

## **Dr. David Williams Discusses Power Point Presentation**

DAVID R. WILLIAMS: I'm going to stand where I think you can see the screen so I'm not in the way. I want to say thanks to Gail Christopher for the invitation to be here and to participate in this conversation with you. I think it's a really important conversation. Gail is right; these are issues of life and death. What I plan to do in the – while you continue to eat is to talk about racism, talk about its modern manifestation in the United States currently, but focusing on – through the lens of health. I am a sociologist who studies health, and I want to show you the patterns of health and share with you some of the science, both on the nature of racism, but also on the consequences that it has for health.

I have a fair amount of territory to cover, and so let me see if I can work the – ah, yes – the technology here – fine. So first of all, I want to begin by talking about a little of health, and then thinking about how racism has really emerged as a major variable, as researchers try to understand it. So first of all, I want to begin with the fact that racial disparities in health exist, and you media experts – that's actually an important issue that national studies reveal most Americans are unaware of. Most adult whites are unaware that there are racial disparities in health; most adult Latinos are unaware that there are racial disparities in health; and most – turning to me – most adult African-Americans in the United States are unaware that disparities even exist.

If you don't perceive a problem, you certainly will not be mobilized to deal with it. The disparities using national mortality data, which has its own set of limitations, show a particularly pronounced pattern of elevated health problems for African-Americans and American Indians from early in life through retirement. The pattern that we see is not only that minorities die at higher rates, but they get sick sooner, that's at younger ages, they have more severe illness and they die sooner than whites, and that pattern exists across a broad range of indicators of health status.

Latinos have higher death rates than whites for a number of conditions, but the pattern of Latino health, which appears more favorable than those of the other groups, should not lull us into complacency. We see a pronounced pattern across all racial populations where immigrants have better health than their native-born counterparts, so white immigrants are better than whites born in this country, black immigrants are better than blacks born here, Asian immigrants are better than Asians born here, Latino immigrants are better than Latinos born in the United States. So with increasing length of stay and increasing generational status, health declines. It's as if the health data is saying to us, the American way of life is dangerous to your health.

Here's a pattern in the life expectancy lags from 1950 to 2006 showing the data for – I think I moved it back up – let's see – yes, showing the data for black and white life expectancy in 1950 all the way to 2006. So two points I wanted to get from this. One is the fact that in the last 50 years, we haven't made much progress in narrowing the black-white gap in health. But the second point I want you to note – look at the life expectancy for whites. In 1950, it was 69.1 years, and we want to ask, how long did it take before African-Americans had the life expectancy that whites had in 1950? Well, that didn't happen until 1990, and if you see here,

71.7 in 1970 was the life expectancy of whites; African-Americans didn't get there until the year 2000. So there's about a 30-year gap in health between blacks and whites in the United States, and those are the two groups for which we have data that goes back awhile.

We can also look at the patterns for American Indians over time. The Indian Health Service was started in 1955. The Indian Health Service doesn't cover all of the Indian population, but about 60 percent of that population which lives on their reservations. And for comparison purposes, I show you death rates from diabetes for whites over time, and they're fairly stable. They will increase dramatically because of the obesity epidemic in the future, but if you look at what's happening for American Indians, the dramatic increase in death rates from diabetes over time. So for some health outcomes, what I'm saying, not only are we not making progress, we're actually losing ground because the gaps today are wider than they were in the past.

How do we understand this? Among the sociologists, I know that socioeconomic status, whether mentioned by income, education, occupational status is the strongest predictor of virtually everything in society, and here is data from Princeton, New Jersey on SAT scores by family income, and you can see as family income increases, SAT scores increase. It's a graded, straight-line relationship. Every higher level family income is associated with better SAT scores. That has enormous implications for – but I'm not going to go into it – for discussions of affirmative action and other things as to what these scores actually measure.

Well, that's important because in the United States, race and socioeconomic status are importantly intertwined. So here's 2000 Census data on percent college graduates of the population by race. You can see, 27 percent of whites are college graduates, many Asian immigrant groups, there's dramatic diversity within the Asian population as well. The Mong, the Laotian and the Cambodian have higher rates of poverty than African-Americans or American Indians, but on average, Asian immigrant groups have very high rates of college completion. But importantly, you see African-Americans, American Indians, native Hawaiians and Pacific Islanders and Latinos having markedly lower rates.

If you look at poverty, another indicator of socioeconomic status, you see a similar pattern with African-Americans, American Indians, Latinos having markedly higher rates of poverty, so that part of the reason why we see these racial differences in health is there are these racial differences in socioeconomic status. It's important to keep this mind, and I think you know this, but I like to emphasize this to individuals, that although the rate of poverty is higher for minority populations, most – there are twice as many poor whites as poor African-Americans and twice as many poor whites as poor Latinos, and most poor people in the United States are white. So it's important to keep in mind when you look numerically at a population, those are the patterns in fact that we have.

Well, here is national data for the United States looking at premature mortality – that's death before the age of 60 – by income status, and what you see here, as income status increases, the likelihood of dying before the age of 60 declines. In fact, low-income persons – this is the relative risk – are three times more likely to die before the age of 60 than high-income persons. It's a dramatic example of the power of socioeconomic status to predict variations in health.

Let me give you another one that shows the complexity, then, that exists between socioeconomic status and race, and it's going to build a foundation for our conversation of racism. Here is the latest national data I could get this way. Life expectancy at age 25 for African-Americans and whites – and you can see, at age 25, whites will live an additional 53.4 years; blacks 48.4 years. So there's a five-year difference in life expectancy at age 25.

If we look at the variation within whites between whites who have not completed high school compared to whites who are college graduates, the difference is 6.4 years, larger than the black-white gap. That pattern is true for a broad range of indicators, and even many researchers in the field are not aware of it, that the gaps within each race by socioeconomic status – if I used income, the same pattern would exist – are larger than the racial gaps.

If we look within the African-American population, we see the same pattern, the gap between low-education and high-education African-American is 5.3, slightly larger than the overall black-white gap. Some have suggested, therefore, we shouldn't even collect data by race, just focus on socioeconomic status, because the socioeconomic gaps are really larger than the racial ones. Not so fast.

If we look at blacks and whites – and the same pattern is true where we have data on Latinos and other groups – at every level of education, you see – black and white high-school dropouts. Well, white high-school dropouts still live 3.1 years longer at age 25, and one researcher calls this the pattern of diminishing returns. And that is that even as education increases for African-Americans – I keep messing up the technology – even as education increases for African-Americans, the gap widens. So the gap between black and white college graduates is 4.2 years, larger than the gap at the low levels of education.

So the point is, what that story clearly tells us, it tells us a story about economic status as a powerful driver of variations in health, and part of why we have racial disparities in health is because of racial-ethnic disparities in economic status, but it also says, there's something else about race, even after you've taken socioeconomic status into account, that is driving health. So you have to look with a twin focus at both race and socioeconomic status.

Let me illustrate that with another example. This is national data for the United States. All births in a given year to women age 20 and over – it's all data '90-'95; more recent data shows the same pattern, but the government typically does not record data by race and socioeconomic status together, and so it's hard to get data to actually illustrate this – what you see here, this is infant mortality, that's the likelihood of a baby dying before its first birthday. And you could see, as mother's education increases from less than a high school to a college grad, infant death rates decline for whites and infant death rates decline for African-Americans. The power of socioeconomic status exactly what you would expect to find.

What is also evident here that is quite stunning is the magnitude of the racial difference at every level of socioeconomic status. Even more dramatically, the most advantaged group of African-American women have a higher rate – this is black women with a college degree or more education; again, it's not a sample, it's not one community, this is all births in the United

States for a given year to mothers age 20 and over – the most advantaged group of African-American women have a higher rate of infant mortality than that of white women who have dropped out of high school. How on earth do we make sense of this pattern?

And here is the data for all racial-ethnic categories, and you can see the pervasive – now, keep in mind, these African-American women are doing the best among black women. So these are the most advantaged group, but they have a higher rate of infant mortality than women of all other racial-ethnic categories except American Indians who have not completed high school. Again, we are seeing something very profound, very powerful about race that is predicting variations in health.

A colleague – we researchers always talk about the complex web of causation that drives these issues, and a colleague of mine at the Harvard School of Public Health said, well, we need to identify the spiders spinning the web if we will make progress to in fact address this issue –

JOHN A. POWELL: Could I ask you two questions, really quickly?

MR. WILLIAMS: Sure.

MR. POWELL: One, that last slide you showed, what I would see is not just a complex role of race, but the complex role of blackness, right?

MR. WILLIAMS: Oh, absolutely.

MR. POWELL: So it's not race, because race is more specific than that, you're talking about black women, and in the second one, do you compare this data looking at either wealth or geography in terms of people living in – (inaudible) – poverty?

MR. WILLIAMS: These are nationally reported data from NCHS, so there's no wealth data in data systems. So unless you have the right indicators, then you don't have it. But from other studies, we know that wealth affects health over and above income, and I have racial data on wealth coming up in my talk. Yes?

LANI GUINIER: Could you just clarify, are the women in each of these categories about the same age as your classifying them by –

MR. WILLIAMS: These are women age 20 – this is births in a given year for all women of all racial categories, age 20 and over.

MS. GUINIER: Right, so theoretically, the black women who have a college degree could be having children at the age of 40, compared to the Latina women with a college degree who are having children at the age of 30.

MR. WILLIAMS: In theory, that's true. It's not – I mean, it's not adjusted for age, it's just looking at all births in a given year. It's descriptive and not analytic, yes. I think I saw another hand. The point is, the pattern that exists here is not unique. What's unique here is how

big the gap is and the fact that the worst-off African-Americans are doing more poorly – or, the best-off African-Americans are doing more poorly than the worst-off whites and other groups.

That pattern does not exist for every single health indicator. For example, the best of African-Americans are doing worse than the worst-off whites, for example. That is not true for every health indicator, but for virtually all health indicators, we see a residual effect of race even when you take socioeconomic status into account. So the fact that there are factors linked to race, racism that affect health over and above economic status is true for virtually every indicator you look at, even when you use statistical adjustment for a range of other factors. And I will – I think I will touch on some examples of that in a minute.

Okay. Continuing, the spiders – I'm suggesting to you that racism is one of the spiders, is a powerful spider, and someone – I get pushback from my students. Racism is a thing of the past, hasn't this society made remarkable progress? And I want to say, I want to begin by saying, yes, we have. There are limits, but yes, we have. And this is an example from – I'm going to give you a couple slides of attitudinal data from national sample of whites where the identical question was asked repeatedly over time, and so here, for example, is – the question was whether whites have a right to keep blacks out of their neighborhood.

It was first asked in a national sample of whites in 1963, and you could see, 60 percent of whites said that whites have the right to keep blacks out of their neighborhood if they want to, and you could see over time, that has declined. The last time it was asked, in 1996, and you see by 1996, only 13 percent of whites. So you see a change over time of over 50 percentage points. This is non-trivial as looking at social indicators in a society.

However, there is something that researchers who study racial attitudes and racial predators call the principle implementation gap, and that is, more whites support something in principle than, say, they would support the implementation of it. So what I'm doing is showing you the first information I show you before of the dramatic decline in the principle that anyone can live anywhere they want to, but if you look at the implementation item, which was first asked in 1973 – and this sample of whites were asked if there was discrimination, if homeowners had a right to decide who they wanted to sell their house to, even if they wanted to exclude African-Americans from selling those homes.

And you could see, when it was first asked, you could see almost 70 percent of white supported – would support a law to let homeowners discriminate, but this has declined over time, but note the gap that still exists in 1996 between the principle and the implementation. So more than a third of whites in 1996 are still saying, we would not support policies to implement no discrimination. That's the key point I want to make, and I want to give you a second example. This is a study asked in the national sample of whites first asked in 1944, and the question was, do – should Negroes have an equal right to a job as whites or should whites have the first chance at any job in the country?

And you could see, back in 1944, 55 percent of whites said, we believe in affirmative action for whites. Whites should have the first chance at any job. And you can see the dramatic decline in that question over time. It has not been asked since 1972 because by 1972, only 3

percent of whites endorsed a view that whites should have the first chance at any job. Again, I'm making the point that there has been dramatic shifts in the level of racial attitudes in the United States, and I have debates with my students whether this is meaningful or not. At least the norms have changed, and the fact that the norms have changed still says something – it doesn't tell the whole story, but it still says something. Yes?

WADE HENDERSON: Just a question about your housing slide. Do we have comparable data about African-American's attitudes on the same issue? That is to say, if African-Americans had the chance to discriminate in housing, would they want that option?

MR. WILLIAMS: These are from national studies – the book is by Howard Shuman, et al., that has the data, and most of the studies, they are studies of blacks. More specifically, we find a principle implementation gap within the African-American population. It's smaller than the gap for whites. Most studies, it's half the size of the gap for whites, or smaller, but a similar pattern does exist, and some argue as well, it's not just racism, since you see that pattern within African-Americans too. However, other research has looked at this, and it's not just opposition to government intervention that drives this. It's more complicated than that.

Okay. I'm again looking at the principle implementation gap in employment, and again, you could see the view that whites should have the first chance at any job dramatically decline, which, another way of thinking of that is meaning that most whites are now saying, blacks and whites should have an equal change of a job. I suggest that's changed.

But there's a question that was asked about implementation, which was that if discrimination exists in jobs, the government should act to ensure no discrimination with jobs, and the researchers ask the question, give respondents sent out, or do you have not enough interest in this issue that you don't care one way or the other?

And what you see is a fairly high percentage of whites – you see stats at around 38 percent – and even in the last time it was passed in 2004, 29 percent of whites opposed to government action to ensure no discrimination. And the percentage of whites who say, I could care less about this issue, I don't care about it – when it's actually increasing over time.

So I'm making the point that although we can celebrate the fact that racial attitudes have changed, we see a principle implementation gap – much more support for the principle of equality than for policies to implement it, and some evidence of growing apathy. Now, these questions where people have responded, and their social desirability effects – we talk about them – that people's true values are not always revealed.

I want to continue by making the point that there's a lot of evidence to suggest that racial discrimination actually persists. One example of that is work done by Divine (ph) Pager (ph); it's an audit study; it's an audit study that was done with a wrinkle – you had black and white males with identical resumes applying for entry-level jobs – in this case, in Milwaukee, Wisconsin. The wrinkle was one of the African-Americans and one of the whites did serve an 18-month prison sentence for cocaine possession.

And what she found was stunning – was not just that there was racial discrimination – remember, the resumes are identical, here – but that it was easier for a white male with a criminal record to get a call-back for a job than an African-American male whose record was clean. A stunning example of the persistence – this was done in 2004 – of racial discrimination in the United States.

Okay, so there's research that suggests, then, that racism can affect health in multiple ways. There are multiple mechanisms; there are institutional mechanisms; there are interpersonal dimensions. And I want to talk at length about one of the institutional mechanisms, residential segregation. I'll touch on some of the others but I want to spend most of my time talking about residential segregation as a powerful institutional mechanism by which racism affects health.

I have written a paper that was in your background reading where I argue that residential segregation by race is the fundamental cause of racial disparities in health in the United States. I'm not unique in suggesting that residential segregation plays such a pivotal role.

Myrdal suggested it back in 1944 as the basic to understanding racial inequality in America; the Kerner Commission in '68 said it was the lynchpin of race relations and the source of the large and growing inequality by race and socioeconomic status.

John Sellers, a historian at Duke University, he wrote a book on the origins of segregation in South Africa and the U.S. South, where he argued that segregation by race was one of the single most successful domestic policies of the 20<sup>th</sup> century in the United States because once implemented, it's beneath the radar screen of most people, but it has pervasive effects.

Doug Massey and Nancy Denton are two sociologists who studied a lot on racism, and they also argue it's the key structural factor for the perpetuation of black poverty and the missing link in efforts to understand urban poverty.

Well, what is segregation? What are we talking about? Well, it's the physical separation of the races by enforced residence. It developed historically in the United States after the Civil War in both Northern and Southern cities, levels of black/white segregation increased dramatically between 1860 and 1940, and they've been fairly stable since 1940. It was imposed by legislation; it was supported by the culture and the society in multiple ways; it was certainly supported by ideology that supported white supremacy.

How segregated are we today? Well, in the 2000 Census, the level of segregation declined, and that was touted by many – from 1990 to 2000, from 70 to 66. 66 means that across the United States, two-thirds of African-Americans would have to move in order to have an even distribution of blacks with other groups in the country.

However, the decline is largely due to a few blacks moving into predominantly all-white census tracts. The decline has had no impact on the very high percentage black Census tracts

on the residential isolation of most African-Americans, and on the concentration of urban poverty. So it's really on the edges do we have an impact of the decline.

Well, what does segregation have to do with health, anyway? Well, there's research suggests – and I'll show you a little of it – that segregation determines your economic status. So even the relationship – I talked about the racial differences in income and education – those are not acts of God; those didn't just happen. They're driven by underlying segregation because segregation determines, on average, the quality of schools that you go to; your access to employment opportunities; the quality of housing and neighborhoods; whether your environment promotes health or discourages health; and segregation dramatically affects access to medical care.

What's some of the research on this topic? That there's been an exodus of low-skilled, high-paid jobs from segregated areas lead into what researchers call a spatial mismatch and a skills mismatch. There are still jobs in central city areas, but they require high skills that the residents there, with the schools they've gone to, haven't prepared them to take advantage of those jobs.

It also facilitates individual discrimination based on race and institutional discrimination based on race. I want to give you an example of the institutional one because we seldom think about that.

So to do that, I look at the Wall Street Journal. An analysis of the 35,000 largest companies in the U.S. during the economic downturn of 1990 to '91 found that African-Americans was the only group that had a net loss of jobs. None of these job losses reflected individual discrimination – an employer firing a black person individual because of his or her race. In fact, it reflected normal corporate downsizing and restructuring in the United States.

Well, how is that possible? Well, here are some examples. Sears, where 16 percent of its workforce was black – 54 percent of all Sears employees who lost their jobs during that economic downturn were African-American. You see at Coke, 18 percent of the workforce was black but 42 percent of the people who lost their jobs during the economic downturn were African-American.

Why? In most cases, it's because these corporations moved their plants from areas where African-Americans lived to other areas. So no individual discrimination, but systematic, institutional discrimination.

Researchers have studied auto companies moving to the United States – both domestic companies moving their plants and foreign companies moving into the U.S. – and one of the things they take into account in terms of the location of the plants – not the only thing – they look at the union membership of the market area and they look at the racial composition of the market area. And there's an attempt to systematically move their plants away from where minorities live. And I'll show you some stereotype data that will show that maybe that's rational if you believe the stereotypes.

This is a study by David Cutler, a famed Harvard economist and colleague, that looked at the impact of segregation nationally on young African-Americans and whites making it into the labor force and over their careers.

They estimated with their fancy economic models that I cannot even fully explain – but using the highest quality level of data – that if you could statistically eliminate residential segregation, you would completely wipe out black/white differences in income, education, unemployment, and reduce black/white differences in single motherhoods by two-thirds.

That's stunning to think that there is a magic bullet that could completely erase racial differences in inequality in the United States, and that is segregation. Yet, there was no discussion or debate about segregation in the last presidential election, or any of our elections recently. No one is talking about this factor that's driving it.

Well, segregation dramatically affects neighborhood quality – you probably know this – and housing quality – you know this – access to environments to promote good health – you know this. It also dramatically affects access to medical care. What the research is suggesting that in segregated areas; pharmacies are not as well-stocked, hospitals in segregated areas are more likely to close; physicians in those areas are less likely to participate in Medicaid; and researchers thought for a long time it was due to the poverty concentration. And this study showed it's not the poverty concentration; it's the racial concentration that matters in terms of segregation.

Blacks are more likely than whites to reside in areas where the quality of care is poor. And one of the reasons why blacks receive poorer quality-of-care is the areas, in fact, where they reside.

A summary from two sociologists, William Julius Wilson and Robert Sampson; they studied the 171 largest cities in the country and said, there's not even one where the conditions where the blacks and whites live are similar; social conditions on which they live. And they concluded that the worst urban context in which whites reside is considerably better than the average context of black communities, all of this being driven by residential segregation.

Research also reveals that why are African-Americans' outcomes so distinctive? Well, no group in the history of this country has lived under the high levels of segregation that currently characterize the African-American community. So for example, even the wealthiest blacks – this is 2000 Census data from Doug Massey – are more segregated than the poorest Latinos and Asians, although there is a disturbing trend of dramatically increasing segregation among Latino kids. So that's a very worrisome trend on the horizon.

How segregated, really, are we in the United States? Well, here's a comparative example. The segregation score in South Africa in 1991 was 90, which meant that 90 percent of black South Africans would have to move to have an even distribution of blacks and whites in South Africa under legally mandated apartheid.

Well, in the year 2000, most of America's largest cities are only slightly below the level of apartheid in South Africa under legally mandated apartheid – and you see where the U.S. ranks at 66.

Put that 66 into context. Scholars who study segregation use a value of 60 or higher as hyper-segregation. So all of America, then, or all African-Americans, are living under conditions of hyper-segregation by the standards normally used.

What sustains this segregation and racism at multiple levels? I will suggest it's the high levels of racial stereotypes, which is another dimension of race that we have to keep in mind as we look at the attitudinal shifts and reluctance to support policies that implement it.

Well, what data do I have? Here is data from the General Social Surveys – this is 1990 data, so it's a little dated. There are smaller regional studies that show the same pattern. This is the percent of whites – so basically it shows that 44 percent of whites say that most blacks are lazy; 56 percent that blacks prefer to live off welfare as opposed to be self-supporting; 51 percent that blacks are prone to violence; 29 percent that blacks are unintelligent.

Well, to understand this data, let's look at how whites rated themselves. So you could see that while 44 percent of whites say that blacks are lazy, only 5 percent of whites say that whites are lazy. So you can see the relative difference – it's not only that blacks are being rated negatively, but much more negatively than they rate themselves.

Another way to think of this data – these questions were asked on a 7-point scale where four was “I neither agree nor disagree.” And I'm collapsing the three high levels and the three low levels on each end of the scale.

So we can look at the positive. What is evident here is that in contrast to how whites view themselves, one in five or fewer whites were willing to say that blacks are hardworking; blacks prefer to be self-supporting; blacks are not violence-prone; blacks are intelligent. So there are very high levels of negative stereotyping and very low levels of positive views of African-Americans in the U.S.

I'm showing you the data now for all the groups that were asked in that study because the pattern here, in the interest of time, I will not show you all of them. But this pattern exists for all of them.

So I'm just showing you the welfare stereotype, 56 percent of whites believe that blacks prefer to live off welfare while that was true of 4 percent of whites. The pattern was all minority groups were viewed more negatively than whites, with Hispanics viewed twice as negatively as Asians, with Jews viewed more positively than whites in general, and with Southern whites viewed more negatively than whites in general. And that pattern, that ranking of groups, exists for all of the stereotypes. I'm not going to show you the data in the interest of time.

How are the stereotypes consequential? The stereotypes, recent research suggest, is what supports segregation. There's a new study out by Maria Krysan and Mick Cooper from

Michigan that shows that even when you show whites in metropolitan Detroit and Chicago the identical – they showed a videotape – identical neighborhoods and asked them to rank the neighborhoods on the chance that the property values will increase, on the quality of the schools those neighborhoods would have.

Where they varied is whether in the neighborhood they showed some black people on the street or some white people on the street. The neighborhoods themselves were identical. What they found was if there was a black person evident in the picture on the street, whites viewed the neighborhood more negatively, viewed the schools more poorly, thought it was a worse place; on every dimension, it was viewed more negatively just by the – remember, the neighborhoods themselves were identical. Where they varied was the racial composition of people that were evident on the street.

This is one out of Chicago that shows that employers, suburban employers, use an applicant's address to determine their probability of being a good worker. And these were some of the values they said were connoted by coming from the inner city; these were some of the values – some of the images that came to these employers' minds by coming from the suburbs.

DENNIS ARCHER: Dave, can I interrupt you for one second.

MR. WILLIAMS: Yes.

MR. ARCHER: One thing that's a very interesting phenomenon in Detroit, which goes along the lines with this, is Detroit is 90 percent – (inaudible, cross talk).

MR. WILLIAMS: Oh, yes.

MR. ARCHER: And you hear people all of the time who say, in order for their housing values in the neighborhood to improve, white folks need to move in. So we ourselves have that same view of what is valuable and what brings value.

MR. WILLIAMS: Yes, there are two things to that. The data – when I say Detroit, it is exactly metropolitan Detroit, so it's Wayne, Oakland and Macomb counties for where those data come from. Your point is well-taken. There is an element of truth to that; I'm going to show you other data in a minute; if I don't answer your question, I'll come back to it in a minute.

So these are the perceptions of Chicago area employers of inner-city blacks, and here is actually a quote from the research that was done – a report on the perception of black workers: It's unfortunate, but black men, you know, they tend to be known to be dishonest. I think that's too bad, but that's the image they have: an image problem of being dishonest men and lazy. They're known to be lazy – they are – and he laughs. I hate to tell you, but it's all an image, though. Whether they are or not, I don't know.

And it's an example of – but these are the same employers who said, they used those images to make hiring decisions. Segregation affects the economic stress; inherent wealth

differences in the United States by income level – let me put them in a way that you can readily understand.

So this is national data from the Census Bureau. Under “level of wealth,” so, on average in the U.S., the median wealth of white households is \$79,000. That’s their net worth. You take all of their assets, you look at all of their liabilities and you subtract them. For every dollar of wealth whites have nationally, blacks have 9 cents and Latinos have 12 cents. This is dramatic because it shows how the groups – when we focus – as all of our social welfare programs do – focus on income, you dramatically understate the true level of economic resources of households.

What’s also evident here is if you look at the poorest quintile of income – that’s the bottom 20 percent in terms of the income distribution – poor whites have \$24,000 in wealth on average – median. For every dollar of wealth poor whites have, poor African-Americans have one penny and poor Latinos have two pennies. And even when you look at the richest 20 percent of the U.S. population in terms of income, you still see racial differences in wealth persisting.

And you say, well, does it reflect racial differences in saving behavior? No, there are no racial differences in savings behavior at comparable levels of income. What it does reflect are, one, intergenerational transfers of wealth: Whites are more likely to receive money when their relatives die than Hispanics or African-Americans; that’s one.

It also reflects the historic legacy of the housing policies in the post-World War II period where many of the federal housing programs did not allow blacks to own homes; could not participate in those programs and the legacy of home equity. And certainly, it reflects the fact that if an African-American and a white person buy a house of identical value – one in a black neighborhood and one in a white neighborhood – and you look at them 20 years later, there will be greater growth in home equity in the white neighborhood because what drives growth in home equity? Demand. And there is more demand for homes in white areas than for African-American areas. So that is, in fact, part of the story. So there is an element of truth to that, in terms of if you look historically. Yes?

ROD GILLUM: David, your comment on housing is well-taken. If you look at the G.I. Bill after World War II, which really gave a kind of jumpstart to that population in terms of wealth creation.

MR. WILLIAMS: Yes, exactly. Yes, creation of the suburbs, yeah. Absolutely, absolutely. So there’s a long-term legacy. Yes, sorry, Maria?

MARIA KUMAR: Can you explain a little bit – because I know that one of – part of the – (inaudible, off mike) – when you start with Latino household incomes is the fact that, oftentimes, it’s not just the mother and the father that contribute to that household income; there are sometimes actually kids that should be in school.

So when you start talking about wealth creation and you're talking about – (inaudible) – generations that haven't been in high school that will be – that basically – (inaudible) – absent from that. Does that make sense?

MR. WILLIAMS: It makes perfect sense and you are absolutely right. So let me give you an example – not a better example, but another example that would make the point well – with the Asian population.

If we look at median income in the United States, Asians have the highest level of median family income in the country; higher than whites. If you look at per capita income – that is, per person income – whites have the highest level of income.

And what distorts that pattern is that Asians, on average, have more persons contributing to the household income than whites do. And so you would get the total household income but because there are more workers on average in an Asian household than in a white household. So I think that point, I've seen less analysis of that as you for Latinos, but I think it is an important issue.

I think for Latinos, although their health profile looks very positive, the disturbing trends I just mentioned – let me give you a statistic. In metropolitan Chicago, the simple correlation between percent African-American and percent Latino and percent poor – so percent minority and percent poor – is .90.

Let me state the problem in a different way: Most poor white kids – remember, there are more poor white kids than poor Latino kids and poor African-American kids – but most poor white children in this country go to schools where the majority of children are middle class. Most poor Latino and African-American kids go to schools where the majority of kids are poor.

If you are a teacher with 25 students, it makes a world of difference if 20 out of the 25 students are poor – as occurs in many African-American and Latino communities – than if you have 4 out of the 25 students are poor. The dynamics and the role of the teacher or social worker is very different in those different contexts. Yes?

MARTIN REYNOLDS: You mentioned that – I think this was in there – that fewer whites – (inaudible, off mike) – double jeopardy comes in, right? So not only being poor, but then also living in neighborhoods that are also poor.

But why is it that whites are able to not – they may be poor, but they live in a middle-class community. How is that possible?

MR. WILLIAMS: I think if you look at the historic forces that created public housing, that created segregated conditions, and when you looked at blacks moving from the South to the North, they all were poor. And so I think it's the historic forces that created residential segregation and created very distinctive patterns of appropriate places of residence.

And then, remember, proportionately in any community there are fewer whites. Now, numerically, there are a lot, but proportionately, they are more. Not that all poor whites live in very nice neighborhoods, but you don't have the degree of poverty concentration that you have for the Latino and African-American population. Yes?

MR. POWELL: There's two interesting points. Even though economic and racial segregation's going down, education segregation's going up.

MR. WILLIAMS: Economic segregation is increasing, yes.

MR. POWELL: So segregation in schools sees a rise even when residential segregation goes down which suggests that even whites moving to areas – they don't use the public schools. But also, there's recent studies showing that in terms of steering – it's not just historical – that blacks and middle class blacks are steered into black neighborhoods. And if you look at subprime loans, the higher you go up the income, the great disparity there is between whites and blacks in terms of getting subprime loans. So it's not just historical, it's actually continuing to actually happen today.

MR. WILLIAMS: Okay. Exactly. Okay let me try to wrap up quickly. I just was making the point that the black poor are poorer than the white poor. But let me just move on. What is the impact of these stereotypes on minority populations? There's not a lot of research on that question. But there is research, some of it on to the rubric of internalized racism – work like Jerome Taylor and colleagues looking at this impact on health. Or the work of Claude Steele looking at this impact on educational performance suggest that these larger stereotypes have consequences for minorities. I'm just going to move on from that.

I also want to give you another dramatic example of the impact of the stereotypes on access to medical care. "Unequal Treatment" is a title of a report released in 2003 by the Institute of Medicine. The question that was asked by Congress to the Institute of Medicine was, when African-Americans and other minorities enter health-care settings in the United States – we're not to deal with insurance problems and access problems. But once you get care, is there a difference in the quality and intensity of care that you receive?

And what a study found was across virtually every therapeutic intervention, from the most high-tech procedure to the most elementary forms of medicine, blacks and other minorities received poorer medical care than whites do. And it exists in contexts even like the VA health system where we wouldn't think it would matter. Let me give you one example, this is one example of hundreds of studies that show this pattern.

Dr. Todd was an emergency room physician at UCLA and he asked a very simple question. When a patient comes into the UCLA emergency room with a long bone fracture, a broken bone in the arm or legs, is there a difference by ethnicity in whether this patient receives pain medication or not. The patient has a broken bone, arm or legs; is there a difference, by ethnicity, in whether the patient receives pain medication? And Dr. Todd found that 55 percent of Hispanics did not get pain medication compared to 26 percent of whites.

And he's a good researcher, so he thought of everything: what time they came to the ER, how long they came to the ER, did they get injured on the job, could they speak English or not? When he statistically adjusted for all of the factors, the single strongest predictor of whether you got pain medication or not was whether you were Latino or not. Dr. Todd decided to do a second study. Could it be that there's some cultural expression to the manifestation of pain among Latinos? (Laughter.) This is serious. This is serious. That physicians are just not cueing into the right symbols of pain.

And he found when he had patients report the pain they were in and have providers rate the pain they thought the patients were in, physicians could equally tell the severity of pain in Latino patients than other patients. But still they got less pain medication. Dr. Todd moved from UCLA to Emory University in Atlanta, repeated the same study in the three largest emergency rooms in Atlanta and found exactly the same thing.

A black person showing up with a broken bone in the arm or leg in Atlanta is less likely to get pain medication than a white patient. And but that pattern is not just about pain medication, it's about virtually every area of medicine. There are hundreds of public, peer-reviewed studies that show this pattern. How do we make sense of this?

One of the ways we make sense of this – it's not the only factor, but we think it's a powerful one – is the phenomenon that social psychologists have studied for four decades called unconscious or unthinking discrimination. It's not about race, it's not about the United States, it's not about white people. It's about how humans process information. We put things in categories. And if you hold negative beliefs about a category, you will treat an individual who belongs to that category differently and you honestly will not know that you're doing it.

It's automatic and it's unconscious. And it occurs even among people who are not prejudice. In fact, this is not just about race. If you have negative beliefs about fat people, about old people, about gay people, about women – you can just go down the group, these same processes will operate. But it's an example of how the persistence of the negative stereotypes in our culture actually drives human behavior and leads to inequalities.

Let me just note that discrimination – Martin Luther King suggested it – interpersonal discrimination is also another way in which racism affects health. This is an area of growth in terms of research. I did a paper published earlier this year with a colleague. We looked at the last three years in the PubMed MEDLINE database. There were over 115 new studies, just in the last three years, documenting a relationship between discrimination and health. One of the most dramatic things about the new studies, many of them are coming from outside the United States.

There are now studies of immigrant groups in virtually every European capital. There are national studies from New Zealand, from Australia, from South Africa, that all show discrimination affects health over and above income and education. It's another way in which racism continues to affect health. Give you two examples of the kinds of work that's been done. I developed this questionnaire, every day discrimination, looking not at the big things that happen to people but the day-to-day little indignities.

Not being treated with courtesy and respect, receiving poorer service – is that consequential? Well, two studies that have measured the level of everyday discrimination that African-Americans face – they measured annually over five years. So they accumulated over five years the level of discrimination they faced and they found that black women who had higher levels of everyday discrimination report higher levels of subclinical carotid artery disease. That means they measured the development of plaque in the carotid artery, and it actually measuring the progression of heart disease in these women.

So it's not just in their mind. They can actually measure the consequences of discrimination and – (inaudible) – classification, even when statistically adjusted for all the other traditional risk factors and health behaviors. This is independent of those. What I'm saying is, we are identifying discrimination as a new risk factor, in this case, for heart disease. But it exists for a range of other disease conditions as well.

Another dramatic example – no direct measure of discrimination – in the wake of September 11<sup>th</sup>, there was well-documented increased harassment and discrimination of Arab-Americans in the United States. So this researcher, Dan Lauderdale, looked at data just for the state of California where she could identify women who were of Middle Eastern background. And she looked at the birth outcome six months before September 11<sup>th</sup> and six months after. And she found among Arab-American women only – it was not true for black women, Latino women, American Indian women, Pacific Islander women – just for Arab-American women only, six months after September 11<sup>th</sup> they had higher risk of low birth rate and higher risk of pre-term birth in their kids.

So in other words, the discrimination is not only affecting the adults, it's affecting the next generation as well, in terms of health consequences. It's time for us to act. Disparities in health are costly. A new study just reported – well let me even go to this new study – 229.4 billion – my thing is off – is the medical cost of disparities between 2003 to 2006. The higher levels of illness and disease that minorities have cost this country \$229.4 billion during 2003 to 2006. And the cost was a trillion dollars if you took into account the cost of low worker productivity and premature death.

So the total cost of disparities during this four year period was \$1.24 trillion, is the cost to the U.S. economy. That is more than the gross domestic product of India and it's more than a \$309 billion annual loss to the economy as a result of disparities in health. And you remember, health is only domain. But just in health we are finding. What I'm saying is, take home message – social justice can actually be cost effective for the society and doing nothing has a cost that we should not continue to bear.

My conclusions: There are racial disparities in health. They are large, pervasive, persistent over time. They didn't just happen. They reflect the successful implementation of social policies. And institutional strategies by race is a part of that. We need political will and commitment to implement new countervailing policies to do the kinds of campaigns that Kellogg is talking about – to change the conversation, to raise awareness levels and to have a level of new strategies to address this problem because it is actually costly to us in multiple dimensions. And

one of the dimensions that I'm talking about is in terms of health. Thank you so much. (Applause.)

MS. CHRISTOPHER: Well, we probably will take 5 minutes for questions before we – (inaudible).

MS. GUINIER: So we've been talking about trying to influence public opinion and I think we should definitely take your show on the road. (Laughter.) So don't go back to Cambridge. But my question has to do with the early conclusions that all of these things were due to quote, unquote, "segregation" because if, in fact, you take the later part of your presentation that a lot of this is internalized, unconscious bias, even if you had desegregation but the doctors in the hospital who are all white and the nurses who are all white and the teachers in the school who are predominately white – how can you say that the consequences are simply due to segregation and not to the white racial attitude.

They could say that segregation promotes those attitudes but is there evidence that desegregation diminishes them and here, for example, and I don't recall the source of the study but in college, when they have roommates, they say that a white person with a black roommate shows lower levels of internalized bias over time but a white person who has an Asian-American roommate shows higher levels of bias toward black people over time because the Asian-American, in these studies, comes in with certain biases about blacks that they then influence their white roommate to share. So how can we conclude that it's simply segregation?

MR. WILLIAMS: Great questions. It is not my position – I don't think the data is consistent – that segregation is the only cause of disparities in health. It's a major cause. It's a big one. It's one that drives even some of the intermediate pathways. So we know that income and education apart of it, well, segregation, in fact, creates some of the racial differences in income as David Cutler's work shows. So I don't think I'm arguing that segregation is the only pathway. It is a major pathway.

And if you look up front, I had a slide showing multiple mechanisms of racism. Segregation is a big one. I think I emphasize it for two reasons. One is, it's neglected. No one's talking about it. And unless we begin to address segregation, whether it's a new Marshall Plan to improve the economic conditions in disadvantaged communities – so there's nothing inherently negative about living next to people of your own race. So it's not that. It's what Wilson calls the concentration effects and the concentration of poverty and the social ills that co-occur with it that's the driver.

MS. GUINIER: Just to follow up briefly, the reason I'm concerned is that the issue of segregation has been talked about primarily in the context of schools.

MR. WILLIAMS: Yes.

MS. GUINIER: Right? That was what –

MR. WILLIAMS: Yes.

MS. GUINIER: And I see numerous studies saying that part of the problem with, quote, “desegregation” is that the black kids end up in schools with white teachers who harbor great stereotypes about the black kids. And so even though they’re in a, quote, “desegregated” environment, they are still experiencing the consequences of segregation, meaning the teachers’ bias. And whatever you think about Nick Kristof, he had an op-ed last week saying that if black kids actually had teachers who were in the top 25 percent of the most effective teachers, that the gap in educational accomplishment is reduced to zero if they have those teachers for four years.

MR. WILLIAMS: I agree with you. I think the Education Trust has a report, it was published in 2005 before the Obama phenomenon, it’s entitled “Yes, We Can.” And it looks at – (laughter) – really what does it take to make schools successful. And the evidence suggests the single biggest predictor of student performance is teacher quality. Teacher quality is the single – so I completely agree with that, that we need to do that. Let me also just say this point and please don’t take it wrong. But the phenomenon of unconscious discrimination is not a phenomenon that works exclusively of whites dealing with minorities.

Minorities can bind to the largest stereotypes in their society and treat minorities differently based on race, in fact. Some of the research on discrimination and health finds that when you are discriminated against by a person of your own race, the negative effects on health are even stronger, even more negative. And in part, because one of the things we know that matters for stress is when stress is unexpected. So there’s a sense in which given socialization in a society, there’s certain things you expect to happen. But there’s a sense of betrayal when it comes from someone you really didn’t expect it to come from.

MS. CHRISTOPHER: And that plays out in the work place?

MR. WILLIAMS: Absolutely.

MS. CHRISTOPHER: It absolutely does. Yes, go on.

MARK STEITZ: A question – right now we’re going through a housing crisis unparalleled in our nation’s history, I think. And the turmoil is just starting and it – I just encourage us all to think that, how can we use this crisis as an opportunity to do things that would be otherwise impossible? There are large groups – this mostly affected Hispanic and conservative Whites – are two. Hispanics and conservative whites are two of the most impacted groups in the excerpts, in the fast growing excerpts. And this had led to a lot of the immigration debates.

But there are all sorts of opportunities that large numbers of radically changed housing – (inaudible, background noise) – of housing that have radically changed in value and they offer – and I just don’t know how to seize that opportunity. But it’s going to be here for the next two years and we got to get moving on it.

MR. WILLIAMS: I don’t have brilliant ideas but I think we certainly want to seize opportunities.

MS. CHRISTOPHER: We'll take two more questions or comments and I'll go to John – (inaudible).

MR. POWELL: I think the market is exactly right. One thing – we're having a conference in November on that very issue. We're bringing together people from Fannie Mae, from all over – Gail mainly has the members – she's supporting this work. (Laughter.) With the housing crisis happening we said, look, this is an incredible opportunity to restructure this. Fannie Mae is now part of the government, which they shouldn't have been. But they brought them in and now they're subject – they have \$5 trillion portfolio in terms of housing. And we have a chance to remake this. And so we're trying to bring attention to it. So we'll highlight that.

The other thing is that in terms of implicit – (inaudible) – which Mahzarin Banaji, David's colleague at Harvard, shows that everybody has these biases. Blacks have biases toward other blacks – less than whites – but we have them too. Women have biases towards women because of social phenomenon. And there are things we can do to de-bias. So both of those things I want to mention.

MR. WILLIAMS: Yeah, thanks.

MR. HENDERSON: I just want to raise a question about the disconnect between this very compelling research which I found persuasive and policy and the public frame. Right now there's a huge debate supposedly taking place in Washington purported to be the best health-care reform.

And I've found your presentation very compelling but I was, sort of, trying to place myself in the position of a policy-maker from Washington and asking myself, well, would I really care? Who would I care – (inaudible) given the fact that it is talking about seemingly unconscious attitudes that have not necessarily been affected by the positive changes over time that many of us see on a daily basis.

One thing that I thought that was really especially compelling was the policymakers with the numbers that you – (coughs) – excuse me, presented over the cost of the patients. And yet even with those numbers there is an inherent skepticism about their legitimacy because they talk about the billions and trillions of dollars in cost and there's no explanation, per se, about how you arrived at those numbers other than to say that they'd never make productivity like – (inaudible) – et cetera, et cetera. So the only thing I'm suggesting or saying now is that, I mean, I am following the health-care debate. We're working at it.

And listening to how these issues are framed and discussed, there is absolutely no connection between what you have shown and the discussion in Washington about how this issue is developed and moving forward. So when it's all done, when it's all done, the system we kept and, quote, "reformed" and these issues will remain unaddressed.

MR. WILLIAMS: I did take part in a meeting at the White House led by Secretary Sebelius on health disparities and health-care reform. And one of the things I said at the meeting was, unless we put health into health-care reform – health-care reform is about insurance. Just that you know, another statistic you want to take home with – medical care accounts for 10 percent of variations in health in the United States. 10 percent, that's the surgeon general's estimate that most policymakers use. So health is created in the places where we live, learn, work, play and worship and the opportunities to be healthy in those environments.

So I want health-care reform, I want access to insurance but that alone is just a start. We really need to work upstream at this social fact as to drive health if we will be successful. I just want to mention also because the task that Gail is doing I completely support. This is why I didn't need another trip this week but I came here for Gail because I think this work is so important. But research done by political scientists and political sociologists has been very clear, historically. And that is, Americans are not particularly interested in doing things for the poor.

Wait. They are less interested in doing the same things – they've done these experiments. And you frame the issue for the poor and you look at the level of support. Then you frame the same issue for minorities – typically African-Americans – there's even less support. So we need to find new, creative ways to connect with fundamental American values, number one and to show that this is in all our best interests to address the issue else we will not be successful.

MANNY RUIZ: It's a patriotic duty, patriotic duty. We're thinking about our nation in the short-term and getting caught up in all the racial stuff and we don't realize that if our country, which is becoming more multicultural, continues to have these huge disparities, we're going to be a weak, weak –

MR. WILLIAMS: Exactly.

MR. RUIZ: So we've got to go ahead and be brave – (inaudible, background noise). (Applause.)

MS. CHRISTOPHER: Our challenge is, of course, to connect all these dots and figure out what to do when and what's most effective. I sat in on some of your sessions and I was just extremely energized. Every time I listened to that concentration of information, it moves me to tears because it makes me realize just how hard it is to do this. But anything worth doing is difficult and because –

(END)