There are well-known Black-White disparities in adverse birth outcomes, health behaviors, and chronic diseases such as asthma, diabetes, and hypertension. These disparities hold across socioeconomic status and have remained stable for the past 50 years despite efforts to reduce them. This theoretical review argues that such disparities may be largely a function of residential segregation, ie, the separate and unequal neighborhoods in which most Blacks and Whites reside irrespective of their socioeconomic status. We review evidence that Black neighborhoods have significantly poorer healthcare facilities staffed by less competent physicians, higher environmental exposures, and poorer built environments than do White neighborhoods, and we argue that these neighborhood disparities are 3 pathways through which segregation contributes to health disparities. We summarize the research needed on the role of segregation in health disparities and emphasize the hypothesis that these may be differences between Whites and segregated Blacks alone. (Ethn Dis. 2009; 19:179–184)

**Key Words:** Health Disparities, Blacks, Segregation, Neighborhoods

**INTRODUCTION**

Disease and death are not randomly distributed in the United States but vary by ethnicity and socioeconomic status (SES). Ethnic minority and low-SES populations exhibit disparities in chronic disease morbidity and mortality in a patterned, predictable manner that is empirically well-documented and hence represents both a scientific and a moral challenge. Black health disparities are particularly challenging in their magnitude, scope, and persistence despite efforts to reduce them. For example, the prevalence of asthma among Black adults and children is significantly higher than among their White counterparts, irrespective of SES. Likewise, diabetes prevalence and mortality rates among Blacks have been twice those of Whites for many years, irrespective of SES. Disparities in cardiovascular disease (CVD) incidence and mortality are similar, with Black CVD mortality rates 2–3 times those of Whites for the past 40 years, and hypertension accounts for 50% of that disparity. Likewise, Blacks exhibit higher incidence of most cancers, and higher mortality from all cancers than Whites. Similarly, adverse birth outcomes (eg, low birthweight) are 2–3 times higher among Blacks than among Whites, irrespective of SES. Disparities in health-risk behaviors (eg, diet and physical activity) also persist and contribute to disparities in obesity. Moreover, disparities in the quality of treatment for diabetes, hypertension, and other diseases have been stable for decades, even when controlling for SES.

Eliminating these disparities is a priority goal of the National Institutes of Health. Progress toward that goal has been slow, however, and hampered in part by the absence of an etiologic model of disparities that explains both their scope and their persistence across Black SES levels. This theoretical review presents such a model, one that focuses on a largely neglected variable: residential segregation. Although segregation has been gaining attention as a possible contributor to Black health disparities, only 1 article described pathways through which segregation might play such a role. This review expands on the prior one by detailing the empirical evidence for 3 separate pathways through which segregation contributes to, and indeed may account for, Black health disparities.

**RESIDENTIAL SEGREGATION**

Residential segregation refers to the geographic separation of Whites from ethnic minorities in residential areas. The most commonly used measure of segregation, the dissimilarity or segregation index (SI), is available in census datasets. SI indicates the differential distribution of Blacks (or other minority group) vs Whites across the neighborhoods of a city. SI ranges from 0 (a fully integrated city) to 100 (a totally segregated city) and is interpreted as the percentage of Blacks (or Whites) who would have to move to achieve citywide integration. SI data indicate that 60%–80% of the Black (or White)