Black-White Infant Mortality Disparity in the United States: A Societal Litmus Test

Commentary on "A Partnership to Reduce African American Infant Mortality in Genesee County, Michigan"

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In 2000, former Surgeon General David Satcher launched Healthy People 2010, setting targets for U.S. health indicators. Healthy People 2010 called for improved outcomes for all population subgroups and the elimination of health disparities between groups. Infant mortality, a major indicator of population health, warrants attention at every level, from local to national. Despite a 90% decline in the infant mortality rate in the U.S. during the 20th century,[1] racial and ethnic sub-group analyses of population figures have consistently revealed significant disparity between African American and white infants.[2] This difference, sometimes referred to as the black-white gap, has remained fixed with African American infant mortality persisting at roughly two to four times that of white infants, despite the decrease for both groups.

Invariably the question of "why" this gap is "fixed" arises, and often leads to the age-old genetics/environment debate: is it "nature" or "nurture"? While on the "nature" question, the work of David and Collins et al.[3] elegantly dispelled the notion that low infant birthweight (the leading cause of infant mortality) for African American babies is constitutional with a study of birthweight comparisons between babies born to African American women, recent immigrants from West Africa, and U.S. white women, investigations of the role of "nurture" show the persistence of high African American infant mortality even when African American women enroll in early prenatal care at high rates[4] and show that college-educated, middle-class African American women still have higher rates of low birthweight and infant mortality than poorly educated, impoverished whites,[5] suggestive of genetics being a more powerful determinant. The inability of research efforts to isolate a single etiologic cause for the persistence of the black-white gap suggests a problem that is multifactorial in genesis and one that will require a multidisciplinary approach. Such an approach to infant mortality requires the identification and bringing to bear of resources, both human and fiscal, from every level, local to national. In this time of scarce resources, issues such as infant mortality and health disparity that do not yield a "quick fix" and that require a sustained effort often lose priority and support. Thus, the synergy required to significantly reduce infant mortality is attainable only by efforts that bring together government, private interest groups, grassroots community coalitions, public health agencies, and others.[6]

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Efforts to study infant mortality have continued to trend toward studying the problem at the molecular level: the missing or defective gene, the environmental toxin. Such efforts, while personally rewarding to investigators, risk irrelevancy and unethical indictment when existing solutions operate at the macroscopic level. Group empowerment socioeconomically, health education, and abolition of racism have no gene markers, but they do raise a different issue. When infant mortality and disparity are examined in these contexts, there is no question that we know enough. The question is: as a resource-rich society facing significant health disparities that can potentially be resolved, are we "good" enough? Do we have the collective goodwill as a society to continue lowering infant mortality and close the gap between groups? I leave this as an open question to the reader.

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