practice.[3,4] Yet, from the social-justice perspective of public health, the shift away from "race" to "ethnic group" is in some respects minimizing the health impact of racism, especially for populations subjected to social prejudice because of their dark skin and facial features. A growing body of scientific evidence suggests that racism is a pathogen with biological consequences.[5] The detrimental effects are reflected in longstanding health disparities. Some scholars argue that efforts to remove race as a scientific variable are unwarranted. Instead, we need to do a better job at understanding how to measure race, racism, and social inequality in medical care and public health practice.[5–9]

The work of Dorothy Roberts on race and reproductive health provides an example of how racism influences health through social inequality and institutional power relationships.[10] Roberts describes a series of events beginning in the late 1980s and continuing into the early 1990s, a rash of criminal prosecutions of women for using drugs during pregnancy. Legal authorities in South Carolina charged these women with crimes that included the distribution of drugs to a minor, child abuse, and even manslaughter if the baby died. Some of the women were charged with assault with a deadly weapon. Implementation of the policy required the cooperation of physicians, public health workers, the solicitor general, and police. The program was implemented at a public hospital that served an indigent Black population. Pregnant women were tested for drugs and if the results were positive, were given one chance to consent to mandatory drug treatment. If they did not obey the consent order, given by the nurses, they were arrested. Some were arrested within hours of giving birth and some were arrested while still pregnant and were brought, wearing leg irons, shackles, and handcuffs, into the hospital for prenatal care; they were then shackled to the bed during the delivery. Poor Black women who smoked crack during pregnancy constituted the vast majority of women jailed under this policy.[10] This example highlights the potential impact

The author is with the Center for Minority Health, Department of Health Services Research, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pa.

Requests for reprints should be sent to Stephen B. Thomas, PhD, Center for Minority Health, Graduate School of Public Health, University of Pittsburgh, 125 Parran Hall, 130 Desoto St, Pittsburgh, PA 15261 (e-mail: sbthomas@pitt.edu).

This commentary was accepted January 9, 2001.

of racism on public health efforts to increase prenatal care and reduce infant mortality, 1 of the 6 areas targeted in the national campaign to eliminate racial and ethnic health disparities.[11]

A public health effort to eliminate syphilis provides another example of how racism influences health through social relations and institutional power. Thomas and colleagues used a social ecology framework to describe factors affecting the transmission of syphilis in 12 counties in North Carolina.[12] They identified race relations as a factor that accounted for disparities in syphilis rates. There was, according to Thomas and colleagues,

> exclusion of local minorities [Blacks] from positions of influence and prestige, such as the board of health or the county commission in counties with higher than expected [syphilis] rates. Conversely, in a county with a rate lower than expected, the position of health director was shared between an African American female and a white male. This health department also had a reputation of having earned the trust of African American residents.[12(p1086)]

Racial prejudice and racial stereotypes have also invaded physicians' offices. Freeman and Payne describe a disturbing body of scientific evidence of inferior medical care for Black Americans, compared with Whites, even after socioeconomic factors were controlled for. According to the authors, there is "a subtle form of racial bias on the part of medical care providers. The level and extent of this problem are unknown, but it is real and potentially harmful, even though predominately unintentional."[8(p1046)] The evidence that "blacks are less likely than whites to receive curative surgery for early-stage lung, colon, or breast cancer"[8(p1046)] has more to do with racial bias in health care than with the social customs of those Blacks in need of care.

In each of these examples, the issue of race, within the broader context of power relations, social inequality, and racism, should not be ignored. We must pay attention to power relationships in the society as a whole. When we focus on race in reproductive health, syphilis control, cancer treatment, and other interventions, it seems clear that racism may affect the way decisions are made by medical and public health professionals. If ethnicity replaces race as a variable in research, this observation may be lost. This is the context in which the elimination of race as a research variable potentially blinds us to the subtle ways institutional racism continues to shape the behavior of health care providers and policy decision makers toward people from racial minority groups.

To shift exclusively to the language of ethnicity clearly moves toward a greater emphasis on people's cultural and behavioral attitudes, beliefs, lifestyle patterns, diet, and environmental living conditions. From this perspective, interventions to address health disparities would focus more on individual behavior change. From the perspective of racial discrimination as a root cause of health disparities, however, interventions would focus on addressing social inequality and power relations in the society through community mobilization and policy initiatives. To adequately address racial and ethnic health disparities, we need data that include race as a variable, even if race cannot be defined precisely. Public health researchers and practitioners should continue to track it, in order to study the relationship between racial discrimination and health status. Without racial/ethnic data, we cannot monitor progress or setbacks in addressing racial/ethnic inequalities in health.[13] We must be cautious, however, in our use of race as a variable, taking care to define what race means in our research, avoiding assumptions of biological differences, and accounting for distinctions between race and socioeconomic status.

In a recent editorial, Hillel Cohen and Mary Northridge stated that "political action" is the most efficient means of reducing and eliminating racial/ethnic health disparities in the United States. According to the authors, "the long established and growing health disparities are rooted in fundamental social structure inequalities, which are inextricably bound up with the racism that continues to pervade US society."[9(p841)] Who benefits when race is removed as a research variable in medicine and public health?

To focus exclusively on ethnicity moves away from the political and economic factors that are more central when the focus is on race. It is in this latter "political" context that the field of public health makes its unique contribution to improving the health and longevity of all Americans, especially the most vulnerable segments of our society.

The Historical Perspective

As early as 1906, W.E.B. Du Bois authored a volume, *The Health and Physique of the Negro American*, documenting the health disparities between Blacks and Whites.[14] In 1914, Booker T. Washington, founder of Tuskegee Institute, viewed the poor health status of Black Americans as an obstacle to economic progress. He issued a call for "the Negro people . . . to join in a movement which shall be known as Health Improvement Week."[15]

Ultimately, National Negro Health Week evolved into a comprehensive year-round program, named the National Negro Health Movement, that integrated community development, health education, professional training, and health policy initiatives, all designed to improve Black health status. Race was critical to this initiative, as Washington and other leaders made a direct linkage between health status, economic progress, and improvement of the social and political standing of Black Americans. The movement came under the auspices of the Office of Negro Health Work in the US Public Health Service, and when the move toward racial integration led to the dismantling of the office in 1951, the National Negro Health Movement came to an end.[16]

In many ways, the National Negro Health Movement emerged as a resilient response to the segregation and racism prevalent throughout medicine and public health. At the time, health interventions were focused on White Americans. As Oppenheimer notes, during the early years of the 20th century, "the public health problems of the Black population were seen, in general, as problems of and for *their* communities."[1(px)]

There remains today a great need for research to investigate intervention strategies, including culturally competent and linguistically appropriate approaches to cancer and other diseases for which there is effective treatment and prevention. This is the context in which the "transition" term "race/ethnicity" may serve us well. However, Oppenheimer cautions that race, an ideologically strong category during most of US history and one central to how most Americans think, cannot easily be eliminated from our consciousness. As a social category, race remains the most potent force for mobilizing the American people against injustice. By taking away the ability to link health status and race, we remove one of the most powerful tools used by disenfranchised people to fight for social justice, not only in medical care and public health, but also in our development as one nation. □

References

1. Oppenheimer GM. Paradigm lost: race, ethnicity, and the search for a new population taxonomy. *Am J Public Health*. 2001;91:1039–1045.
2. Haynes MA, Smedley BD, eds. *The Unequal Burden of Cancer: An Assessment of NIH Research and Programs for Ethnic Minorities and the Medically Underserved.* Washington, DC: National Academy Press; 1999.
3. Cooper R. A case study in the use of race and ethnicity in public health surveillance. *Public Health Rep*. 1994;109:46–51.
4. Fullilove MT. Comment: abandoning "race" as a variable in public health research—an idea whose time has come. *Am J Public Health*. 1998;88:1297–1298.
5. Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying

health consequences of discrimination. *Int J Health Serv*. 1999;29:295–352.
6. Williams D. Racism and health: a research agenda. *Ethn Dis*. 1996;6:1–6.
7. LaVeist T. Why we should continue to study race . . . but do a better job: an essay on race, racism and health. *Ethn Dis*. 1996;6:21–29.
8. Freeman H, Payne R. Racial injustice in health care. *N Engl J Med*. 2000;342:1045–1047.
9. Cohen HW, Northridge ME. Getting political: racism and urban health [editorial]. *Am J Public Health*. 2000;90:841–842.
10. Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Pantheon Books; 1997.
11. Goodwin N. The presidential initiative to eliminate racial and ethnic disparities in health: an interview with the surgeon general of the United States, David Satcher. *Health Promot Pract*. 2000;1:29–31.
12. Thomas J, Clark M, Robinson J, Monnett M, Kilmarx P, Peterman T. The social ecology of syphilis. *Soc Sci Med*. 1999;48:1081–1094.
13. Krieger N. Counting accountably: implications of the new approaches to classifying race/ethnicity in the 2000 census. *Am J Public Health*. 2000;90:1687–1689.
14. Du Bois WEB. *The Health and Physique of the Negro American*. Atlanta, Ga: Atlanta University Press; 1906.
15. Washington BT. Quoted by: Patterson F. Statement concerning National Negro Health Week. *Negro Health News*. April–June 1939;7:13.
16. Quinn S, Thomas S. The National Negro Health Week, 1915 to 1951: a descriptive account. *Wellness Perspect*. 1996;12:172–179.