Although I have personally spent a substantial amount of time contemplating the correlation between race and health, Lee, Mountain and Koenig expose yet another pertinent area of discussion: how new genomic knowledge may affect our understanding of biological “difference” between human groups. In lecture, Barbara Keonig reminded us of two major causes which must be considered when studying health disparities: do they persist as a consequence of unequal distribution of resources (affected by racism and/or SES) or are they due to “inherent characteristics of the individual?” The paper identifies three social and scientific trends which responsible for reinforcing attention to differences in human biology (inherent characteristics):

1) the U.S. government’s health disparities initiative to eliminate inequalities in health status among racially and ethnically identified populations by 2010.

2) The completion of the Human Genome Project.

3) The increasing amount of genetic research that focuses of population variation.

The authors criticize the use of race as a legitimate scientific variable and emphasize the negative consequences of creating “racialized diseases.” They assert that this phenomena would lead to a shift toward population based care, involving targeted genetic testing for racially identified “at risk” groups and consequent stigmatization and discrimination. Ashkenazi Jewish women with a higher than average risk for breast cancer is a reoccurring example in the paper illustrating how a group could become stigmatized. In the near future such a stigma could negatively affect how insurance companies cover certain patients and how the patients view their own health (potentially preoccupied).
To conclude, Lee and colleagues assert three points:
- Public policy must strive to avoid the “racialization of new diseases” and the stigmatization of groups which would inevitably follow.
- Over-emphasis of genetic reductionism may lead to a negation of critical etiological explanations which may be at the actual root of health disparities (eg. environment, social stucture, poverty, or interactions of these factors).
- Increased knowledge of genomics in a danger by reinforcing “rebioligization” of race as definable category. This could result in faulty, counter productive data.

Ultimately they argue that “in order to meet the vital policy goal of eliminating health disparities among diverse U.S. populations, it is critical to distinguish between biological and sociocultural contributions to the increased morbidity, mortality, and truncated access to services experienced by minority populations and the poor.”

I felt that the authors should have criticized the unrealistic goal of the governments health disparities initiative. I try to be optimistic but if we are to in fact eliminate health disparities along racial lines, we must also eliminate economic disparities along racial lines. Throughout U.S. history, race and SES have been inseparable and to try to equalize the nation’s economic distribution in 8 years is not feasible.

My final point/question – if we are to eliminate health disparities along “race,” would this involve finding a cure for breast cancer? This is just an example of the ambiguity of the goals of the government initiative. If we want to eliminate ethnically identifiable disparities of morbidity and mortality with breast cancer, wouldn’t we have to find a treatment to ensure Ashkenazi Jews would not suffer more from breast cancer compared to other groups? I fear that this would involve excessively expensive research and development when resources could be better spent trying to understand non-genetic causation of health disparities.