Inequity As Violence: Race, Health and Human Rights in the United States

H. Jack Geiger

By every conventional index, the United States is the most violent society among industrialized nations. Consequently, violence and its effects have become a national preoccupation, the repetitive staple of the media, the subject of a broad spectrum of concern (ranging from sociological conferences to electoral politics), and a key factor in the ongoing American divisions of race and class. Yet paradoxically, in every venue from public discourse to congressional debate, our definitions and discussions of violence are strikingly restrictive, diverting attention from injuries more massive than those conventionally defined.

With few exceptions, our concerns refer only to violence as the use of physical force by individuals to cause injury—and so we talk of guns and gangs, and domestic battering, rape and murder, militias and bombs. Of course these phenomena are serious and deserve our urgent attention. But there are other kinds of violence—actions and policies which, by intent or omission, result in predictable harm to the physical and mental health of large populations and, further, are a major stimulus to conventionally defined violence. There is, for example, what has been called *constructive violence*: to overcome or prevent resistance by threat or (more pertinently in the United States) by systematic deprivation. There is violence by failure to observe established restraints: in Mississippi at this moment, for example, a district attorney is seeking the death penalty for a 13-year-old child marginally involved in a car-jacking.

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I argue that pervasive personal and institutional racism and racial discrimination are, by these broader definitions, a major form of violence in the United States. It might be termed *structural violence*, entrenched in the social fabric and political economy. It has specific, measurable, and damaging effects in health care, health status, and even health research. It is manifest currently in a wide variety of social policies and legislative actions.

Structural violence seeks its justification—as it has since the era of slavery—in a flawed biological determinism: the beliefs that racial labels such as "Black" and "White" classify human beings into groups with genetic homogeneity for everything from cognitive abilities to health outcomes; that racial differences in behavior are mainly genetically determined; and that racial discrimination may be dismissed as an explanation for racial disparities in health, income, employment, educational achievement, or family structure. Biological determinism implies that we need pay no attention to the discriminatory mechanisms in American society that might operate as cumulative exposures over a lifetime; it permits us to ignore the different experiences of people of color in access to labor markets, housing, education, or health care, or in exposure to the toxic pollutants that are concentrated in low-income and minority neighborhoods. Most of all, biological determinism fosters denial of the effects of repeated experiences of racial stereotyping, itself a form of interpersonal assault.

Pseudoscientific studies such as *The Bell Curve* are examples of attributing social, economic, and other disparities to intrinsic properties of the person (or the supposedly genetically defined group) while ignoring the social determinants of inequity, caste, and class discrimination.[1] If race as used in such efforts is a fallacious biological construct, it is nevertheless a powerful social construct, and it is the *social perception* of race that drives much of the violence that afflicts our society.

As Ruth Sidel has noted, it is social perception that drives most efforts toward so-called welfare reform. For example, it portrays poor, single mothers, particularly Aid to Families with Dependent Children (AFDC) recipients, as "the ultimate outsiders—stigmatized as nonworkers in a society that

claims belief in the work ethic, marginalized as single parents in a society that holds the two-parent, heterosexual family as the desired norm, and vilified as poor people in a society that worships success and material rewards."[2] During debate on welfare reform in the House of Representatives last year, the women were described as animals; one congressman held up a sign that said "Don't feed the alligators." That the data on AFDC mothers refutes the stereotype was irrelevant; the legislation passed overwhelmingly.

Will it create injury? We know that approximately one million *additional* children will be thrown into poverty, and we know that poverty is a powerful predictor of morbidity and mortality. But there are lesser-known injuries as well. For example:

1) Some 65,000 grandparents, caretakers of minor children, will be cut off from assistance entirely after two years and required to work during those two years;
2) Roughly 300,000 children with severe disabilities will be cut off from Supplemental Security Income (SSI) benefits and at least 50,000—including children with pulmonary tuberculosis, schizophrenia, mental retardation and autism—will also lose Medicaid coverage;
3) Among legal immigrants (who are primarily people of color), some 350,000 low-income elderly, including 150,000 disabled people, will lose SSI benefits, and none will be eligible for food stamps.

It is fair, I believe, to regard this legislation as structural violence—that is, as a violent assault with predictable consequences to physical and mental health. We can be sure that these policies will increase poverty, and that poverty interacts with residential racial segregation (and major American cities are now more segregated than they were in the 1960s) to feed the cycle of high rates of crime, property abandonment, mortality, and educational failure. In what Douglas Massey has described as "American Apartheid," he notes that "all of these deleterious conditions occur through the joint effect of rising poverty and high levels of racial segregation.

They can be produced at any time through a simple increase in Black poverty rates...the level of Black residential segregation is the strongest predictor of Black infant mortality rates...whereas racial segregation sharply increases mortality among Blacks, it strongly reduces it among whites."[3]

The differential allocation of resources by race, more likely to be rooted in stereotyping than in science, is evident in health care itself. A multitude of studies, many of them well controlled for such possible confounders as age, sex, Medicare and other insurance status, income, disease severity, and concomitant morbid conditions, have found deficiencies in the most basic components of clinical care for Black and poor patients as compared with patients who are more affluent, although all were equally insured under Medicare.[4] Other studies have shown that Blacks are less likely to receive renal transplants, hip or total knee replacements, and undergo gastrointestinal endoscopy, among other procedures, but are more likely to undergo hysterectomy and amputation of the lower limb. In studies of the Veterans Affairs system, Blacks were 33 percent less likely to undergo cardiac catheterization, 44 percent less likely to undergo angioplasty, and 54 percent less likely to undergo coronary artery bypass grafting than their White counterparts.[5] A 1993 study of more than 26 million Medicare beneficiaries found that race was the overriding determinant of equally dramatic disparities in care for ischemic heart disease, cancer of the prostate, and other serious conditions.[6]

It is now almost 30 years since the National Advisory Commission on Civil Disorders—the Kerner Commission—warned that "our nation is moving toward two societies, one black, one white—separate and unequal... discrimination and segregation have long permeated much of American life; they now threaten the future of every American."[7] That was in the midst of what we called the Civil Rights Movement, a period that launched landmark efforts at desegregation, voting and other rights, affirmative action, and an apparent commitment to change. How, then, are we to explain the present vicious backlash? What went wrong?

In a study for the Carnegie Council on Children, Richard H. deLone pointed out that in the effort to ameliorate

inequality, reformers have always had a choice of two different strategies.[8] One is to make profound direct changes in distribution of wealth and privilege in the society—to alter the ground rules, the focus of decision-making, the means of decision-making, and the nature of decisions in both the economic and political spheres. The second is to avoid such fundamental structural change and concentrate instead on assistance to individuals. Liberal reformers have consistently chosen the latter.

"Such reforms have failed," he concluded, "because they were not accompanied by more direct and structural change. Without structural change...efforts to equalize opportunity can at best only change the cast of characters who occupy pre-existing numbers of positions on the top and on the bottom...by ignoring or dismissing the extent to which social class, social dynamics and institutional structures affect individuals and their options, social policy has implicitly stacked the deck."

When it becomes evident that reform through individual assistance has failed, deLone noted, it is rarely considered that instead of trying to reduce inequality by helping individuals, we may be able to help individuals by reducing inequality, by recognizing that the dynamics of our social structure (and most especially racism) are not likely to produce more equality of opportunity unless there is more equality to begin with. Instead, "when individuals fail to profit from the 'help' they receive, the blame may be laid on the individual...Blaming the victim...has been a pervasive habit in the history of liberal reform."[9] At its most vicious, it appears as a form of racism, proclaiming that the poor, especially minorities, are genetically debased. Indeed, resurrection of the genetic hypothesis is often the final stage of reform. As the cycle completes itself, reform's emphasis on the individual—rather than on addressing what I have called structural violence—serves equally well as the rallying cry for racism, individual blame, and reaction.

Thus, now, *The Bell Curve.* Thus, welfare "reform." Thus, assaults on affirmative action. Thus, construction of prisons and destruction of public housing—all, it should be noted, during a time of dramatically increasing inequity in

the distribution of income and wealth. Thus, the pejorative use of the term "underclass" as a revival of the discredited theories of a culture of poverty—and as a code word for race.

There has been a second error in the strategies of those of us seeking a more equitable—and therefore healthier—society. We have tended to call these disparities problems of "civil rights" and treat them as uniquely American. I believe that limits our understanding. We need to see them as issues of *human rights,* and to recognize that Mississippi, Central Harlem, Sarajevo, and Myanmar are points on a single continuum, and that violence in one form or another is present at every point on that continuum, and consistently destructive of health. For health workers, certainly, the dichotomy between domestic civil rights and international human rights is false.

It will, in any case, be a long struggle to right these wrongs, for they have deep roots. More than a hundred years have passed since Rudolph Virchow observed that medicine is politics writ large—that is, that health status always reflects social policy. And three decades before Virchow, Dr. John Simon, the first health officer of the City of London, published an appeal for structural change that is astonishingly relevant today, more than 140 years later. In a report entitled *A Ministry of Health*, he wrote:

> I would beg any educated person to consider what are the conditions in which alone life can thrive; to learn, by personal inspection, how far those conditions are realized for the masses of our population; and to form for himself a conscientious judgment as to the need for great, even revolutionary reforms. Let any such person devote an hour to visiting some very poor neighborhood in the metropolis...let him breathe its air, taste its water, eat its bread. Let him think of human life struggling there for years...Let him gravely reflect whether such sickening evils...ought to be the habit of our laboring population; whether the legislature, which his voice helps to constitute, is doing all that might be done to palliate these wrongs; whether it be not a jarring discord in the civilization we boast, that such things continue, in the midst of us, scandalously neglected.[10]

Notes

1. R.J. Herrnstein and C. Murray, The Bell Curve: Intelligence and Class Structure in American Life (New York: Free Press, 1994).
2. R. Sidel, "The Enemy Within: A Commentary on the Demonization of Difference." *American Journal of Orthopsychiatry* 66 (4) (1996):490-495.
3. D. Massey, "American Apartheid: Segregation and the Making of the Underclass." *American Journal of Sociology* 96 (2) (1990):329-357.
4. K.L. Kahn, M.I. Pearson, E.R. Harrison, et al. "Health Care for Black and Poor Hospitalized Medicare Patients." *JAMA* 271 (1994):1169-1174.
5. E.D. Peterson, S.M. Wright, J. Daley, G.E. Thibault. "Racial Variation in Cardiac Procedure Use and Survival Following Acute Myocardial Infarction in the Department of Veterans Affairs." *JAMA* 271 (1994):1175-1180.
6. M.E. Gornick, P.W. Eggers, T.W. Reilly, et al. "Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries." *New England Journal of Medicine* 335 (1996):791-799.
7. *Report of the National Advisory Commission on Civil Disorders* (New York: Bantam Books, 1968).
8. R. deLone and Carnegie Council on Children, *Small Futures: Inequality and the Limits of Liberal Reform* (New York: Harcourt Brace Jovanovich, 1979).
9. Ibid.
10. J. Simon, "A Ministry of Health," May 15, 1854, in: City of London Reports, (London: Eyre and Spottswood, Her Majesty's Printers, 1870).

Suggested Readings

B.C. Amick, S. Levine, A.R. Tarlov, D.C. Walsh (eds.), *Society and Health* (New York: Oxford University Press, 1995).

C. Hartman, (ed.), *Double Exposure: Poverty and Race in America* (Armonk, New York: M.E. Sharpe).

J.C. Boger, J.W. Wegner (eds.), *Race, Poverty and American Cities* (Chapel Hill: University of North Carolina Press, 1996).

W.J. Wilson, *When Work Disappears: The World of the New Urban Poor* (New York: Alfred A. Knopf, 1996).