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.

OXONIA Roundtable on

Towards a New Aid Architecture

The Oxford Institute for Economic Policy (OXONIA) will host on November 26 a panel with leading academics, policy-makers and practitioners on

Towards a New Aid Architecture

in cooperation with Oxford University's Economics Department. The aim is to reflect on the current design of the development architecture and to draw some directions for the way ahead. The Roundtable is part of OXONIA's research programme 'Strengthening Economic Cooperation'.

The Oxford Institute for Economic Policy (OXONIA) is an independent and non-profit organization. It provides a global forum for engaging a broad consortium of those in the public policy community into the analysis, discussion, and dissemination of policy issues, with the aim of encompassing innovative academic research into the broad public policy framework. Subscription to the Institute is free and open to everyone. More information is available at:

http://www.oxonia.org

Secretary-General honoured again

The Society's secretary-general, Professor Richard Portes, has been made Fellow of the prestigious British Academy, the National Academy for the Humanities and Social Sciences and counterpart of the Royal Society.

Established by Royal Charter in 1902, the British Academy is an independent learned society promoting the humanities and social sciences. It is composed of Fellows elected in recognition of their distinction as scholars in the humanities and social sciences.

Election to Fellowship comes as the culmination of a rigorous selection process in which each of the Academy's eighteen Sections, organised by academic discipline, is involved. The number of Ordinary Fellows elected in each year is limited by statute to 35.

Professor Portes was made a CBE in the 2003 New Year's Honours List