# Reparations

## A Viable Strategy to Address the Enigma of African American Health

DAVID R. WILLIAMS
*University of Michigan*
CHIQUITA COLLINS
*University of Texas at Austin*

*Black-White differences in health are large, persistent, and in some cases, worsening over time. Racial segregation is a central determinant of Black-White differences in health. The physical separation of the races in residential areas is an institutional mechanism of racism that remains a primary determinant of racial differences in economic circumstances. These differences in social and economic conditions are largely responsible for racial differences in health status. Reparations are a potentially effective strategy to rebuild the infrastructure of disadvantaged, segregated communities. Such investment would enhance the economic circumstances of African American families and communities and also improve their health.*

***Keywords:*** *race; racism; residential segregation; health status; reparations*

**This article argues that improving** the socioeconomic conditions of African American (or Black) families and communities is a prerequisite to improving the health of African Americans and reducing the Black-White gap in health. It begins with an overview of the magnitude of racial differences in health. It next describes the central role of socioeconomic status (SES) in producing these disparities, followed by a discussion of the role of racial residential segregation in creating racial inequality and the multiple mechanisms by which segregation affects health. The article concludes that reparations are essential to eliminate the negative effects of segregation and are very likely to dramatically reduce racial differences in health.

We use the term *reparations* in the technical sense of its singular form, *reparation*, that emphasizes restitution and compensation to the victim because of

**Authors' Note:** *Preparation of this article was supported by Grant MH59575 from the National Institute of Mental Health and Grant 5R24HD42849 from the National Institute of Child Health & Human Development. We wish to thank Scott Wyatt, Nari Kim, and Trisha Matelski for research assistance and Car Nosel for preparing the manuscript.*

AMERICAN BEHAVIORAL SCIENTIST, Vol. 47 No. 7, March 2004 977-1000
DOI: 10.1177/0002764203261074

the unjust behavior of the aggressor (Osabu-Kle, 2000). Allen (1998) indicated that very early on consideration was given to paying reparations to former slaves. The first call for Blacks in the United States to receive reparations to redress "the unparalleled wrongs" and "unmitigated oppression" of slavery came in 1854. In 1865, the Freedman's Bureau Act passed by the U.S. Congress recognized the justice of reparations and allocated 40 acres of land at nominal rent to every former male slave. After this was vetoed by President Andrew Jackson, an alternative proposal in 1867 to provide 40 acres and $50 to all former slaves was also rejected by Congress. However, reparations were never paid to the former slaves, and discrimination supported by law and/or custom has prevented their descendants from closing the Black-White SES gap in the past 140 years. This long-term economic inequality, rooted in residential segregation, is the central determinant of the current African American health disadvantage. Accordingly, this article argues that reparations in the form of compensatory social and economic development programs are a needed intervention for eliminating racial differences in economic status and health. These financial reparations would not be paid to individuals but would be targeted at enhancing human capital and building the economic base of disadvantaged communities (Robinson, 2000).

## RACIAL DIFFERENCES IN HEALTH

For almost 200 years, research has documented that Blacks report poorer health than Whites for a broad range of indicators of health status (Krieger, 1987). In 1999, the life expectancy at birth of 77 years for Whites was 6 years longer than that of African Americans (National Center for Health Statistics [NCHS], 2002). Contributing to this life expectancy difference is an elevated rate of illness and death for African Americans compared to Whites for almost every indicator of physical health. Higher mortality rates for Blacks than Whites are especially marked for heart disease, cancer, stroke, diabetes, kidney disease, homicide, hypertension, and AIDS (NCHS, 2002).

During the past 50 years, there have been many major initiatives in the United States to improve the health and economic circumstances of vulnerable social groups. The Hill-Burton program sought to increase access to medical care by increasing the number of hospital beds in underserved areas. Medicare and Medicaid provided increased access to medical care for the aging population and the poor. Federal spending on medical care and medical research has skyrocketed, and the U.S. population has reaped benefits from important advances in medical knowledge and technology. In addition, the civil rights movement and the war on poverty sought to open doors of economic opportunity to racial minorities, women, and the poor.

In concert with these changes, the health of both Blacks and Whites has improved over time. Overall death rates for Whites were about 40% lower in

2000 than in 1950 (NCHS, 2002). For African Americans, the decline was almost 34%. At the same time, there has been no progress in reducing the relative difference in health between Blacks and Whites in the past 50 years. The age-adjusted overall death rate for African Americans was 22% higher than that of Whites in 1950 but 33% higher in 2000 (NCHS, 2002). Moreover, the Black/White ratios of mortality from coronary heart disease, cancer, diabetes, and cirrhosis of the liver were larger in 2000 than in 1950 (NCHS, 2002). The death rate of infants prior to their first birthday provides another vivid illustration of the persisting racial disparities in health. Although the infant mortality rate has declined for both racial groups over time, a Black baby born in the United States was 1.6 times as likely to die before his or her first birthday than his or her White counterpart in 1950 but is 2.5 times as likely in 2000 (NCHS, 2002). Such large and persistent racial disparities in health are striking.

These racial differences in health are not just dry statistics. They reflect dramatic loss of life during the most economically productive years. National data on survival for 1999 provide a glimpse of the magnitude of these differences (Anderson & DeTurk, 2002). For every 100,000 Black and White females born, some 97,000 White females survive to see their 45th birthday compared to 94,000 Black females. Similarly, 87,000 White women survive to age 65 compared to 78,000 Black women. The differences are even more dramatic for males. Of every 100,000 Black and White males born in the United States, 5,400 fewer Black males survive to age 45 and 16,000 fewer Black males live to see their 65th birthday. A 1985 government report estimated that these racial differences in health translated into almost 60,000 "excess deaths" for the Black population each year (Department of Health and Human Services, 1985). That is, 60,000 African Americans die each year that would not die if the Black population had mortality rates that were similar to those of the White population. An update of that report using 1991 data found that the number of excess deaths had increased to 66,000 per year (NCHS, 1994).

To place this annual level of premature deaths in the African American population into perspective, Table 1 lists the number of combat deaths in the major wars fought by the United States throughout its history. Only the total casualties for the Civil War and World War II exceed the annual number of excess deaths among Blacks. A more recent national tragedy is the terrorist attacks of September 11, 2001. The scope and significance of these events cannot be calculated only in terms of casualties. Nonetheless, they provide a dramatic, contemporary, though imperfect benchmark. The total loss of life for the September 11 attacks is estimated at 2,819 deaths. Thus, the elevated death rates for African Americans can be viewed as a major national tragedy that begs for a comprehensive national response to prevent the loss of so many American lives each year. However, effective intervention is contingent on identifying and addressing the fundamental causes of these disparities.

**TABLE 1: Number of Combat Deaths in America's Major Wars**

| *War* | *Deaths* |
|---|---|
| Revolutionary War | 4,435 |
| War of 1812 | 2,260 |
| Mexican War | 1,733 |
| Civil War | 184,594 |
| Spanish-American War | 385 |
| World War I | 53,513 |
| World War II | 292,131 |
| Korean War | 33,651 |
| Vietnam War | 47,369 |
| Gulf War | 148 |
| Excess deaths for Blacks (annually) | 65,960 |

SOURCE: United States Civil War Center (2002).

## CENTRALITY OF SES

Existing racial categories do not capture biological distinctiveness, and genetic differences at best make a small contribution to racial disparities in health (Goodman, 2000). For example, sickle cell disease accounts for three tenths of 1% of the Black-White differences in mortality (Cooper, 1984). Research has identified socioeconomic status as one of the strongest determinants of variations in health in general (Link & Phelan, 1995; Williams & Collins, 1995) and the major contributor to racial differences in health, in particular (Williams, 1997). SES accounts for much of the racial differences in health, and it is frequently found that SES differences within each racial group are substantially larger than overall racial ones (Williams, 1999).

The key role that SES plays in racial differences in health can be illustrated with self-rated health—a global indicator of health status that is a valid and reliable indicator of overall health status (Idler & Benyamini, 1997). In 1995, national data revealed that 15.4% of African Americans reported to be in fair or poor health compared to 8.7% of Whites (NCHS, 1998). Table 2 presents national data on self-assessed health. Two points are noteworthy. First, for both men and women and Blacks and Whites, income is a strong predictor of variation in health. Poor individuals (below the federal poverty level) have rates of ill health that are 4 to 7 times greater than their high-income peers (household income greater than $50,000). Instructively, the differences by income within each racial group are larger than the overall racial difference. Second, at every level of income, Blacks report poorer health status than Whites, suggesting that although much of the racial difference in health is accounted for by income, race has an effect on health that is independent of its association with SES. A similar pattern exists for other health outcomes, such as coronary heart disease mortality and life expectancy (NCHS, 1998).

**TABLE 2: Percentage of Men and Women Reporting Fair or Poor Health by Race and Income, 1995**

| | *Men* | | *Women* | |
|---|---|---|---|---|
| *Household Income* | *White* | *Black* | *White* | *Black* |
| Poor | 30.5 | 37.4 | 30.2 | 38.2 |
| Near poor | 21.3 | 22.6 | 17.9 | 26.1 |
| Middle income | 9.3 | 13.1 | 9.2 | 14.6 |
| High income | 4.2 | 5.0 | 5.8 | 9.2 |

SOURCE: National Center for Health Statistics (2000).
NOTE: Poor = below federal poverty level; near poor = less than twice the poverty level; middle income = more than twice the poverty level but less than $50,000; high income = $50,000 or more.

The residual effect of race after SES is controlled could reflect the nonequivalence of SES indicators across race, the long-term consequences of exposure to adversity in childhood, and the effect of other aspects of racism (Williams & Collins, 1995). Two studies have reported that experiences of discrimination make an incremental contribution to explaining racial differences in self-rated health after SES is accounted for (Ren, Amick, & Williams, 1999; Williams, Yu, Jackson, & Anderson, 1997). Other aspects of racism may also contribute to these disparities. A recent Institute of Medicine report documented that African Americans and other minorities receive less intensive and poorer medical care than Whites in virtually every area of medicine (Smedley, Stith, & Nelson, 2003). The report concluded that discrimination based on health care providers' negative stereotypes of Blacks is a likely contributor to these disparities.

In the United States, large and persistent Black-White differences in health co-occur with large and persistent Black-White differences in SES. There has been little change in the economic gap between Blacks and Whites in the last quarter of the 20th century (*Economic Report of the President*, 1998). For example, in 1978, Black households had earned 59 cents for every dollar earned by Whites and had a poverty rate that was 3.5 times higher and an unemployment rate that was 1.9 times higher. In 1996, compared to Whites, African Americans had a poverty rate that was 2.5 times higher, an unemployment rate that was twice as high, and median household earnings that were still 59 cents for every dollar earned by Whites.

Analysis of economic and health data during the past 50 years reveals that the narrowing and widening of the Black-White gap in economic status has been associated with a parallel narrowing or widening of the Black-White gap in health (Williams, 2001). The expansion of the Black middle class and the narrowing of the Black-White gap in income were greatest in the 1960s, and the economic progress of Blacks relative to Whites halted in the mid 1970s (*Economic Report of the President*, 1998). Between 1968 and 1978, the period of

narrowing racial economic inequality, Black men and women experienced a larger decline for multiple causes of death both on a percentage and an absolute basis than their White counterparts (Cooper, Steinhauer, Schatzkin, & Miller, 1981). Life expectancy data during this period showed larger gains for Blacks than Whites on both a relative and an absolute basis.

In contrast, during the 1980s, in the wake of substantial changes in national social and economic policies, the median income of Black households relative to White households fell from the levels of the late 1970s (*Economic Report of the President*, 1998). Throughout the 1980s, Blacks' median household income remained below the 59 cents level (for every dollar earned by Whites) that it was in 1978. It fell as low as 55 cents in 1982 and did not return to at least 59 cents until the early 1990s. During the early 1980s, the health status of economically vulnerable populations worsened in several states (Lurie, Ward, Shapiro, & Brook, 1984; Mandinger, 1985). Similarly, the Black-White gap in health status widened between 1980 and 1991 for multiple health outcomes, including life expectancy, excess deaths, and infant mortality (NCHS, 1994; Williams & Collins, 1995). These patterns reflected not only the relative but also the absolute deterioration in the health status of the Black population. For 5 consecutive years after 1984, there was a progressive decline in the life expectancy at birth for Blacks from the 1984 level. Life expectancy for African Americans began to increase in 1990 and by 1992 was slightly higher than in 1984 (NCHS, 1995). In contrast, the life expectancy of Whites progressively increased during this period so that the Black-White gap in 1992 was wider than in 1984. Thus, effective efforts to reduce racial disparities in health status should seriously grapple with reducing racial disparities in socioeconomic circumstances.

## SEGREGATION: KEY DETERMINANT OF RACIAL DIFFERENCES IN SES

Racial residential segregation is the foundation on which Black-White disparities in SES have been built in the United States. Segregation is a fundamental cause of differences in health status between African Americans and Whites because it shapes socioeconomic conditions for Blacks at the level of the individual, household, and community. The available evidence suggests that segregation is a key determinant of racial differences in socioeconomic mobility and also creates poor health-damaging conditions in the social and physical environment.

There has been a long history of interest in the central role that segregation has played in truncating socioeconomic opportunities for African Americans. In the early 1940s, Myrdal (1944) indicated that although its influence was indirect and impersonal, housing segregation was "basic" to understanding racial inequality in America. Two decades later, sociologist Kenneth Clark (1965) indicated that the "invisible walls" and distinctive "economic colonies" created

by residential segregation was a key to understanding racial inequality. Similarly, after the urban riots of the 1960s, the Kerner Commission identified residential segregation as the "linchpin" of American race relations and the source of the large and growing racial inequality in SES (U.S. National Advisory Commission on Civil Disorders, 1988). Historian John Cell (1982) indicated that residential segregation was "one of the most successful political ideologies" of the last century and is "the dominant system of racial regulation and control" in the United States. In the most comprehensive recent treatise on segregation, Massey and Denton (1993) showed that segregation is "the key structural factor for the perpetuation of Black poverty in the U.S." (p. 9) and the "missing link" in efforts to understand urban poverty.

## HISTORICAL BACKGROUND

*Segregation* refers to the physical separation of the races by enforced residence in restricted areas. Cell (1982) showed that the ideology of segregation was developed and advocated by White moderates more than 100 years ago as a very conscious and deliberate strategy to combat some of the perceived populist and democratizing tendencies of urbanization and industrialization. It was imposed by legislation, supported by major economic institutions, enshrined in the housing policies of the federal government, enforced by the judicial system, and legitimized by the ideology of White supremacy that was advocated by the church and other cultural institutions (Cell, 1982; Jaynes & Williams, 1989). These institutional policies combined with the efforts of vigilant neighborhood organizations, discrimination on the part of real estate agents and home sellers, and restrictive covenants to limit the housing options of Blacks to the least desirable residential areas. Segregation was designed to be a "complex, interlocking system of control that regulated the lives" of Blacks (Cell, 1982). Prior to the Civil War, segregation was not a feature of life in the South (Cell, 1982; Lieberson, 1980; Massey & Denton, 1993). In the late 19th and early 20th century, segregation emerged most aggressively in the developing industrial urban centers of the South, and as Blacks migrated to the North, segregation ensured that Whites were protected from residential proximity to Blacks. Accordingly, in both Northern and Southern cities, levels of Black-White segregation increased dramatically between 1860 and 1940 and have remained strikingly stable since then (Massey & Denton, 1993).

The segregation of African Americans in the United States is distinctive. First, although most immigrant groups have experienced some residential segregation in the United States, no immigrant group has ever lived under the high levels of segregation that currently characterize the African American population (Massey & Denton, 1993). Second, early in the 20th century, segregation increased for Blacks at the same time that it was declining for immigrants. For example, in the late 19th century and up through 1910, Blacks were less segregated than several European immigrant groups (Lieberson, 1980). However, in

the post-1910 period, segregation for these European groups and Blacks moved in opposite directions, with average segregation declining for European immigrants such that the second generation was less segregated than the first. At the same time, the segregation of Blacks became more pronounced. Third, the nature of segregation in immigrant enclaves did not compare to the very high levels of segregation for the Black population. Immigrant enclaves were never homogeneous to one immigrant group and always contained persons from multiple nationalities. In most immigrant ghettos, the ethnic immigrant group after which the enclave was named typically did not even constitute a majority of the population of that area. In addition, unlike the pattern for Blacks, most members of European ethnic groups did not live in an immigrant enclave (Lieberson, 1980; Massey & Denton, 1993). Thus, ethnic enclaves were temporary in the process of assimilation in contrast to the permanence of hypersegregation for Blacks.

## PERSISTENCE OF SEGREGATION IN THE UNITED STATES

The Civil Rights Act of 1968 made discrimination in the sale or rental of housing units illegal in the United States, but studies reveal that explicit discrimination in housing persists (W. A. V. Clark, 1992; Fix & Struyk, 1993). Moreover, in more subtle ways, Blacks are still discouraged from residing in White residential areas, and Whites continue to move out of communities when the Black population increases (Shihadeh & Flynn, 1996; Turner, 1993). Thus, although African Americans express the highest support for residence in integrated neighborhoods (Bobo & Zubrinsky, 1996), their residential exclusion remains high and distinctive.

A recent analysis of the 2000 census data documented that levels of segregation remain very high in the United States (Glaeser & Vigdor, 2001). Although this report claims that the level of segregation has "declined dramatically" between 1990 and 2000 and is now at its lowest point since about 1920, closer inspection of the data indicates the persistence of extremely high levels of segregation in the United States. On the one hand, the report indicated that segregation declined in 272 of the 317 Metropolitan Statistical Areas (MSAs) between 1990 and 2000 while it increased in 19 MSAs. On the other hand, the magnitude of this decline was small, with the average decline being 5.5 percentage points. Nationally, the index of dissimilarity for the United States declined from .70 in 1990 to .66 in 2000. An index of .66 means that 66% of Black U.S. residents would have to move to achieve a perfect representation of their group. Generally, a dissimilarity index value above .60 is thought to represent extremely high segregation (Massey & Denton, 1989). In the 2000 census, there were more than 74 MSAs with dissimilarity scores greater than .60. Instructively, these metropolitan areas contain the majority of the Black population.

The report revealed that the decline in segregation was due to the movement of Blacks into formerly all-White census tracts rather than the integration of overwhelmingly Black (80% or more) census tracts. In fact, between 1990 and 2000, the number of census tracts where more than 80% of the population was African American remained constant (Glaeser & Vigdor, 2001). Accordingly, the decline in segregation is due to the reduction of all-White census tracts and has had no impact on very high percentage African American census tracts, the residential isolation of most African Americans, or the concentration of urban poverty (Glaeser & Vigdor, 2001). The report also indicated that segregation had declined the most in small growing cities, especially those of the Southwest and West, and had remained relatively stable in the large metropolitan areas of the Northeast and Midwest. Moreover, there was an inverse relationship between the Black percentage of the population in an entire MSA and the decline in segregation. Segregation declined 2.8% in MSAs that were more than 25% Black in 1990. Thus, most of the reduction in segregation has come from the MSAs where the percentage of Blacks in the population is very small.

## SEGREGATION AND SES

By determining access to education and employment opportunities for African Americans, residential segregation has truncated socioeconomic mobility for Blacks and been a central mechanism by which racial inequality has been created and reinforced in the United States (Jaynes & Williams, 1989; Massey & Denton, 1993). First, residential segregation has led to highly segregated elementary and high schools and is a fundamental cause of racial differences in the quality of education. Because of residential segregation, despite an almost 50-year-old unanimous Supreme Court decision in *Brown v. Board of Education* that intentional segregation in schools was inherently unequal and unconstitutional, elementary and high school education in the United States remains highly segregated and decidedly unequal (Orfield & Eaton, 1996). Residence determines which public school students can attend, and the funding of public education is under the control of local government. Thus, community resources importantly determine the quality of the neighborhood school.

There is a very strong relationship between residential segregation and the concentration of poverty. Nationally, the correlation between minority (Black and Hispanic) percentage and poverty is 0.66; in metropolitan Chicago, the correlation is 0.90 for elementary schools (Orfield, 1996). Although there are millions of poor Whites in the United States, poor White families tend to be dispersed throughout the community, with many residing in desirable residential areas (Wilson, 1987). Accordingly, in 96% of predominantly White schools, the majority of students come from middle-class backgrounds (Orfield, 1996). In contrast, public schools with a high proportion of Blacks and Hispanics are dominated by poor children.

The concentration of poverty and not racial composition per se is the basic cause of the problems that plague segregated schools. The catalogue of challenges include lower test scores, fewer students in advanced placement courses, more limited curricula, less qualified teachers, little serious academic counseling, fewer connections with colleges and employers, more deteriorated buildings, higher levels of teen pregnancy, and higher dropout rates (Orfield & Eaton, 1996). These conditions often give rise to peer pressure against academic achievement and in support of crime and substance use. Moreover, levels of segregation for Black and Latino students are on the increase (Orfield, 1996). The end result is that these minority students are concentrated in urban schools that have different and inferior courses and lower levels of achievement than the schools attended by White students in adjacent suburban school districts (Orfield & Eaton, 1996). One recent study found that as a growing number of minority families moved to the suburbs between 1987 and 1995, the presence of residential segregation there has led to increased levels of segregation in suburban schools (Reardon & Yun, 2001). Even in integrated schools, Black students are disproportionately allocated or tracked into low-ability and non-college-preparatory classes that are characterized by a less demanding curriculum and lower teacher expectations (Jaynes & Williams, 1989). Thus, the high school dropout and graduation rates, the competencies and knowledge of a high school graduate, and the probability of enrollment in college varies by race.

Research also reveals that segregation is a critical determinant of employment opportunities and thus income levels for African Americans. Audit studies (in which trained Black and White job applicants with identical qualifications apply for employment) have found that discrimination occurred that favored White over Black applicants in one in every five audits (Fix & Struyk, 1993). Such data highlight the role of employment discrimination at the individual level in adversely affecting employment opportunities for Blacks. Equally important, institutional discrimination, based on residential segregation, severely restricts access to jobs for Blacks. In the past several decades there has been a mass movement of low-skilled, high-pay jobs from many of the urban areas where Blacks are concentrated to the suburbs (Kassarda, 1989; Wilson, 1987, 1996). This has created a spatial mismatch in which African Americans reside in areas different from those that have access to high-paying entry-level jobs. It has also led to a skills mismatch in which the available jobs in the urban areas where African Americans live require a level of skill and training that many do not have. Some corporations explicitly use the racial composition of areas in their decision-making process regarding the placement of new plants and the relocation of existing ones (Cole & Deskins, 1988). Negative racial stereotypes of African Americans and the areas where they are concentrated play an important role in these decisions (Kirschenman & Neckerman, 1991; Neckerman & Kirschenman, 1991). Thus, during routine "nonracial" restructuring, relocation, and downsizing, employment facilities are systematically moved to suburban and rural areas where the proportion of Blacks in the labor

force is low. A *Wall Street Journal* analysis of more than 35,000 U.S. companies found that Blacks were the only racial group that experienced a net job loss during the economic downturn of 1990-1991 (Sharpe, 1993). African Americans had a net job loss of 59,000 jobs, whereas there was a net gain of 71,100 for Whites, 55,100 for Asians, and 60,000 for Latinos.

Residential segregation also affects employment opportunities by isolating Blacks in segregated communities from both role models of stable employment and social networks that could provide leads about potential jobs (Wilson, 1987). The social isolation created by these structural conditions in segregated residential environments can then induce cultural responses that weaken the commitment to norms and values that may be critical for economic mobility. For example, long-term exposure to conditions of concentrated poverty can undermine a strong work ethic, devalue academic success, and remove the social stigma of imprisonment and educational and economic failure (Shihadeh & Flynn, 1996).

## THE CONSEQUENCES OF SEGREGATION: RACIAL DIFFERENCES IN SES

By determining access to educational and employment opportunity, segregation has been a central force in producing large racial differences in SES. An empirical analysis of the effects of segregation on young African Americans making the transition from school to work documented that getting rid of residential segregation would lead to the elimination of Black-White differences in earnings, high school graduation rates, and idleness and would reduce racial differences in single motherhood by two thirds (Cutler, Glaeser, & Vigdor, 1997).

Table 3 presents selected socioeconomic characteristics for Blacks and Whites in the United States. It shows that the median family income for White households in 1996 ($38,787) was almost 1.7 times higher than that of African Americans ($23,482). Compared to Whites, Blacks are 3 times more likely to be poor. If we combine persons in poverty with persons who are near poor (incomes above poverty but less than twice the poverty level), then one quarter of White households but more than half of African American households are in this economically vulnerable category. Rates of poverty are especially high among children. In 1996, 40% of Black children younger than the age of 18, compared to 11% of their White peers, were growing up poor. Moreover, almost one third of White children and more than two thirds of Black ones were either poor or near poor. The average level of education was relatively high in the United States in 1996, but racial differences in educational attainment were also evident. Among persons aged 25 to 64, 9 out of 10 Whites and 8 out of 10 African Americans had a high school diploma or more. Whites are also twice as likely as Blacks to have graduated from college (29% vs. 15%).

The unemployment rate for Blacks is more than twice that of Whites. Racial differences in educational attainment account for part of this disparity. However,

**TABLE 3: Selected Socioeconomic Indicators for Blacks and Whites in the United States, 1996[a]**

| *Indicator* | *White* | *Black* |
|---|---|---|
| Income | | |
| Median income | $38,787 | $23,482 |
| Poverty | | |
| Percentage poor | 8.6 | 28.4 |
| Percentage poor and near poor | 25.6 | 55.1 |
| Percentage children younger than 18 poor | 11.1 | 39.9 |
| Percentage children younger than 18 poor and near poor | 30.8 | 68.0 |
| Educational attainment, age 25 to 64 | | |
| Percentage high school graduate or higher | 90.5 | 79.8 |
| Percentage college graduate or higher | 28.8 | 14.8 |
| Unemployment[b] | | |
| Percentage unemployed | 4.7 | 10.5 |
| High school graduate | 4.6 | 10.8 |
| College graduate | 2.1 | 3.3 |
| Current occupation, age 25 to 64 | | |
| Percentage white collar, males | 52.6 | 33.5 |
| Percentage blue collar/service, males | 44.1 | 64.5 |
| Percentage white collar, females | 77.6 | 59.3 |
| Percentage blue collar/service, females | 21.3 | 40.5 |
| Individual income by education, age 18 and older[b] | | |
| Median income, high school graduate, male | $28,591 | $22,267 |
| Median income, college graduate, male | $48,014 | $35,558 |
| Median income, high school graduate, female | $16,270 | $15,379 |
| Median income, college graduate, female | $28,667 | $29,311 |
| Household income by education, age 25 and older | | |
| Median income, high school graduate, male | $41,200 | $36,020 |
| Median income, college graduate, male | $67,952 | $54,500 |
| Median income, high school graduate, female | $37,000 | $23,556 |
| Median income, college graduate, female | $64,007 | $47,100 |
| Wealth (data for 1995)[c] | | |
| Median net worth | $49,030 | $7,073 |
| Lowest income quartile | $ 9,720 | $1,500 |
| Highest income quartile | $123,781 | $40,866 |

a. National Center for Health Statistics (1998).
b. Bureau of the Census (1998).
c. Davern and Fisher (2001).

large racial differences in unemployment persist even at equivalent levels of education (Council of Economic Advisors, 1998). There is also an overrepresentation of African American workers in the lowest paying sectors of the economy, which accounts in part for the racial differences in income. White-collar occupations (executive, professional, managerial, administrative, technical, clerical, and sales) have higher average compensation than blue-collar and service jobs. Among male civilian workers in the United States, Whites are 1.6

times more likely than African Americans to be employed in white-collar positions. Blacks are also one and a half times more likely to hold blue-collar and service jobs. Similarly, compared to White women, African American women are 1.3 times less likely to be white-collar workers but about twice as likely to be employed in service and blue-collar occupations.

However, many socioeconomic indicators are not equivalent across race (Kaufman, Cooper, & McGee, 1997; Williams & Collins, 1995). As noted earlier, a given level of education may not reflect the same degree of educational preparation and skills across race. There are also racial differences in the income returns for a given level of education, with Blacks earning less income than Whites at comparable levels of education. These racial differences are more marked for men than for women. In addition, American women of all racial groups earn less than their similarly educated male counterparts. This gender difference in earnings combined with racial differences in household structure (Black households are more likely than White ones to be headed by a female) means that racial differences in individual earnings at equivalent levels of education understate racial differences in household income. Table 3 shows that in 1996, Black households with a college-educated male earned 80 cents ($54,500) for every dollar ($67,952) earned by a comparable White household. Such racial differences in the returns to education are evident at all levels of educational preparation but are more marked for women than for men. For every dollar earned by a household with a similarly educated White woman, households with Black women who completed high school earned 64 cents and those with a college degree earned 74 cents.

The largest racial difference evident in Table 3 is for wealth. The median net worth of Whites is almost 7 times that of Blacks. This underscores the extent to which racial differences in income understate racial differences in economic status and resources. At every level of income, Blacks have considerably less wealth than Whites (Davern & Fisher, 2001). For example, the net worth at the lowest quintile of income is $9,720 for White households compared to $1,500 for African American households. At the highest quintile of income, White households have a net worth of $123,781 compared to $40,866 for Black households. Racial differences in wealth also link the current situation of Blacks to historic discrimination. For most American families, housing equity is a major source of wealth. Thus, today's Black-White differences in wealth are to a considerable degree a direct result of the institutional discrimination in housing practiced in the past (Oliver & Shapiro, 1997).

## SEGREGATION AND THE EFFECTS OF PLACE

Table 4 presents sociodemographic data for the seven cities ranked highest on segregation (dissimilarity index) in the 2000 census and seven of the lowest ranked cities. These data illustrate that a high level of residential segregation and a high percentage of the population being Black do not necessarily co-occur.

Chicago ranked highest on segregation but was only 37% Black. Several points are noteworthy about the two groups of cities. In both high and low segregation cities, Whites have higher levels of educational attainment than Blacks. With one exception, Newark, the education levels of Blacks tend to exceed that of Whites. Unemployment and poverty rates for both racial groups tend to be higher in high versus low segregation cities. In general, White households also have a higher median income in all cities, with Whites earning more than twice the income of Blacks in some cities. Home equity is a major source of wealth for most Americans, and the median value of owner-occupied houses are higher for Whites than for Blacks, with the greatest gap observed in highly segregated cities. In our nation's capital for example Black homeowners owned houses with a median value of $125,000, whereas White homeowners' median home value was $380,000. Most important, for multiple SES indicators (education, income, and home value), the Black-White gap is markedly smaller in low segregation cities compared to those high on segregation. The poorer profile on some SES indicators for Whites in highly segregated cities raises the question of whether this reflects an adverse effect of some of the structural characteristics of highly segregated cities or a selection effect in which more vulnerable Whites (in terms of SES, age, and health) opted not to migrate out of highly segregated cities.

Racial residential segregation has also led to unequal access for most Blacks to a broad range of services provided by municipal authorities. Compared to more affluent areas, political leaders have been more likely to cut spending and services in poor neighborhoods in general and African American neighborhoods in particular (Shihadeh & Flynn, 1996; Wallace, 1990, 1991). Because poor and minority persons are less active politically, elected officials are less likely to encounter vigorous opposition when services are reduced in these areas. This disinvestment of economic resources in these neighborhoods has led to a decline in the quality of life in those communities (Alba & Logan, 1993). The selective out-migration of many Whites and some middle-class Blacks from cities to the suburbs has also reduced the urban tax base and the ability of some cities to provide a broad range of supportive social services to economically deprived residential areas. Segregation also leads to racial differences in the purchasing power of income. Many commercial enterprises withdraw from segregated urban areas. There are often fewer services in highly segregated Black areas, and the available ones tend to be poorer in quality but higher in price. On average, Blacks pay higher costs than Whites for housing, food, groceries, insurance, and other services (Williams & Collins, 1995). Research also indicates that residential segregation leads to smaller returns on the investment in real estate for African Americans compared to Whites. That is, the growth in housing equity over time, a major source of wealth for most American families, is smaller for Blacks in highly segregated areas than for comparable homes in other areas (Oliver & Shapiro, 1997). All of the aforementioned factors combine to reduce the neighborhood and housing quality of highly segregated residential areas.

**TABLE 4: Demographic Profile of Seven Cities With High Scores on the Dissimilarity Index (D) and Seven Low Segregation Cities, 2000**

| *City* | *D* | *Population Size (000)* | *Black (%)* | *Black High School Graduate + (%)* | *White High School Graduate + (%)* | *Black Jobless Rate (%)* | *White Jobless Rate (%)* | *Black Poverty Rate (%)* | *White Poverty Rate (%)* | *Black Median Household Income (000)* | *White Median Household Income (000)* | *Black Median Home Value (000)* | *White Median Home Value (000)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High segregation | | | | | | | | | | | | | |
| Chicago | 88 | 2,896 | 36.8 | 70.7 | 85.2 | 18 | 5 | 29 | 8 | 29 | 49 | 92 | 165 |
| Atlanta | 86 | 416 | 61.4 | 66.8 | 94.2 | 17 | 10 | 33 | 8 | 23 | 62 | 78 | 324 |
| New York | 85 | 8,008 | 26.6 | 70.4 | 84.7 | 14 | 5 | 26 | 12 | 31 | 51 | 178 | 240 |
| Ft. Lauderdale | 85 | 152 | 28.9 | 50.3 | 90.5 | 12 | 4 | 35 | 9 | 23 | 45 | 77 | 194 |
| Washington, DC | 84 | 572 | 60.0 | 70.4 | 97.5 | 15 | 7 | 25 | 8 | 30 | 67 | 125 | 380 |
| Newark | 82 | 274 | 53.5 | 65.1 | 51.1 | 19 | 10 | 32 | 16 | 25 | 34 | 111 | 140 |
| Philadelphia | 82 | 1,518 | 43.2 | 68.4 | 77.1 | 15 | 7 | 29 | 13 | 26 | 37 | 45 | 73 |
| Low segregation | | | | | | | | | | | | | |
| Moreno Valley, CA | 32 | 142 | 19.9 | 85.0 | 87.2 | 11 | 7 | 20 | 8 | 42 | 55 | 127 | 124 |
| Clarksville, TN | 40 | 103 | 23.2 | 82.4 | 86.4 | 10 | 6 | 19 | 7 | 31 | 40 | 80 | 86 |
| Aurora, CO | 42 | 276 | 13.4 | 87.5 | 92.8 | 7 | 3 | 13 | 5 | 39 | 51 | 148 | 145 |
| Garland, TX | 43 | 216 | 11.9 | 84.5 | 89.4 | 7 | 3 | 13 | 4 | 41 | 55 | 87 | 89 |
| Lansing, MI | 46 | 119 | 21.9 | 80.7 | 85.7 | 12 | 4 | 27 | 12 | 30 | 36 | 78 | 73 |
| Virginia Beach, VA | 48 | 425 | 19.0 | 85.9 | 92.1 | 8 | 3 | 12 | 5 | 39 | 51 | 98 | 130 |
| Las Vegas, NV | 48 | 478 | 10.4 | 76.1 | 87.6 | 14 | 5 | 24 | 7 | 30 | 49 | 122 | 143 |

SOURCE: Bureau of the Census (2000), Logan (2002).

Some evidence suggests that it is difficult even for middle-class Blacks to escape some of the negative neighborhood conditions associated with segregation. There is increasing segregation in some suburban areas (Reardon & Yun, 2001), and middle-class Blacks are less able than their White counterparts to translate their higher economic status into desirable residential conditions. Research reveals that middle-class suburban African Americans reside in neighborhoods that are less segregated than those of poor central-city Blacks (Alba, Logan, & Stults, 2000). However, compared to White counterparts, middle-class Blacks live in poorer quality neighborhoods with White neighbors who are less affluent than they are. A recent analysis of 1990 census data revealed that suburban residence does not buy better housing conditions for Blacks (Harris, 1999). The suburban locations where African Americans reside tend to be equivalent or inferior to those of central cities. One recent national study found that whereas residence in the suburbs was associated with lower mortality rates for Whites, it predicted markedly elevated mortality rates for Blacks, especially for Black men (House et al., 2000).

High levels of segregation create distinctive ecological environments on multiple dimensions for African Americans. Sampson and Wilson (1995) reported that in the 171 largest cities in the United States, there was not even one where Whites lived in comparable ecological conditions to Blacks in terms of poverty rates or rates of single-parent households. These researchers came to the striking conclusion that "the worst urban context in which Whites reside is considerably better than the average context of Black communities" (Sampson & Wilson, 1995, p. 41). This highlights the almost insurmountable challenge of introducing statistical controls for an area effect in Black-White contrasts.

## DIRECT EFFECTS OF SEGREGATION ON HEALTH

Research reveals that residential segregation is related to elevated risk of adult and infant mortality and tuberculosis (Williams & Collins, 2001). There are multiple mechanisms by which the concentrated poverty created by segregation could adversely affect health (Schulz, Williams, Israel, & Lempert, 2002; Williams & Collins, 2001). First, the conditions created by poverty and segregation make it more difficult for residents of those areas to practice desirable health behaviors. The higher cost and poorer quality of grocery items in economically disadvantaged neighborhoods can lead to poorer nutrition. Both the tobacco and alcohol industries heavily bombard poor minority communities with advertising for their products. The lack of recreation facilities and concerns about personal safety can also discourage leisure-time physical exercise.

Second, access to high-quality medical care is often a challenge in many segregated neighborhoods. Health care facilities are more likely to close in poor and minority communities than in other areas (Whiteis, 1992), and pharmacies in

minority neighborhoods may be less likely to be adequately stocked with medication (Morrison, Wallenstein, Natale, Senzel, & Huang, 2000). Third, given the strong association between SES and the distribution of stress, the concentration of poverty leads to exposure to higher levels of economic hardship as well as other types of chronic and acute stress at the individual, household, and neighborhood levels. For example, African Americans are much more likely than Whites to be victims of all types of crime (Council of Economic Advisors, 1998). The weakened community and neighborhood infrastructure in segregated areas can also adversely affect interpersonal relationships and trust among neighbors (Schulz et al., 2002). These resources can potentially reduce at least some of the negative effects of stress on health. Fourth, poor, segregated communities are often victims of institutional neglect and disinvestment. The resulting decline in the urban infrastructure and physical environment results in disproportionate exposure to environmental toxins and poor-quality housing (Bullard, 1994).

Black-White differences in mortality are largest for homicide. Research reveals that residential segregation is at the core of a complex set of mechanisms driving this disparity (Sampson, 1987). The poor educational and employment opportunities in segregated communities results in a small pool of employable or stably employed males. High rates of male unemployment and underemployment in turn generate the high rates of out-of-wedlock births, female-headed households, the "feminization of poverty," and the extreme concentration of poverty in many Black communities (Testa, Astone, Krogh, & Neckerman, 1993; Wilson & Neckerman, 1986). For both Blacks and Whites, male employment and earnings are positively related to entry into marriage, and economic instability is positively related to marital dissolution (Bishop, 1980; Mare & Winship, 1991; Wilson, 1987). In turn, single-parent households lead to lower levels of social control and guardianship. Sampson (1987) found a strong association between family structure and violent crime that was similar for both Blacks and Whites. Thus, the high rates of violent crime and homicide for African Americans are determined by their greater exposure to poverty and lack of jobs created by segregation and to the resultant family structures and processes that are induced by these economic conditions.

## REPARATIONS AND THE REDUCTION OF BLACK-WHITE INEQUALITIES IN HEALTH

The evidence reviewed documents the persistence of racial inequalities in health. Although more than half of the African American and White public are unaware of the existence of these disparities in health (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000), the U.S. government has recently made a commitment to eliminating them. On February 21, 1996, President Clinton devoted his Saturday morning radio address to the nation to the problem of

racial differences in health. He declared that "racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now." In response, Healthy People 2010, a major planning initiative of the federal government, made the elimination of racial disparities in health in six target areas by the year 2010 a national priority for the Department of Health and Human Services. This initiative has focused on community-based demonstration projects addressing prevention and treatment, educational outreach, and increased research and training.

The success of Healthy People 2010 and related current and future efforts to eliminate racial disparities in health is contingent on identifying and effectively addressing the fundamental causes of these disparities. Efforts to eliminate racial disparities in health that focus only on intermediate causal factors such as increased access to health care, enhanced levels of health information, and behavior change are unlikely to improve the health of the Black population and eliminate racial disparities in health (Link & Phelan, 1995; Smedley & Syme, 2000; Williams, 1997). Comprehensive efforts that address the underlying social conditions that give rise to health problems are needed.

This article has considered the central role of residential segregation and other aspects of racism in shaping the social and economic circumstances and thus the health of the African American population. Racial disparities in health illustrate how the long arm of America's racial past continues to affect the constitutionally guaranteed pursuit of life, liberty, and happiness by the historically disadvantaged. Black-White disparities in health indicate that the achievement of racial parity in SES and health requires more than merely the reduction of negative racial attitudes and values in the United States. What is also needed is a systematic dismantling of racist structures such as residential segregation.

The persistence of high levels of residential segregation for most African Americans also reflects the failure of prior policies to reduce racial economic inequality in the United States. As noted, there has been no narrowing of racial gap in economic status in the past 25 years (*Economic Report of the President*, 1998). Other evidence suggests that the increasing racial and ethnic diversity of the U.S. population is unlikely to reduce the entrenched patterns of segregation for African Americans. Data from Los Angeles indicate that Hispanics were as hostile as Whites to having Blacks as neighbors and Asians were more hostile than Whites (Bobo & Zubrinsky, 1996).

There is nothing inherently negative about living in close proximity to persons of one's own race. Rather, the problems attendant to segregation are linked to the concentration of poverty and the absence of an infrastructure that promotes social and economic opportunity (Massey & Denton, 1993; Sampson & Wilson, 1995; Wilson, 1996). Thus, the elimination of the negative SES and health effects of segregation will require a major infusion of economic capital to rebuild the physical and economic infrastructure of disadvantaged Black communities. Monetary reparations are a viable approach to accomplish this (Oliver & Shapiro, 1997).

Opponents of reparations argue that reparations are unnecessary for multiple reasons (Kaminer, 2000; McWhorter, 2001; Reed, 2000; Zinsmeister, 2001). These include the fact that America has already paid its debt to African Americans because (a) there was a large loss of life during the Civil War, (b) the U.S. government has already invested trillions of dollars to improve the social circumstances of Blacks (through various welfare programs), and (c) affirmative action and other opportunities have brought economic success to many Blacks in recent decades. Moreover, it is argued that there are too many logistical difficulties attendant to making financial payments to the descendants of slaves. Compelling responses have been made to these objections (Allen, 1998; Cha-Jua, 2001; Robinson, 2000). The payment of reparations is based on established legal principles, and there are precedents both in the United States and internationally (Allen, 1998). Moreover, given that the injuries caused by legal segregation persist and there has been systematic decapitalization of African American areas, reparations provides one strategy to infuse capital and create economic opportunities in Black areas. Targeting reparations to "investment in education and training, housing, health and business development" (America, 1999) avoids most of the feared logistical difficulties in identifying specific descendants of slaves for monetary payments.

Neglected in this debate is the potential for reparations to address the nationally recognized problem of racial disparities in health. This article emphasizes that the concentration of poverty and the social and physical deterioration of segregated neighborhoods are the result of the successful implementation of public policies, including those of the federal government (Massey & Denton, 1993; Massey & Kanaiaupuni, 1993; Wallace & Wallace, 1997). Reparations can trigger a new set of countervailing processes to effectively negate the forces that maintain racial inequality. It should also be noted that it is in the interest of the entire society to reduce the racial gap in SES and health. The forces that affect the health of the African American population are the same factors on a less intensive scale that determine the health of the rest of the population (Cooper et al., 1981). Moreover, health problems that are initially confined to segregated areas often spread to more affluent areas (Wallace & Wallace, 1997). Thus, investments to improve the social conditions of African Americans can have long-term positive consequences for non-Blacks as well.

## CONCLUSION

A large gap in health exists between Blacks and Whites, and it is inextricably linked to the history of race and racism in the United States. Racial differences in SES and health are the predictable results of the successful implementation of residential segregation, a policy that was deliberately set up to create separate and unequal living conditions for Blacks. It and other aspects of racism remain central determinants of racial differences in health. Thus, the legacy of slavery

and legal discrimination still matters for African Americans in the 21st century. According to government estimates, conditions linked to race were responsible for the premature deaths of more than 1 million African Americans in the past two decades. Reparations can break the cycle of racial economic inequality for the health of the African American population. A Marshall Plan type of economic investment funded by a reparations initiative or some similar mechanism is indispensable for any effective effort that would markedly improve the economic well-being and the health of the African American population.

## REFERENCES

Alba, R. D., & Logan, J. R. (1993). Minority proximity to Whites in suburbs: An individual-level analysis of segregation. *American Journal of Sociology*, *98*, 1388-1427.

Alba, R. D., Logan, J. R., & Stults, B. J. (2000). How segregated are middle-class African Americans? *Social Problems*, *47*, 543-558.

Allen, R. L. (1998). Past due: The African American quest for reparations. *The Black Scholar*, *28*(2), 2-17.

America, R. F. (1999). Reparations and public policy. *Review of Black Political Economy*, *26*(3), 77-83.

Anderson, R. N., & DeTurk, P. B. (2002). *United States life tables, 1999* (National Vital Statistics Reports, Vol. 50, No. 6). Hyattsville, MD: National Center for Health Statistics.

Bishop, J. H. (1980). Jobs, cash transfers, and marital instability. A review of the evidence. *Journal of Human Resources*, *15*, 301-334.

Bobo, L., & Zubrinsky, C. L. (1996). Attitudes on residential integration: Perceived status differences, mere in-group preference, or racial prejudice? *Social Forces*, *74*, 883-909.

Bullard, R. D. (1994). Urban infrastructure: Social environmental, and health risks to African Americans. In I. Livingston (Ed.), *Handbook of Black American health: The mosaic conditions, issues, policies, and prospects* (pp. 315-330). Westport, CT: Greenwood.

Bureau of the Census. (1998). *Statistical abstract of the United States: 1998*. Washington, DC: Government Printing Office.

Bureau of the Census. (2000). *Census of housing and population. Summary File 3*. Washington, DC: Government Printing Office.

Cell, J. (1982). *The highest stage of White supremacy: The origin of segregation in South Africa and the American South.* New York: Cambridge University Press.

Cha-Jua, S. K. (2001). Slavery, racist violence, American apartheid: The case for reparations. *New Politics*, *8*(31), 46-64.

Clark, K. B. (1965). *Dark ghetto: Dilemmas of social power.* New York: Harper & Row.

Clark, W. A. V. (1992). Residential preferences and residential choices in a multiethnic context. *Demography*, *29*, 451-466.

Cole, R. E., & Deskins, D. R., Jr. (1988). Racial factors in site location and employment patterns of Japanese auto firms in America. *California Management Review*, *31*(1), 9-22.

Cooper, R. S. (1984). A note on the biologic concept of race and its application in epidemiologic research. *American Heart Journal*, *108*, 715-723.

Cooper, R. S., Steinhauer, M., Schatzkin, A., & Miller, W. (1981). Improved mortality among U.S. Blacks, 1968-1978: The role of antiracist struggle. *International Journal of Health Service*, *11*, 511-522.

Council of Economic Advisers for the President's Initiative on Race. (1998). *Changing America: Indicators of social and economic well-being by race and Hispanic origin*. Washington, DC: Government Printing Office.

Cutler, D. M., Glaeser, E. L., & Vigdor, J. L. (1997). Are ghettos good or bad? *Quarterly Journal of Economics*, *112*, 827-872.

Davern, M. E., & Fisher, P. J. (2001). *U.S. Census Bureau, current population reports, household economic studies series. Household net worth and asset ownership: 1995*. Washington, DC: Government Printing Office.

Department of Health and Human Services. (1985). *Report of the secretary on Black and minority health*. Washington, DC: Author.

*Economic report of the president*. (1998). Washington, DC: Government Printing Office.

Fix, M., & Struyk, R. J. (1993). *Clear and convincing evidence: Measurement of discrimination in America*. Washington, DC: Urban Institute Press.

Glaeser, E. L., & Vigdor, J. L. (2001). *Racial segregation in the 2000 census: Promising news*. Washington, DC: Brookings Institution.

Goodman, A. H. (2000). Why genes don't count (for racial differences in health). *American Journal of Public Health*, *90*, 1699-1702.

Harris, D. R. (1999). *All suburbs are not created equal: A new look at racial differences in suburban locations* (Research Report No. 99-440). Ann Arbor: Population Studies Center, University of Michigan.

House, J. S., Lepkowski, J. M., Williams, D. R., Mero, R. P., Lantz, P. M., Robert, S. A., et al. (2000). Excess mortality among urban residents: How much, for whom, and why. *American Journal of Public Health*, *90*, 1898-1904.

Idler, E. L., & Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *Journal of Health and Social Behavior*, *38*, 21-37.

Jaynes, G. D., & Williams, R. M. (1989). *A common destiny: Blacks and American society*. Washington, DC: National Academy Press.

Kaminer, W. (2000). Up from reparations. *American Prospect*, *11*(13), 38-39.

Kassarda, J. D. (1989). Urban industrial transition and the underclass. *Annals of the American Academy of Political and Social Science*, *501*, 26-47.

Kaufman, J. S., Cooper, R. S., & McGee, D. L. (1997). Socioeconomic status and health in Blacks and Whites: The problem of residual confounding and the resiliency of race. *Epidemiology*, *8*, 621-628.

Kirschenman, J., & Neckerman, K. M. (1991). We'd love to hire them, but . . . : The meaning of race for employers. In C. Jencks & P. E. Peterson (Eds.), *The urban underclass* (pp. 203-232). Washington, DC: Brookings Institution.

Krieger, N. (1987). Shades of difference: Theoretical underpinnings of the medical controversy on Black/White differences in the United States, 1830-1870. *International Journal of Health Services*, *17*, 259-278.

Lieberson, S. (1980). *A piece of the pie: Black and White immigrants since 1880*. Berkeley: University of California Press.

Lillie-Blanton, M., Brodie, M., Rowland, D., Altman, D., & McIntosh, M. (2000). Race, ethnicity, and the health care system: public perceptions and experiences. *Medical Care Research and Review*, *57*, 218-235.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior* (extra issue), 80-94.

Logan, J. R. (2002). *Separate and unequal: The neighborhood gap for Blacks and Hispanics in metropolitan America*. Albany, NY: Lewis Mumford Center for Comparative Urban and Regional Research, University of Albany.

Lurie, N., Ward, N. B., Shapiro, M. F., & Brook, R. H. (1984). Termination from Medi-Cal—Does it affect health? *New England Journal of Medicine*, *311*, 480-484.

Mandinger, M. (1985). Health service funding cuts and the declining health of the poor. *New England Journal of Medicine*, *313*, 44-47.

Mare, R. D., & Winship, C. (1991). Socioeconomic change and the decline of marriage for Blacks and Whites. In C. Jencks & P. E. Peterson (Eds.), *The urban underclass* (pp. 175-202). Washington, DC: Brookings Institution.

Massey, D. S., & Denton, N. A. (1989). Hypersegregation in U.S. metropolitan areas: Black and Hispanic segregation along five dimensions. *Demography*, *26*, 373-392.

Massey, D. S., & Denton, N. A. (1993). *American apartheid: Segregation and the making of the underclass*. Cambridge, MA: Harvard University Press.

Massey, D. S., & Kanaiaupuni, S. M. (1993). Public housing and the concentration of poverty. *Social Science Quarterly*, *74*, 109-122.

McWhorter, J. (2001). Blood money. *American Enterprise*, *12*(5), 18-22.

Morrison, R. S., Wallenstein, S., Natale, D. K., Senzel, R. S., & Huang, L.-L. (2000). "We don't carry that": Failure of pharmacies in predominantly non-White neighborhoods to stock opioid analgesics. *New England Journal of Medicine*, *342*, 1023-1026.

Myrdal, G. (1944). *An American dilemma: The Negro problem and modern democracy.* New York: Harper & Brothers Publishers.

National Center for Health Statistics. (1994). *Excess deaths and other mortality measures for the Black population: 1979-81 and 1991.* Hyattsville, MD: Public Health Service.

National Center for Health Statistics. (1995). *Health, United States, 1994* (PHS 95-1232). Hyattsville, MD: Public Health Service.

National Center for Health Statistics. (1998). *Health, United States, 1998 with socioeconomic status and health chartbook.* Hyattsville, MD: Department of Health and Human Services.

National Center for Health Statistics. (2000). *Health, United States, 2000 with adolescent health chartbook.* Hyattsville, MD: Department of Health and Human Services.

National Center for Health Statistics. (2002). *Health, United States, 2002, with chartbook on trends in the health of Americans.* Hyattsville, MD: Department of Health and Human Services.

Neckerman, K. M., & Kirschenman, J. (1991). Hiring strategies, racial bias, and inner-city workers. *Social Problems*, *38*, 433-447.

Oliver, M. L., & Shapiro, T. M. (1997). *Black wealth/White wealth: A new perspective on racial inequality.* New York: Routledge.

Orfield, G. (1996). The growth of segregation: African Americans, Latinos, and unequal education. In G. Orfield & S. Eaton (Eds.), *Dismantling desegregation: The quiet reversal of* Brown v. Board of Education (pp. 53-71). New York: New Press.

Orfield, G., & Eaton, S. E. (1996). *Dismantling desegregation: The quiet reversal of* Brown v. Board of Education. New York: New Press.

Osabu-Kle, D. T. (2000). The African reparation cry: Rationale, estimate, prospects, and strategies. *Journal of Black Studies*, *30*, 331-350.

Reardon, S. F., & Yun, J. T. (2001). Suburban racial change and suburban school segregation, 1987-95. *Sociology of Education*, *74*, 79-101.

Reed, A., Jr. (2000). The case against reparations. *Progressive*, *63*(12), 15-17.

Ren, X. S., Amick, B., & Williams, D. R. (1999). Racial/ethnic disparities in health: The interplay between discrimination and socioeconomic status. *Ethnicity and Disease*, *9*, 151-165.

Robinson, R. (2000). *The debt: What America owes to Blacks*. New York: Dutton.

Sampson, R. J. (1987). Urban Black violence: The effect of male joblessness and family disruption. *American Journal of Sociology*, *93*, 348-382.

Sampson, R. J., & Wilson, W. J. (1995). Toward a theory of race, crime, and urban inequality. In J. Hagan & R. D. Peterson (Eds.), *Crime and inequality* (pp. 37-54). Stanford, CA: Stanford University Press.

Schulz, A. J., Williams, D. R., Israel, B. A., & Lempert, L. B. (2002). Racial and spatial relations as fundamental determinants of health in Detroit. *Milbank Quarterly*, *80*, 677-707.

Sharpe, R. (1993, September 14). Losing ground: In latest recession, only Blacks suffered net employment loss. *The Wall Street Journal*, p. A1.

Shihadeh, E. S., & Flynn, N. (1996). Segregation and crime: The effect of Black social isolation on the rates of Black urban violence. *Social Forces*, *74*, 1325-1352.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

Smedley, B. D., & Syme, S. L. (2000). *Promoting health: Intervention strategies from social and behavioral research*. Washington, DC: National Academy Press.

Testa, M., Astone, N. M., Krogh, M., & Neckerman, K. M. (1993). Employment and marriage among inner-city fathers. In W. J. Wilson (Ed.), *The ghetto underclass* (pp. 96-108). Newbury Park, CA: Sage.

Turner, M. A. (1993). Limits on neighborhood choice: Evidence of racial and ethnic steering in urban housing markets. In M. Fix & R. J. Struyk (Eds.), *Clear and convincing evidence: Measurement of discrimination in America* (pp. 117-152). Washington, DC: Urban Institute.

United States Civil War Center. (2002). *Statistical summary, America's major wars*. Retrieved December 12, 2002, from http://www.cwc.lsu.edu/cwc/other/stats/warcost.htm

U.S. National Advisory Commission on Civil Disorders. (1988). *The Kerner report*. New York: Pantheon.

Wallace, R. (1990). Urban desertification, public health and public order: "Planned shrinkage," violent death, substance abuse, and AIDS in the Bronx. *Social Science and Medicine*, *31*, 801-813.

Wallace, R. (1991). Expanding coupled shock fronts of urban decay and criminal behavior: How U.S. cities are becoming "hollowed out." *Journal of Quantitative Criminology*, *7*, 333-356.

Wallace, R., & Wallace, D. (1997). Socioeconomic determinants of health: Community marginalisation and the diffusion of disease and disorder in the United States. *British Medical Journal*, *314*, 1341-1345.

Whiteis, D. G. (1992). Hospital and community characteristics in closures of urban hospitals, 1980-87. *Public Health Reports*, *107*, 409-416.

Williams, D. R. (1997). Race and health: Basic questions, emerging directions. *Annals of Epidemiology*, *7*, 322-333.

Williams, D. R. (1999). Race, SES, and health: The added effects of racism and discrimination. *Annals of the New York Academy of Sciences*, *896*, 173-188.

Williams, D. R. (2001). Race and health: Trends and policy implications. In J. A. Auerbach & B. K. Krimgold (Eds.), *Income, socioeconomic status, and health: Exploring the relationships* (pp. 67-85). Washington, DC: National Policy Association, Academy for Health Services Research and Health Policy.

Williams, D. R., & Collins, C. (1995). U.S. socioeconomic and racial differences in health. *Annual Review of Sociology*, *21*, 349-386.

Williams, D. R., & Collins, C. A. (2001). Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Reports*, *116*, 404-415.

Williams, D. R., Yu, Y., Jackson, J., & Anderson, N. (1997). Racial differences in physical and mental health: Socioeconomic status, stress, and discrimination. *Journal of Health Psychology*, *2*, 335-351.

Wilson, W. J. (1987). *The truly disadvantaged*. Chicago: University of Chicago Press.

Wilson, W. J. (1996). *When work disappears: The world of the new urban poor*. New York: Knopf.

Wilson, W., & Neckerman, K. M. (1986). Poverty and family structure. The widening gap between evidence and public policy issues. In S. H. Danziger & D. H. Weinberg (Eds.), *Fighting poverty* (pp. 232-259). Cambridge, MA: Harvard University Press.

Zinsmeister, K. (2001). Has the debt been paid? *American Enterprise*, *12*(5), 4-6.

***DAVID R. WILLIAMS*** *is the Harold W. Cruse Collegiate Professor of Sociology, a professor of epidemiology, a senior research scientist in the Survey Research Center, and a faculty associate in the Center for AfroAmerican and African Studies at the University of Michigan. His previous academic appointment was at Yale University. He is centrally interested in the*

*trends and determinants of socioeconomic and racial differences in mental and physical health and has authored more than 100 scholarly papers in scientific journals and edited collections. In 2001 he was elected as a member of the Institute of Medicine of the National Academy of Sciences.*

***CHIQUITA COLLINS** is an assistant professor of sociology and a research associate with the Population Research Center at the University of Texas at Austin. She is also affiliated with the Center for African and African American Studies. She was a fellow of the Robert Wood Johnson Foundation Scholars in Health Policy Research Program (1999-2001). Her research interests include racial differences in mortality, African American health, AIDS awareness and prevention, and the effects of residential segregation on health. Her publications have appeared in the* Annals of the New York Academy of Sciences, Annual Review of Sociology, Public Health Reports*, and* Sociological Forum.