rates. The effect is substantial: the probability of dying at any age increases by about 5 percent moving from a low (gini 0.35) to a high (gini 0.45) city. This finding has attracted attention among those who think of income inequality as a form of social pollution that is a direct hazard to health. The correlation is spurious, but the story behind it is an interesting one that brings us back to racial differences in health. In cities where there is a large African American population, white incomes are higher, and black incomes lower, which carries through to higher income inequality in the city. Predominantly black cities are unequal income cities. Once we condition on the fraction black, there is no correlation between mortality rates and income inequality. But why should people (both black and white) die younger just because they live in cities with substantial black populations?

Recent work has helped resolve the city puzzle, and casts light on why blacks have worse health outcomes than whites. Because blacks and whites are so residentially segregated, and because people seek physicians and hospitals in their own communities, there are essentially different sets of physicians and hospitals for blacks and for whites. A group led by Peter Bach at Sloan-Kettering Cancer Centre, publishing in the New England Journal of Medicine in August this year, finds that eighty percent of doctor visits by black patients are made to less than a quarter of doctors who, in turn, rarely see white patients. Work by Jonathan Skinner and colleagues at Dartmouth documents the fine geographical structure of healthcare, and shows that both whites and blacks do worse in hospitals that treat more blacks. These findings hold for Medicare patients, whose age entitles them to close to free treatment at the point of care. The Sloan-Kettering study shows that the doctors who predominantly treat blacks are less well-qualified and are less likely to have access to the resources needed for advanced treatment.

On the positive side, these results mean that it is unlikely that discrimination by white physicians can play much of a role in black-white health differences; there is just not enough overlap of patients within doctors to do much harm, even if they are all racial stereotypers, and even if health care is an important cause of differences in health. Such a result is consistent with the fact, noted above, that Hispanics and several other ethnic minorities have longer life-expectancy than whites. (Creating the false impression that everyone has worse health than whites is an important part of the ‘white doctors stereotyping’ argument, and is extremely unhelpful for thinking about policy responses.) Both studies undermine the case that is being made in some quarters for a ‘matched’ health-care system, in which patients are treated by doctors of the same racial or ethnic group. On the negative side, it is clear that the US has a health care system that is run on something close to apartheid lines, with separate but unequal facilities for blacks and whites. The racial segregation of American cities supports this arrangement, so that areas where the population is largely black are served by less sophisticated health care, less well-trained physicians, and less well-funded hospitals. These poorer facilities hurt the health of everyone who lives in those areas, white and black alike. Income inequality across cities is not the fundamental determinant of health, but simply an indicator of deeper processes of racial segregation and inequality in America.