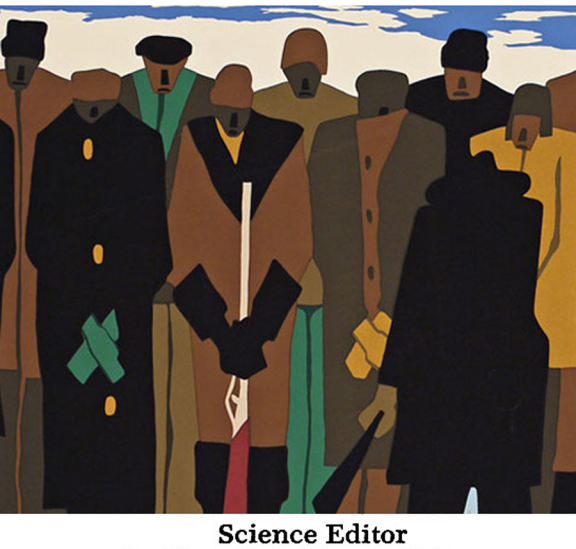
# Prejudice's Awful Toll



Science Editor
the New York *Herald Tribune*

TO THE MEN who count the living and the dead—the statisticians—discrimination against the Negroes carves a picture in their death charts as clear as an inscription on a new tombstone, as pathetic as a dead child's forgotten doll.

The statisticians and the public health experts know that the exclusion of the Negro from the white community means poverty, and poverty kills the Negro and his children long before their time. They know that the American pattern of segregation is not only socially uncomfortable but deadly.

*Item:* The Negro infant mortality rate in the nation is about 42 per 1000 live births; the white infant mortality rate is 22.

*Item:* The cancer death rate for Negro women is rising; the cancer death rate for white women is falling.

*Item:* A Negro man with pneumonia has just one-half the chance of surviving as a white man.

In the light of these numbers—and a dozen more like them—the Negro's struggle hardly seems like a foolish fight for social comforts. When he battles to be served in a particular restaurant or live in a particular house, go to a particular school or get a particular job, he is also engaged in a war against death.

In New York Dr. George James, commissioner of health, knows exactly how the whole pattern of the deprived versus the more solvent serves up harrowing contrasts. In Harlem the number of new cases of TB each year is ten times that of adjoining, predominantly white Kips Bay.

## *Awful Toll*

And if you look at the most sensitive indicator of a group's health—the infant mortality rates—the differences between white and Negro in this city are scandalous: In Central Harlem the infant mortality rate is almost 50 per 1000 live births. A few blocks south the rate stands at 14.7, the lowest in the city.

Poverty produces these numbers by providing its victims with inadequate diet, crowded housing conditions, indifferent medical care, and minimal education. And the Negroes are poor. Median income for whites is $3000 higher today than for Negroes; back in 1930 it was $2000 higher. Although Negro income doubled in three decades and white income has not, the divergence is getting greater because the whites had a bigger base to start with, and Negro income curves have flattened out.

"There is no question that these conditions conspire to produce the death rates we see," Dr. James said in an interview. Dr. Arthur Lesser, director of the Division of Health Services of the U. S. Children's Bureau, reported that the pattern repeats itself over the country.

It repeats itself in any street in Harlem where an 18-year-old girl enters her eighth month of pregnancy without ever having seen a doctor. It is not that no medical facilities are available, it's just that she really doesn't know that they exist. She cannot read very well.

FURTHERMORE, the chances are she has been eating a diet almost devoid of protein. She scarcely has a chance to get or to know about vitamin and calcium supplements. Now she finds that her ankles are swelling.

When she finally does go to the hospital, usually for a premature delivery, the doctors are faced with an undernourished, very sick mother. All this would sound like an overdrawn case history until you looked at the statistics.

In Central Harlem 24 women die in childbirth each year for every 10,000 live children born; again, in Kips Bay-Yorkville, the figure is zero. For the city it is 7.3.

A sick mother also accounts for a sick, premature baby in many instances. The rate of prematurity among Negroes is twice and three times that among whites, whose national average is seven per cent.

There is another, more harrowing aspect to the infant mortality pic-

ture, i. e., the babies that do not die. A study of Negro and white mothers in Baltimore, Maryland, showed that almost half the Negro mothers had some complication of pregnancy—toxemia, high blood pressure, bleeding. Among whites the rate is ten per cent.

That same group of scientists showed that the rate of brain damage among children is related to the complications of pregnancy, so that Negro children tend to have more brain damage than white children.

Of course, there are those who say that the Negro is inferior biologically and therefore more susceptible to disease. Dr. Lesser cites evidence to the contrary from a study of Negro and white subscribers to the Health Insurance Plan of Greater New York.

The prematurity rate among whites was 5.5 per cent and among Negroes 8.8 per cent. While the Negro rate is still somewhat higher (even employed Negroes live in inferior housing conditions), it is far below that for the Negro population as a whole. Dr. Lesser suggested that if Negro and white had the same economic, medical, and social advantages, even the small difference would disappear.

Recently Dr. Iwao M. Moriyama, chief of the Office of Health Statistics Analysis of the National Center for Health Statistics, analyzed the Negro and white infant mortality rates for the nation. Again the impact of discrimination seemed clear.

If you look at the chart comparing Negro to white infant death rates, you will find that both rates declined sharply from 1935 onward. Always, however, the Negro rate was somewhat under twice as high as the white.

THEN IN 1945 the decline began to level off; the Negro made few gains for the next ten years. The white rates did not start leveling off until five years later, so that now the difference between the two rates is even more dramatic. In 1945 it was 55 to 35; today it is 42 to 22. In other words, the Negro is relatively worse off today.

Dr. Moriyama analyzed all the other causes of death among Negroes and whites. By and large, the Negro rates are falling more rapidly than the white rates, which for some diseases have flattened out. Nevertheless, the Negro rates are always higher.

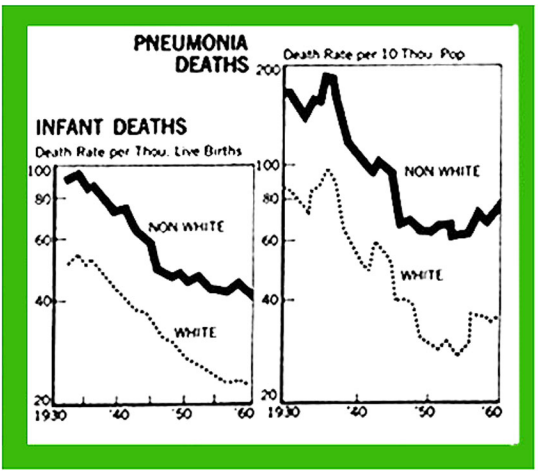
## *Awful Toll*

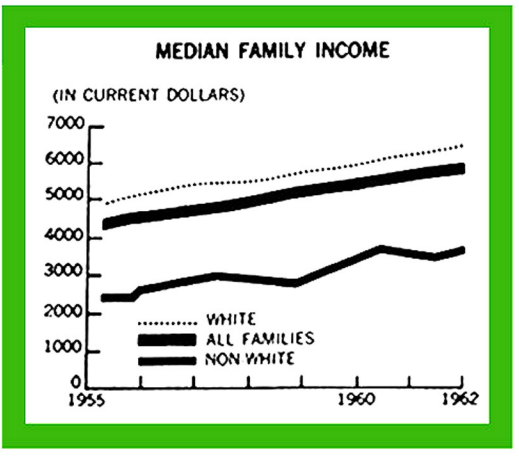
You can see the effect of poor housing conditions in the accidental and violent death rate among children. The white boys, 1 to 4 years old, suffer such deaths at the rate of 32 per 100,000 population. The Negro toddlers of the same age have twice the risk: 60 per 100,000. What is more, although there has been a twofold improvement among whites in the last three decades, the Negro rate has remained virtually unchanged.

Another sign of poor housing can be read in the New York City tuberculosis rates. Dr. James points out that this disease flourishes under crowded conditions as the germ passes from infected mother to her children.

"Right now we're attempting to make poverty tuberculosis-free," Dr. James said. "I don't know if we can succeed. We're going to try by vaccinating thousands of children in the high-risk areas. But it may not be enough."

You can read the outcome of poor medical care in the figures of pneumonia. The white chart for men shows a peak death rate of 100 per 100,000 population in 1936. In the same year the Negro peak was 200 per 100,000.

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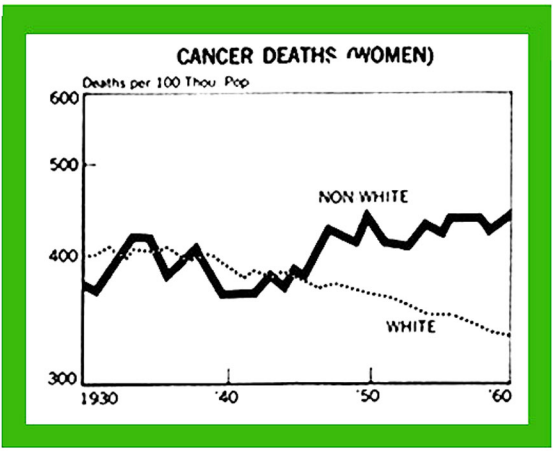


Then with the introduction of sulfa drugs, penicillin, and the other antibiotics, both charts show a steep decline over the next ten years, the white graph hitting a low of 25 in 1954 and the Negro dropping to 59 in about the same year. Again the Negroes are relatively worse off.

However, by a quirk of fate, the Negro position improved relative to the white in the next five years. The pneumonia germs became resistant to the antibotics, and the white rate took a sharp turn upward to about 58; the Negro rate turned up also, but not as sharply, to 72.

This shows that the success against pneumonia in the white population is especially dependent on medicine, i. e., they get good medicine when good medicine is to be had. The Negroes get inferior medical care: Their pneumonia death rate does not drop to the same level, and when the drugs go bad, their death rate doesn't reflect it as much.

The poor medical care arises, particularly in the South, out of discrimination against Negro doctors, against Negro patients in white hospitals, against the Negro population in the dispensation of medical services. Dr. Lesser points out that similar situations pertain to the North. At the Cook County Hospital, Chicago, there are 20,000 births a year; the mothers, mostly Negro, are sent home with their newborn infants within 24 to 48 hours—hardly a technique to foster the continued survival of the child.

In New York Dr. James is attempting to pour more medical care into the deprived areas. "We are trying to tailor our medical clinics to suit the needs of the patient," he said, "rather than the other way around. We cannot take the attitude that a working pregnant woman must give up a day's work to sit six hours in a clinic. We're trying to make it worthwhile

for these women to come in."

You can see the effect of poor education both in the maternal mortality rate and in the cancer rate among women. Dr. Moriyama's cancer chart for white women aged 55 to 64 shows a steady decline in the death rate from 400 per 100,000 in 1930 down to 325. In the same period the Negro women's rate rose from 375 up to 425.

By and large, the advances made against cancer in women have come from surgical treatment of cancer of the womb. Today a large number of white women submit to annual examinations that reveal the presence of this tumor early enough to be removed.

But to have the examination, a woman has to be aware of its availability. Since Negro women in this age group are the product of an indifferent, segregated educational system they tend not to know about this "white man's medicine."

IN SUM, there is no question in any public health expert's mind that to get a real improvement in the death rate picture among Negroes, they must be able to improve their diet, housing, education, and living standards, including medical care. And that can only come about, it seems, by a removal of all the discriminatory barriers on the economic and social level. ■■

PAGEANT
*december, 1964 * p. 117*