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Guest Foreword
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An Aroused Public Opinion?

"The most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have, for instance, been few other cases in the history of civilized people where human suffering has been viewed with such peculiar indifference."

W.E.B. DuBois penned those words in 1899 in *The Philadelphia Negro*[1], his groundbreaking exploration of segregation, poverty, crime, urban blight and African American health and behaviors, arguably the first American sociological study.[2,3]

Today, 111 years later, we can read numerous studies which have followed in DuBois' wake demonstrating how health and illness are patterned along racial and class lines, and how economic and social forces, including racism, shape population health[4,5,6]. Even better, public health and other organizations are now not just describing health inequities but tackling them[7,8]. Several of these pioneering initiatives are described eloquently in this special volume.

But if these initiatives are to expand and be brought to scale, if cross-sectoral coalitions are to be built and health equity put in all policies, sound programs are not enough. Participants in these efforts will have to overcome the 'peculiar indifference'

noted by Dubois which still greets news of population health differences and impedes public support for their work. This is as true today as it was back in 1899.

But talking about inequality is challenging, especially racial inequality, as the cognitive scientists at Cultural Logic have argued in two seminal essays[9,10,11] and we at California Newsreel have learned in the course of literally thousands of screenings of our documentary series on health inequities, *Unnatural Causes.* [12]

The persistence of wide, racialized inequalities in a society such as ours which professes a foundational commitment to equality (Jefferson's "self-evident truths") gives rise to a discomfiting cognitive dissonance. Individuals resolve this dissonance by adopting a frame, or model, to read and 'make sense' of the evidence. In one model, unequal outcomes tend to be attributed to systemic factors considered a betrayal of American democratic ideals: economic and social structures that disproportionately channel power, status and wealth to some at the expense of others. In the more commonly held model, inequalities are attributed not to social conditions but individual choice and personal responsibility, or in the words of Grady and Aubrun, "the inevitable…results of the different ways in which people lead their own lives."[9]

The problem for advocates is that while they tend to invoke unequal outcomes as ipso facto evidence of injustice, for most Americans the same evidence only confirms their normatized view that the world is working as it should, reflecting choices made by self-determining individuals. Inequality is unfortunate, yes, but not necessarily unfair or unjust. 13,14,15,

During the time of slavery and Jim Crow, many white Americans rationalized racial inequality as a reflection of innate biological differences between 'races.' For if

the Negro were like themselves, argued the late-historian Winthrop Jordan, how could they explain the bid on the block, the whip on the back? "Slavery could survive *only* if the Negro were a man set apart."[16,17]

In 1896, the same year the Supreme Court upheld segregation in *Plessy v. Ferguson*, the American Economics Association published Frederick Hoffman's influential *Race Traits and Tendencies of the American Negro.* Hoffman's (mis)reading of the data suggested that black mortality rates were so high that African Americans faced outright extinction. Did Hoffman challenge Jim Crow and embrace other social reforms? To the contrary. "It is not the conditions of life but in the race traits and tendencies that we find the causes of the excessive mortality," he wrote.[18, 19, 20]

Today the idea of race as biology stands largely discredited. Yet in its place sits an essentialized notion of cultural difference which plays a similar rationalizing function when it comes to unequal racial outcomes. Negative racial stereotypes remain common, especially regarding African Americans. But Latinos and Native Americans and Pacific Islanders are also more likely to be perceived by white people as lazy, undisciplined, and unintelligent.[21, 22, 23]

These racial stereotypes have become entwined with the personal responsibility / right choices frame to explain health inequalities: Some people are self-disciplined and smart enough to eat right, exercise and abstain from tobacco and drugs. Others do not. What helps give this explanatory frame staying people is that there is some "common sense" truth to it. While the choices people make certainly are constrained by the choices they have, nonetheless, many people do make self-defeating behavioral choices while others, even under adverse conditions, manage to make healthy ones.

But it's only a partial truth. The right choices frame renders invisible how inequities outside the body – in the jobs people do, the wages they're paid, the neighborhoods they inhabit, the power and resources they can access – shape risk factors for all the chronic diseases. It removes individuals from their societal context, reinforces the divide between "them" (those making bad choices) and "us," and stops political action dead in its tracks.[11] Right choices allows the poorer outcomes of people of color to be cast as individual failure and cultural dysfunction, not racial and economic injustice demanding redress.

The initiatives described in this volume address some of the difficulties of talking about inequality. Rather than just drawing notice to unequal outcomes, they illustrate how many health outcomes have nothing to do with individual choice whatsoever, re-focusing attention on the economic and social structures and institutions that generate and drive those outcomes, what the British epidemiologist Sir Michael Marmot calls, "the causes of the causes."[24] Government and corporate decisions over which individuals have little control can expose them to health threats or health promoters: toxic emissions, corporate shredding of pensions, the quality of schools, where parks and freeways and public transit get built, the wages and benefits jobs pay, whether factories shift jobs overseas, predatory lending, even tax policy. These all shape opportunities to lead healthy and flourishing lives. Why aren't such actions also labeled as healthy or risky behaviors and assessed not only in the currency of profitability but also in the currency of health?[25]

Innovative health equity initiatives also communicate a sense of hope and possibility, that unequal outcomes are not "natural," not culturally determined but rather

arise from political decisions that we as a body politic not just individual bodies have made - and can make differently. For ultimately health equity is unavoidably a public matter of politics, of people working with their neighbors and co-workers and engaging in struggles over how *our* government allocates resources, regulates corporate power and implements the principles of democracy. By illuminating the *causes* of inequality and utilizing participatory approaches to mobilize communities, these initiatives may yet arouse public opinion rather than be met with the same peculiar indifference DuBois noted a century ago.

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