Racial/Ethnic Discrimination as a Direct and Indirect Cause of Health Inequities

Racial/ethnic health disparities in the US can be explained, in large part, by racial/ethnic economic inequalities (see Krieger, 2000; Williams & Collins, 1995). Well-known gaps in life expectancy, infant mortality, and physical and mental health outcomes decline dramatically when researchers statistically control for variables such as income, education, employment, and neighborhood disadvantage. This raises two important questions: (1) What explains racial/ethnic economic inequalities? (2) What explains the racial/ethnic health disparities that remain after accounting for economic inequalities? Perhaps the most important answer to both questions is racial/ethnic discrimination.

First, the reasons African-Americans and other minority groups in the US continue to experience more poverty, lower quality education, and other socio-economic hardships today cannot be separated from the history of slavery, colonialism, segregation, and other forms of institutional discrimination. Although the Civil Rights Movement and anti-racist legislation (i.e., 1964 Civil Rights Act) have reflected and generated positive change, it is difficult to overestimate the extent to which racism has been embedded in the political and economic structures and the dominant ideologies of American society.

One legacy of state-sanctioned discrimination is the large and persistent black-white wealth gap. Because wealth is largely inherited (passed down across generations) and because racial minorities historically were banned from holding certain occupations, owning homes and businesses, and subject to many other forms of oppression, racial inequalities in wealth far exceed racial inequalities in present-day income (see Oliver & Shapiro, 1997).[1] Yet, in a society where one's "life-chances" (e.g., ability to attain a good education and job skills, and hence a decent income; opportunity to live in a safe clean supportive neighborhood; access to quality health care) depend increasingly on inherited wealth (Bowles et al, 2005), African-Americans, American Indians, and some immigrant groups are at a significant disadvantage. Growing up in poverty is stressful; it undermines health directly and indirectly by limiting access to other health-enhancing resources and by increasing the likelihood of poverty in adulthood, thereby repeating the cycle.

Wealth inequalities are not only transmitted across generations; they are also exacerbated by continuing labor market discrimination. Although surveys report overt racism is waning, employers often admit to "statistical discrimination" – refusing to hire young black men, for example, because members of this category are thought to be more likely to engage in theft (Neckerman & Kirschenman, 1991). This is unfair to the vast majority of young black men who would never steal from their companies, yet employers often claim it is not worth their time to evaluate job applicants as individuals. If, as Blank and colleagues (2004) describe, a similar discriminatory filtering process occurs at every stage of the labor market – hiring, promotion, layoffs, rehiring – then racial minorities and other stigmatized groups face severe cumulative disadvantages in the realms of employment, wages, and working conditions. In this way, racial/ethnic economic inequalities, and ultimately racial/ethnic health disparities, are perpetuated.

[1] Whereas income depends on job earnings, social assistance, pensions, and other contemporary but variable sources, wealth refers to one's total stock of accumulated resources (assets minus debts).

Contributing further to such inequities is the continuing high level of residential segregation. Massey and Denton (1993) have documented the primary role of systemic racism in the real estate and banking industries in the formation of urban ghettos in the post-WWII era. Policies and practices such as the redlining of predominantly black neighborhoods, blockbusting and screening by real estate agents, restrictive covenants, and violent attacks and subtle threats on minorities who moved into white neighborhoods helped sustain a situation of *de facto* apartheid long after the abolition of Jim Crow laws. Although the 1968 Fair Housing Act was a step in the right direction, its effectiveness has been limited due to the lack of enforcement mechanisms. When such discrimination was combined with economic transformations, such as the elimination and outsourcing of hundreds of thousands of inner city manufacturing jobs in which blacks historically were concentrated, and with drastic cuts to the social safety net, particularly in the Reagan era, urban ghettos quickly emerged across the nation (Wilson, 1996). In this context, anger, crime and incarceration proliferated, families, support networks and housing conditions deteriorated, and health thereby suffered. Although few studies have directly assessed the health effects of institutional racism, LaVeist (1992) has shown how black neonatal mortality rates are independently associated with residential segregation and poverty, relative black political power, and inequitable allocations of municipal resources (per capita spending, by neighborhood, on healthcare, police, fires, streets, and sewers). Perhaps the most salient recent example of the health impacts of segregation and ghettoization was the disproportionate damage to African-American families and neighborhoods as a result of the 2005 Hurricane Katrina (due to the structure and location of housing, obstacles to fleeing the city quickly, rebuilding after flooding, etc.).

Institutional discrimination persists not only in the housing and labor markets, but also in the health care, education, media, and criminal justice systems. In each system, racial minorities face barriers at multiple stages. In health care, for instance, they may have less comprehensive insurance coverage (partly due to policies that “statistically discriminate” against them), less access to care, poorer quality care, higher prices, and fewer referrals (Institute of Medicine, 2003). In the specific case of cardiac arrest, blacks, compared to whites, are less likely to have CPR attempted by a bystander, less likely to be admitted to a hospital, and less likely to receive the necessary treatment once they are in a hospital (Becker et al, 1993). The implications of these processes for racial/ethnic economic and health disparities are profound. More research is needed to trace (1) how racism at each stage of the health care, criminal justice and other such systems undermines the health of race/ethnic minorities, and (2) how these various systems mutually interact, e.g., how discrimination in education affects labor market outcomes; how poor labor market outcomes affect health; how poor health increases insurance premiums, making it more difficult to access healthcare; and so forth.

Finally, it is crucial to understand why, even after controlling for economic inequalities, racial/ethnic health disparities remain in this country. Why, for example, do blacks have worse average health than whites at the *same* socio-economic level? Contrary to popular opinion, there is no convincing evidence that genetic differences explain the racial/ethnic health gap – first because “race” is not a meaningful biological construct

(Dressler et al, 2005). Similarly, health behaviors, such as diet, exercise and alcohol use, while important for health, explain little of the racial/ethnic health gap. What does help explain the gap that remains after controlling for economic inequities is self-reported racism. A recent review of 138 studies by Paradies (2006:895) concludes "there is an association between self-reported racism and ill health after adjustment for a range of commonly measured confounders" and the strongest and most reliable association is between racism and poor mental health. Acute and chronic experiences of racism not only inflict material deprivation, poor living and working conditions, but also directly trigger stress responses, which may induce mental distress, elevated blood pressure, unhealthy coping patterns (i.e., substance use), and general physiological "wear and tear." More research is needed to clarify how specific types of discrimination (which vary in intensity, duration, perpetrator, etc.) affect specific physiological systems (i.e., cardiovascular, neuroendocrine, immune). Nevertheless, it is clear that the emotional turmoil resulting from racism can alter biological processes and behavior patterns (Williams, 2003). As Krieger (2000:65) explains:

> Perceiving or anticipating racial discrimination provokes fear and anger; the physiology of fear ("fight-or-flight" response) mobilizes lipids and glucose to increase energy supplies and sensory vigilance and also produces transient elevations of blood pressure; chronic triggering of these physiologic pathways leads to sustained hypertension.

To alleviate the anxiety and depression triggered by racism, some may turn to cigarettes, alcohol, or other substances. This often reduces stress in the short run but may lead to fatal overdoses or addictions that undermine long-term health and life expectancy.

Discriminatory treatment also may result in internalized racism, depleting stigmatized groups' sense of control and self-worth. Fanon (1952) eloquently describes how European colonialism and US slavery convinced many blacks to hate themselves and their race and to either accept their subordinate position or strive to be "white" in their language, clothing, and ways of thinking and being. Similarly, Churchill (2004: 27) illustrates how, under 19th and 20th century US federal policy, American Indian children were forcibly removed from their families and sent to residential schools where they were forbidden to speak their native tongues or practice their spiritual traditions, proselytized with Christian doctrine, and taught that white men conquered "the forces of evil" and founded the United States to spread liberty and justice. Survivors of these schools, many of which were not closed until the 1970s, often struggle with post-traumatic stress and related issues. On a subtler note, Steele (1997) shows how racial minorities sometimes are constrained to confirm the stereotypes that others impose upon them. For instance, if black college students are reminded of their race before taking a standardized test, they perform worse than their white counterparts; if they are not reminded of their race, there is no significant difference in test performance. Steele theorizes that the race cue reminds blacks of negative stereotypes they've internalized about their group's academic abilities; this evokes anxiety, which lowers performance and results in a self-fulfilling prophecy.

The cumulative effects of acute and chronic racism and the associated mental distress may be increased "allostatic load" or accelerated aging. Physical signs include decreased cell-mediated immunity, an inability to shut off cortisol in response to stress,

less heart rate variability, excessive epinephrine levels, a high waist-to-hip ratio, smaller hippocampus, poorer memory, high plasma fibrinogen, and hypertension – all of which increases the risk of premature death (Taylor, 2003: 187).

In addition to detrimental health effects for racialized groups, some of the costs of discrimination extend to non-racialized groups. As a recent Swedish report puts it:

> Discrimination has negative consequences in the form of greater ill-health and higher costs for society as a result of absence from work due to ill-health, increased demands on health-care services, and an unutilised labour-force reserve. (National Institute of Public Health, 2006: 7)

Thus, although the precise impact of institutional, interpersonal, and internalized racism may be challenging to measure, the historical and contemporary experience of discrimination has had a dramatic impact on the health and well-being of racial/ethnic minorities in the US. Whether it occurs in the streets, offices, courtrooms, media, banks, schools, or hospitals, and whether or not it is consciously perceived, racial/ethnic discrimination continues to generate health inequities both directly and indirectly through the associated political and economic injustices. Perhaps the one saving gracing is that it has motivated some to fight back and reclaim their dignity.

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References

Becker, L.B., B.H. Han, P.M. Meyer, F.A. Wright, K.V. Rhodes, D.W. Smith, and J. Barrett. 1993. "Racial Differences in Cardiac Arrest and Subsequent Survival." *New England Journal of Medicine 329*: 600-606.

Blank, Rebecca M., Marilyn Dabady, and Constance F. Citro. 2004. *Measuring Racial Discrimination*. Washington, DC: National Academies Press.

Bowles, Samuel, Herbert Gintis, and Melissa Osborne Groves. 2005. *Unequal Chances:Family Background and Economic Success*. Princeton, NJ: Princeton University Press.

Churchill, Ward. 2004. *Kill the Indian, Save the Man: The Genocidal Impact of American Indian Residential Schools*. San Francisco: City Lights.

Dressler, W.W., K.S. Oths, and C.C. Gravlee. 2005. "Race and Ethnicity in Public Health Research: Models to Explain Health Disparities." *Annual Review of Anthropology 34*: 231-52.

Fanon, Frantz. 1952. *Black Skin, White Masks*. New York: Grove Press.

Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Washington, DC: National Academies Press.

Krieger, Nancy. 2000. "Discrimination and Health." Pp. 36-75 in *Social Epidemiology*, edited by Lisa F. Berkman and Ichiro Kawachi. New York: Oxford University Press.

LaVeist, T.A. 1992. “The Political Empowerment and Health Status of African-Americans: Mapping a New Territory.” *American Journal of Sociology 97*: 1080-95.

Massey, Douglas, and Nancy Denton. 1993. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge, MA: Harvard University Press.

National Institute of Public Health, Office of the Ombudsman against Ethnic Discrimination, Office of the Disability Ombudsman, and Office of the Ombudsman against Discrimination on the Grounds of Sexual Orientation. 2006. *Discrimination: A Threat to Public Health*. Stockholm, Sweden.

Neckerman, Kathryn M., and Joleen Kirschenman. 1991. “Hiring Strategies, Racial Bias, and Inner-City Workers.” *Social Problems 38*(4): 433-447.

Oliver, Melvin L., and Thomas M. Shapiro. 1997. *Black Wealth, White Wealth: A New Perspective on Racial Inequality*. London: Routledge.

Paradies, Yin. 2006. “A Systematic Review of Empirical Research on Self-Reported Racism and Health.” *International Journal of Epidemiology 35*: 888-901.

Steele, Claude M. 1997. “A Threat in the Air: How Stereotypes Shape Intellectual Identity and Performance.” *American Psychologist 52*: 613-629.

Taylor, Shelley E. 2003. *Health Psychology*. New York: McGraw-Hill.

Williams D.R. and C. Collins. 1995. “US Socioeconomic and Racial Differences in Health: Patterns and Explanations.” *Annual Review of Sociology 21*: 349–386.

Williams, D.R., H.W. Neighbors, and J.J. Jackson. 2003. “Racial/Ethnic Discrimination and Health: Findings from Community Studies.” *American Journal of Public Health 93*: 200-208.

Wilson, William Julius. 1996. *When Work Disappears: The World of the New Urban Poor*. New York: Vintage Books.