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Racism as a Social Determinant of Health Inequities

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INTRODUCTION

According to Healthy People 2020, our nation's health planning document, *health inequities* are related to "historical and contemporary injustices." Accordingly, achieving health equity requires that we examine and dismantle the social systems that produce injustice, such as racism.(1-3) A vast and growing body of research consistently shows that racism is a social toxin that is not only morally unacceptable, but potentially lethal.(4-6)

EVIDENCE LINKING RACISM AND HEALTH

Racism is a system of beliefs and practices that serves to reinforce the power and well-being of whites at the expense of people of color.(7) One visible manifestation of racism is hate crimes. In 2014, the Federal Bureau of Investigation (FBI) reported over 5,479 hate crime incidents, with the majority of these incidents (57%) attributable to racial or ethnic bias.(8)

Yet, federal hate crimes statistics typically underrepresent the actual count of such events since most crimes are not reported to authorities or processed as acts of racial bias. Moreover, hate crimes are only just one form of racial bias. Indeed, a 2015 poll found that an overwhelming 91% of Americans felt that racism remained a problem in the U.S. and that 49% described it as a "big problem."(9)

An important discovery in the scientific literature is that even small and subtle acts of racial bias, such as being treated with less respect due to one's race, can lead to a large host of health problems.(10) These ongoing and mundane experiences of discrimination are associated with increased risk of health problems such as heart disease, clinical depression, low birth weight infants, poor sleep, obesity, and even mortality.(11-14) The link between experiences of discrimination and illness has been documented among a variety groups,

including African Americans, Arab Americans, Asian Americans, Latinos, and Native Americans.(12, 15-18) Such findings are also seen in other countries, including Australia, Brazil, Japan, and South Africa.(19-22)

Why might racism make people sick? First, racism may hinder one's educational attainment, impede the ability to seek gainful employment, and diminish potential wages.(23) The erosion of these socioeconomic resources may in turn contribute to health outcomes.

Another mechanism by which racism influences health appears to be stress.(24) When stressors are experienced repeatedly, they can contribute to "allostatic load," defined as the "wear and tear" on the body systems, which then lead to a variety of health problems.(25) Experiences of racism are associated with biomarkers of stress, such as cortisol and c-reactive protein.(26, 27) Further, a recent neuroimaging study suggested that discrimination is also associated with the areas of the brain that process social exclusion.(28)

Experiences of racism may also trigger coping mechanisms. Some of these are helpful, such as when people go to church or receive social support from friends. Some of these coping behaviors can also be harmful. Indeed, discrimination is associated with greater use of alcohol, tobacco and other drugs, and risky sexual behaviors.(29, 30) Discrimination may also contribute to avoidance behaviors, such as when patients decide to forgo medications or seek alternative therapies to avoid encountering bias.(31-33)

It is important to recognize, however, that individual experiences of racism are only the "tip of the iceberg" (Figure 1).(34) Below the tip sits a broader foundation of structural racism that is far more difficult to observe, but probably even more important with regard to shaping the well-being of racial minorities.

Structural racism includes the basic operations and norms of a society that serve to maintain a racial hierarchy. These include: segregation of schools, neighborhoods, and workplaces, redlining practices by lending institutions, negative portrayals in the media, mass incarceration, voting restrictions, immigration policies, and many others.(7, 35) The health literature has focused primarily on racial residential segregation. Racially segregated neighborhoods often have greater exposures to environmental toxins, lower tax bases, fewer jobs, and fewer services, such as hospitals.(36, 37) One study estimated that residential segregation was attributable to 176,000 excess deaths in 2000.(38) Other indicators of structural racism have also been associated with illness, including living in areas suffering from redlining by lending institutions, or areas with greater racial animus, as indicated by living in areas with a relatively higher preponderance of racist tweets as compared to other communities.(39-41)

WHAT WOULD HEALTH EQUITY LOOK LIKE IN A SOCIETY FREE OF RACISM?

Health inequities could be considered a marker of the health of race relations. Supposing this is true, then completely eradicating racism would likely dramatically decrease health disparities across racial/ethnic groups. This a very difficult task, however, that goes far beyond sensitivity trainings and diversity initiatives. As long recognized, the elimination of individual prejudicial attitudes and stereotypes would not solve racial inequities because the structural forces that perpetuate racism would remain untouched.(7) Thus, any efforts to eliminate racism must attend to the multiple levels of racism, not simply a single level.(42)

Although it is a difficult task to fix the structural roots of racism, there are reasons to be optimistic. For example, Almond, Chay, and Greenstone noted that the racial disparity in

postneonatal mortality plummeted after the passage of the 1965 Civil Rights acts mandate to desegregate hospitals, resulting in the survival of over 5,000 African American infants in the following decade in the rural south.(43) This analysis did not consider other health outcomes, and it is likely that this study underestimated the potential health benefits of such legislation.

OPPORTUNITIES AND CHALLENGES

Grassroots organizing of local communities has often been at the heart of civil rights activities. Many of these local activities then blossomed into larger initiatives. A good example comes from the area of redlining. Even with the de jure eradication of residential segregation after 1965, many minority communities were thwarted in their attempts to redevelop their communities and to integrate neighborhoods. This is because poor and minority residents were unable to obtain mortgages due to redlining practices by banks. This problem was voiced by local residents in Chicago and elsewhere, which then contributed to a national movement that led legislation such as the Home Mortgage Disclosure Act in 1975 and the Community Reinvestment Act in 1977.(44, 45)

Movements are also happening today with regard to the Black Lives Matter and related organizing efforts.(46) Contemporary organizing is not only happening on the streets, but also in cyberspace. Despite the change in medium, the effects are similar.(47, 48) Individuals are sharing their stories and finding that their experiences are not unique. Moreover, these movements are intertwined with other movements, so that community groups are not only recognizing issues within policing, but other arenas, such as in media representations. Thus, recognizing that racism spans multiple boundaries leads to the strong opportunities for cross-sector collaborations. Collaborations between local community

members, and allies in various sectors, including health and related disciplines, would provide synergies that could benefit all groups.

PRIORITY AREAS FOR DEVELOPMENT OF AN ACTION AGENDA

1. Develop new methods for understanding structural and institutional racism. Much has been learned about interpersonal experiences with racism and health, but much less is known about the role of structural racism.(35, 49, 50) To an extent, the literature has studied segregation, but understudied other forms of structural racism (e.g. mortgage redlining, policing, mass incarceration). In addition, there are yet many untapped forms of institutional discrimination (e.g. within the legal system) that could be further developed conceptually and methodologically within a health equity framework.

2. Consider more fully the role of racism over the life-course. As individuals age, they encounter new social institutions that provide new contexts for racism, such as when young adults exit school and enter the workforce.(51) Research on racism and health must attend to such dynamic change seriously.(52)

3. Attend to cumulative risk. The phrase, "cumulative risk," usually denotes the increased potential harm that occurs when humans encounter multiple environmental toxicants simultaneously, such as lead, mercury, and arsenic. The idea is also useful for consideration of racism, where we can examine the potential increase in morbidity that occurs when racial minorities encounter everyday discrimination, residential segregation, and occupational segregation *simultaneously*. Relatively little has been done in this regard, but understanding how these exposures may act synergistically should be a high priority. For

example, although research has focused on occupational and residential segregation separately, it is unknown how occupational and residential segregation may act together to produce health inequities.

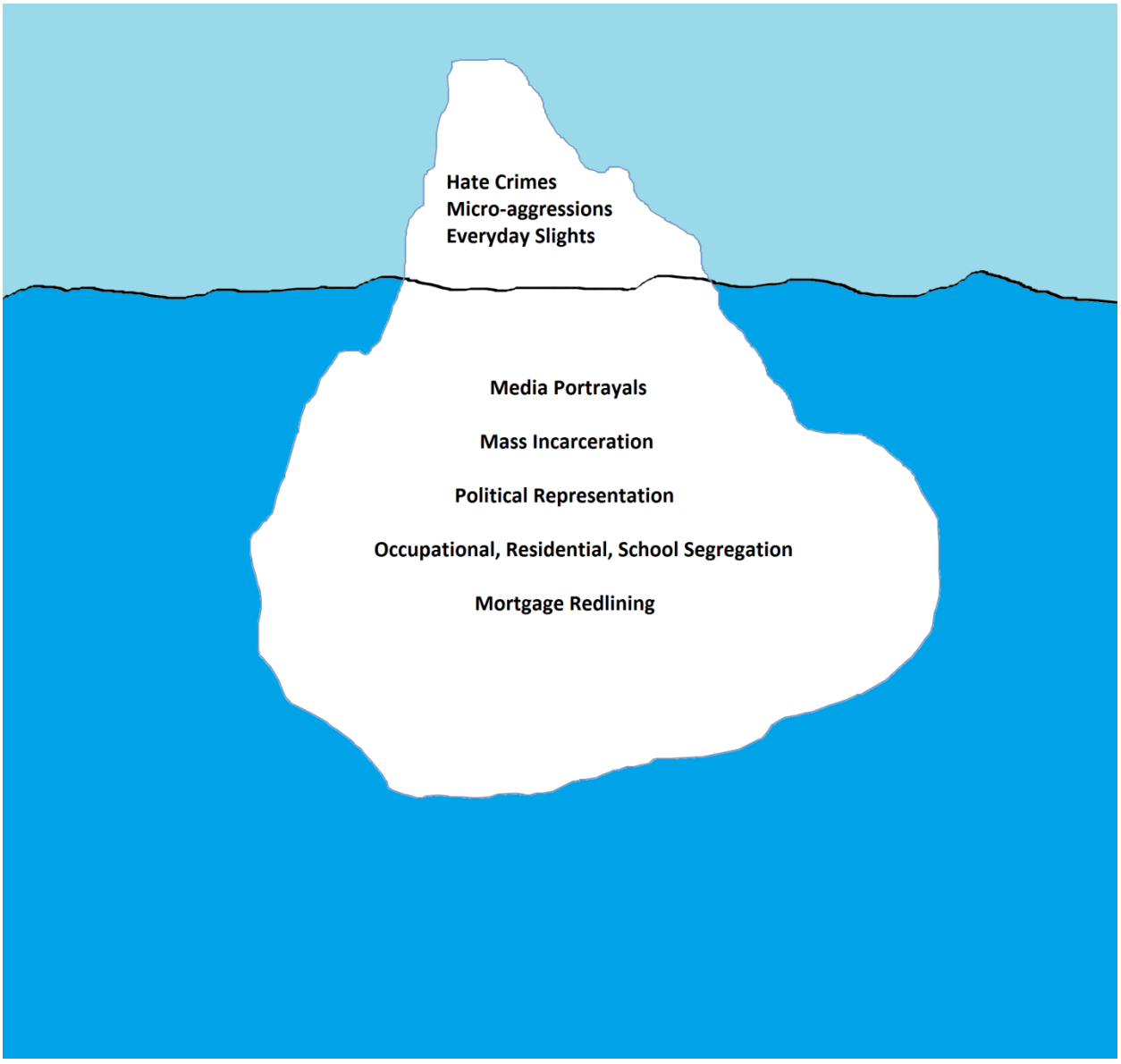
4. Recognize intersectionality. Intersectionality recognizes that experiences of racism are not uniform across social groups, but instead, are contextualized by gender, immigration experience, social class, and many other factors.(53) Numerous accounts denote, for example, how the experiences of racism faced by Black women differ from those of Black men.(54) An emerging literature shows that possession of multiple types of social disadvantages is related to illness.(55) However, this is just the beginning. Intersectionality gets increasingly complex as we begin to recognize other dimensions, such as sexual orientation, age, and social class. We need to strengthen our theoretical understanding of intersectionality and continue to develop the empirical research towards understanding how intersectionality may be related to health inequities.(56)

CLOSING

Racial health inequities have remained entrenched over time and often seem to be intractable. Racism appears to play a key role in generating these inequities. Accordingly, there are good reasons to suspect that health inequities would dramatically decline should we find ways to create a Culture of Health that includes a mandate to foster civil rights and eradicate racism. These actions could include the expansion of new ways to understand and monitor multiple forms of oppression, and further welcome sustained participation by diverse stakeholders. The Civil Rights Act recently passed its 50th anniversary, and the actions of that era have resulted in profound changes to the well-being of diverse

communities. Nonetheless, much work remains to fully achieve the vision of full and equal participation of all members of society, and to develop a Culture of Health equity.

Figure 1. The Racism Iceberg (adapted from Gee, et al., 2007).



REFERENCES

1. LaVeist TA, Pierre G. Integrating the 3Ds--social determinants, health disparities, and health-care workforce diversity. Public health reports (Washington, D.C. : 1974) 2014;129 Suppl 2:9-14.
2. Thomas SB, Quinn SC, Butler J, Fryer CS, Garza MA. Toward a fourth generation of disparities research to achieve health equity. Annual review of public health 2011;32:399.
3. Braveman P. Health disparities and health equity: concepts and measurement. Annu. Rev. Public Health 2006;27:167-194.
4. Ford CL, Airhihenbuwa CO. Critical race theory, race equity, and public health: toward antiracism praxis. American Journal of Public Health 2010;100(S1):S30-S35.
5. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. PloS one 2015;10(9):e0138511.
6. Pascoe EA, Smart Richman L. Perceived discrimination and health: a meta-analytic review. Psychological bulletin 2009;135(4):531.
7. Feagin JR. Systemic Racism: A Theory of Oppression: Taylor and Francis Group; 2006.
8. Investigations FBo. Hate Crime Statistics, 2014; 2015.
9. Shiocet CE. Is racism on the rise? More in U.S. say it's a 'big problem,' CNN/KFF poll finds. In; 2015.
10. Williams DR, Mohammed SA. Racism and health I: pathways and scientific evidence. American Behavioral Scientist 2013:0002764213487340.
11. Barnes LL, de Leon CF, Lewis TT, Bienias JL, Wilson RS, Evans DA. Perceived discrimination and mortality in a population-based study of older adults. Am J Public Health 2008;98(7):1241-7.
12. Gee GC, Spencer M, Chen J, Yip T, Takeuchi DT. The association between self-reported racial discrimination and 12-month DSM-IV mental disorders among Asian Americans nationwide. Soc Sci Med 2007;64(10):1984-96.
13. Earnshaw VA, Rosenthal L, Lewis JB, Stasko EC, Tobin JN, Lewis TT, et al. Maternal Experiences with Everyday Discrimination and Infant Birth Weight: A Test of Mediators and Moderators Among Young, Urban Women of Color. Annals of Behavioral Medicine 2012;45(1):13-23.
14. Slopen N, Lewis TT, Williams DR. Discrimination and sleep: a systematic review. Sleep Medicine 2016;18:88-95.
15. Bratter JL, Gorman BK. Is Discrimination an Equal Opportunity Risk? Racial Experiences, Socioeconomic Status, and Health Status among Black and White Adults. Journal of Health and Social Behavior 2011;52(3):365-382.
16. Hartshorn KJS, Whitbeck LB, Hoyt DR. Exploring the Relationships of Perceived Discrimination, Anger, and Aggression among North American Indigenous Adolescents. Society and Mental Health 2012;2(1):53-67.
17. Padela AI, Heisler M. The Association of Perceived Abuse and Discrimination After September 11, 2001, With Psychological Distress, Level of Happiness, and Health Status Among Arab Americans. American Journal of Public Health 2010;100(2):284-291.
18. Umaña-Taylor AJ, Updegraff KA. Latino adolescents' mental health: Exploring the interrelations among discrimination, ethnic identity, cultural orientation, self-esteem, and depressive symptoms. Journal of adolescence 2007;30(4):549-567.
19. Williams DR, Gonzalez HM, Williams S, Mohammed SA, Moomal H, Stein DJ. Perceived discrimination, race and health in South Africa. Social Science & Medicine 2008;67(3):441-452.
20. Asakura T, Gee GC, Nakayama K, Niwa S. Returning to the "homeland": work-related ethnic discrimination and the health of Japanese Brazilians in Japan. Am J Public Health 2008;98(4):743-50.
21. Paradies YC, Cunningham J. The DRUID study: exploring mediating pathways between racism and depressive symptoms among Indigenous Australians. Social Psychiatry and Psychiatric Epidemiology 2010;47(2):165-173.

22. Bastos JL, Celeste RK, Silva DAS, Priest N, Paradies YC. Assessing mediators between discrimination, health behaviours and physical health outcomes: a representative cross-sectional study. Social Psychiatry and Psychiatric Epidemiology 2015;50(11):1731-1742.
23. Williams DR. Race, socioeconomic status, and health. The added effects of racism and discrimination. Ann N Y Acad Sci 1999;896:173-88.
24. Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans. A biopsychosocial model. Am Psychol 1999;54(10):805-16.
25. McEwen BS. Stress, adaptation, and disease. Allostasis and allostatic load. Ann N Y Acad Sci 1998;840:33-44.
26. Lewis TT, Aiello AE, Leurgans S, Kelly J, Barnes LL. Self-reported experiences of everyday discrimination are associated with elevated C-reactive protein levels in older African-American adults. Brain, Behavior, and Immunity 2010;24(3):438-443.
27. Adam EK, Heissel JA, Zeiders KH, Richeson JA, Ross EC, Ehrlich KB, et al. Developmental histories of perceived racial discrimination and diurnal cortisol profiles in adulthood: A 20-year prospective study. Psychoneuroendocrinology 2015;62:279-291.
28. Masten CL, Telzer EH, Eisenberger NI. An fMRI investigation of attributing negative social treatment to racial discrimination. Journal of Cognitive Neuroscience 2011;23(5):1042-1051.
29. Otiniano Verissimo AD, Gee GC, Ford CL, Iguchi MY. Racial discrimination, gender discrimination, and substance abuse among Latina/os nationwide. Cultural Diversity and Ethnic Minority Psychology 2014;20(1):43.
30. Roberts ME, Gibbons FX, Gerrard M, Weng C-Y, Murry VM, Simons LG, et al. From racial discrimination to risky sex: prospective relations involving peers and parents. Developmental psychology 2012;48(1):89.
31. Cuffee YL, Hargraves JL, Rosal M, Briesacher BA, Schoenthaler A, Person S, et al. Reported Racial Discrimination, Trust in Physicians, and Medication Adherence Among Inner-City African Americans With Hypertension. American Journal of Public Health 2013;103(11):e55-e62.
32. Nelson AR, Smedley BD, Stith AY. Unequal Treatment:: Confronting Racial and Ethnic Disparities in Health Care (full printed version): National Academies Press; 2002.
33. LaVeist TA, Nickerson KJ, Bowie JV. Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. Medical Care Research and Review 2000;57(4 suppl):146-161.
34. Gee GC, Ro A, Shariff-Marco S, Chae D. Racial discrimination and health among Asian Americans: evidence, assessment, and directions for future research. Epidemiol Rev 2009;31:130-51.
35. Gee GC, Ford CL. Structural racism and health inequities. Du Bois Review: Social Science Research on Race 2011;8(01):115-132.
36. Gee GC, Payne-Sturges DC. Environmental health disparities: a framework integrating psychosocial and environmental concepts. Environ Health Perspect 2004;112(17):1645-53.
37. Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. Public Health Rep 2001;116(5):404-16.
38. Galea S, Tracy M, Hoggatt KJ, DiMaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. American Journal of Public Health 2011;101(8):1456-1465.
39. Wallace ME, Mendola P, Liu D, Grantz KL. Joint Effects of Structural Racism and Income Inequality on Small-for-Gestational-Age Birth. American Journal of Public Health 2015;105(8):1681-1688.
40. Chae DH, Clouston S, Hatzenbuehler ML, Kramer MR, Cooper HLF, Wilson SM, et al. Association between an Internet-Based Measure of Area Racism and Black Mortality. PLoS ONE 2015;10(4):e0122963.
41. Gee GC. A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. Am J Public Health 2002;92(4):615-23.

42. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. American journal of public health 2000;90(8):1212.
43. Almond D, Chay KY, Greenstone M. Civil rights, the war on poverty, and black-white convergence in infant mortality in the rural South and Mississippi. 2006.
44. Capraro JF. Community Organizing + Community Development = Community Transformation. Journal of Urban Affairs 2004;26(2):151-161.
45. Squires GD. Capital and communities in black and white: the intersections of race, class, and uneven development: State Univ of New York Pr; 1994.
46. Jee-Lyn García J, Sharif MZ. Black Lives Matter: A Commentary on Racism and Public Health. American Journal of Public Health 2015;105(8):e27-e30.
47. Ebeling MFE. The New Dawn: Black Agency in Cyberspace. Radical History Review 2003;87:96.
48. Brady SR, Young JA, McLeod DA. Utilizing Digital Advocacy in Community Organizing: Lessons Learned from Organizing in Virtual Spaces to Promote Worker Rights and Economic Justice. Journal of Community Practice 2015;23(2):255-273.
49. Feagin J, Bennefield Z. Systemic racism and US health care. Social Science & Medicine 2014;103:7-14.
50. Krieger N. Discrimination and Health Inequities. International Journal of Health Services 2014;44(4):643-710.
51. Gee GC, Walsemann KM, Brondolo E. A life course perspective on how racism may be related to health inequities. Am J Public Health 2012;102(5):967-74.
52. Goosby BJ, Heidbrink C. Transgenerational Consequences of Racial Discrimination for African American Health. Sociology compass 2013;7(8):630-643.
53. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. Social Science & Medicine 2012;75(12):2099-2106.
54. Schulz AJ, Mullings L. Gender, race, class, and health: Intersectional approaches: Jossey-Bass San Francisco, CA; 2006.
55. Grollman EA. Multiple Disadvantaged Statuses and Health: The Role of Multiple Forms of Discrimination. Journal of Health and Social Behavior 2014;55(1):3-19.
56. Lewis TT, Cogburn CD, Williams DR. Self-Reported Experiences of Discrimination and Health: Scientific Advances, Ongoing Controversies, and Emerging Issues. Annual Review of Clinical Psychology 2015;11(1):407-440.