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Perspective

Racism and Health: Three Core Principles

JAMILA MICHENER* and TIFFANY N. FORD†,‡

*Cornell University; †Brookings Institution; ‡University of Illinois at Chicago

Policy Points:

- Racism operates in conjunction with interlocking forms of oppression, so it must be addressed relationally.
- Racism catalyzes processes of cumulative disadvantage as it extends across multiple policy domains along the life course, so it necessitates multifaceted policy solutions.
- Racism is a function of power relations, so the redistribution of power is a necessary precursor to health equity.

Keywords: racism, health equity, power, interlocking oppression, intersectionality.

Profound racial inequities were entrenched in crucial domains of American life long before COVID-19. In the wake of the pandemic, these preexisting disparities deepened. Housing offers an arresting example. In 2019, just before the onset of the pandemic, 46% of renter households were paying more than 30% of their income toward rent, and nearly a quarter were spending more than half their income on housing.[1] Black and Latinx renters were hit hardest: 54% of Black renters and 52% of Latinx renters were cost burdened (i.e., spending disproportionate shares of their income on rent) compared with 42% of White renters.[1] The pandemic exacerbated the financial struggles of renters. By September 2020, 9.7% of Black renter households and 8.7% of Latinx households (compared with 4.4% of White renter households) reported that they were "very likely" to be evicted in the next two months.[2] By March 2021, one year after the COVID-19 pandemic was declared a national emergency in the United States, roughly

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29% of Black renters and 21% of Latinx renters had fallen behind on rent compared with 11% of White renters.[1]

Similar dynamics unfolded across many domains. COVID-19 aggravated prepandemic racial chasms in arenas as varied as education, employment, nutrition, wealth, and health.[3–8]Even as such gulfs were widening, the murder of George Floyd by Minneapolis police officers sparked historic nationwide (and global) uprisings against racial violence.[9] This confluence of catastrophes brought racism to the forefront of American life. In response, health scholars and practitioners grappled more keenly with the health implications of racism. Many incisive essays and articles centered on the connections between racism and health.[10–22] Even with this established and growing corpus of important research, the task of integrating theoretically nuanced and empirically grounded perspectives on racism into our understandings of health remains a work in progress. This essay contributes to the effort by elaborating three core principles. First, racism operates in conjunction with other forms of oppression. Second, racism extends across multiple policy domains, catalyzing cascades of disadvantage along the life course . Third, racism is a function of power relations. In the sections to follow, we explicate the logic and evidence undergirding these observations, and highlight their implications for research, practice, and policymaking.

Defining Racism

We define racism as "the interconnected social, political, economic, and ideological systems that create, maintain, and exacerbate stratification in access to opportunities and resources based on a group's or individual's location in a socially constructed racial hierarchy."[18,23] Racism is systemic. It is not primarily a function of individual prejudices or interpersonal acts of discrimination (although these perpetuate it). Instead, racism is "produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic system."[11] This system embeddedness implicates racism as a set of processes.

Scholars often think about "race" in terms of unequal outcomes (e.g., putatively racial differences in rates of mortality, diabetes, health insurance coverage, etc.). Yet, approaches that spotlight disparities in outcomes often risk reifying and naturalizing "racial" difference.[24]

Shifting from treating "race" as a demographic category correlated with disparities to centering on racism as a set of processesthat creates disparities, moves us beyond the (still important) task of chronicling inequity and toward the vital work of identifying the structural changes necessary to erode and eradicate it.[25] This approach requires building knowledge of how racism relates to other processes of oppression (e.g., gendered racism), how it compounds across interconnected policy domains, and how it is upheld by relations of power. We address these matters (in turn) below.

Racism and Interlocking Systems of Oppression

Health equity "means that everyone has a fair and just opportunity to be as healthy as possible."[26] Pursuing this goal requires contending with racism.[27] Crucially, racism operates alongside interlocking structural forces.[28] Because racism is not a freestanding or isolated phenomena, addressing it entails recognizing and confronting simultaneous systems of oppression.

Although day-to-day life in the United States is teeming with examples of how racism works in conjunction with other structural determinants of health, chattel slavery serves as an early and poignant example. Enslaved Black people were stripped of all rights, treated as the property of elite White overseers, and policed by working-class White people.[29,30] Nonetheless, racism did not singularly structure the lives of enslaved people. Patriarchy was a cooccurring form of oppression that channeled and exacerbated racism in the context of enslavement. For example, controlling the fertility of enslaved Black women and the sexuality of affluent White women were both key to ensuring that the institution of slavery remained viable.[31] For enslaved Black women, this domination was institutionalized via legal frameworks, such as hereditary slave laws, that ensured their children would be born into slavery, maintaining the population of enslaved Black workers.[32] For affluent White women, this domination was protective of their children, as all economic resources would be passed onto any legitimate heir of thetitular slave owner (i.e., affluent White men).[31] Systems of enslavement based on patriarchy thus worked in conjunction with racism to structure experiences and inequalities.[33]

This is just one of many examples. Frameworks such as structural sexism, intersectionality, gendered racism, and related concepts[34] usefully direct our attention toward numerous historical and present-day dynamics of interlocking oppression. Structural sexism, discussed in detail in this issue,[35] refers to systematic exclusion from resources, power, and institutions because of one's gender. Intersectionality, a framework rooted in Black women's experiences, draws attention to the divides in race and gender scholarship, encouraging an understanding of how systems of oppression related to social markers—such as race, gender, sexuality, or class—operate as interacting and mutually constitutive phenomena that shape complex inequalities.[36–41] Gendered racism was originally developed as an analytical frame that captures the ways racialized and gendered oppression uniquely affects Black women.[42] Importantly, however, gender is not synonymous with women.[43] As such, the broadest conceptualization of gendered racism recognizes how racism operates in gender-specific ways.[44]

All of the abovementioned frameworks inform a fundamental insight for research and action on racism and health: racism does not operate in the absence of sexism.[44] Instead, these forces and others act together to structure people's lives.[45] For example, people who are racialized as Black and gendered as men experience some of the worst health and economic outcomes in the United States.[46–48] Inequities in life expectancy, labor market experience, and health care access point to the ways gendered racism operates in the lives of Black men. Black men's lives are 7.6 years shorter than non-Hispanic Black women and 7 years shorter than non-Hispanic White men.[49] At the same time, Black men's unemployment rate has been roughly double White men's since 1972 (the earliest year this metric was publicly available by race and gender simultaneously) and overtook Black women's unemployment in the late 1980s.[50] Black men experienced consistent hiring discrimination before and during the early COVID-19 pandemic,[51] likely the legacy of gendered and racist stereotypes about Black men as threatening and dangerous in the workplace.[52] Given that employment-based insurance is the most common health insurance type in the United States, it should come as no surprise that Black men are less likely to access health care than White men or any group of women and that they are 75% less likely to have health insurance than White men.[47,53] Racialized and gendered oppression create disadvantage in the labor market and constrain health care resources. These and other processes of gendered racism operate in the lives of Black men, contributing to their shortened life span.

Gendered oppression is not the only structural force that intersects with racism across multiplicative categories of difference. Many forms of oppression (e.g., ageism, sizeism, ableism, homophobia, etc.) operate in relation to racism, conveying and perpetuating its effects. For example, after an extended chokehold, the officers who murdered Eric Garner in 2014 are on record making disparaging comments about his body size and assumed level of health.[54] One officer remarked "What choke hold? You mean the attempted 'Carotid Restraint Hold' that lasted for seven seconds on 'Fatso' the walking heart attack. He killed himself by getting so worked up over refusing to follow simple and lawful commands."[54] The callousness in this comment demonstrates the disposability so often associated with anti-Black racism in the United States, but also antifat sentiment, which contributes to poor outcomes for fat people in this nation.[55] As Da'Shaun Harrison, author of *Belly of the Beast: The Politics of Anti-Fatness as Anti-Blackness*, put it, "the Belly—or fatness—is yet another reason for why the Beast—or the Black—can and will never have access to health."[55] [Indent to start new paragraph here] Sizeism, ableism, sexism, and other forms of structural inequality operate in conjunction with racism to create complex and potentially unexpected social realities. Given this, when scholars examine dimensions of the health–racism nexus, they must interrogate how racism and other forms of oppression work together in ways that are relevant to the phenomenon of interest. Correspondingly, when policymakers and other change agents take action to address racism in the context of health, they must be aware of and responsive to interlocking processes of oppression, lest they miss opportunities to design and target their efforts most effectively.

Racism and Cumulative Disadvantage

Racism unfolds across cascading domains of policy throughout the life course. Social scientists have amassed ample evidence of racism playing a role in a wide variety of policy arenas including child welfare, public assistance, banking, incarceration, employment, housing, and more.[56–63] Researchers often study these domains discretely, unearthing the distinct ways each one defines the trajectories of racially marginalized populations. Policymakers often address them separately, tackling one problem at a time. However, people and communities experience these policy arenas as overlapping aspects of daily life.[64] What happens

in one policy venue has implications across multiple domains. Moreover, exposure to racism follows individuals over time, changing in nature, importance, and intensity at different points in life.[65] Concepts like "weathering" direct attention to how disadvantage beginning early in life can be amplified over time as a result of repeatedly experiencing social, economic, and political marginalization.[66,67] In this way, racial inequity becomes entrenched through processes of cumulative disadvantage along the life course. The phenomenon of accumulation is also relevant across policy domains. Structural biases that emerge in one area of policy often systematically spillover into others, generating cascading harm in racially marginalized communities. As Ann Chih Lin and David Harris assert, "the implication of cumulative disadvantage is that racial disparities yield only slowly to overall improvement in equality, because any remaining disadvantages increase one's vulnerability to other disadvantages."[68]

Medicaid work requirements are an apt example of a policy that multipliesdisadvantage across policy domains and life stages. Beginning in 2018, the Trump administration approved Section 1115 waivers making Medicaid coverage contingent on meeting work and reporting requirements.[69] Subsequently, 13 states received approval for waivers containing work requirements. In 2021, the Biden administration issued withdrawals to states with approved work requirements.[69] Notwithstanding this political ebb and flow, work requirements have public support and remain a perennial policy issue.[70] They also have racist origins and produce racially disparate outcomes.[71,72] Building on this knowledge, it is striking to consider the ways that work requirements reflect processes of cumulative racial disadvantage.

Most directly, work requirements deepen the detrimental consequences of racial disadvantage in labor markets. A well-established body of research has demonstrated racial discrimination in labor markets, particularly among low-wage Black and Latinx workers.[63,73,74] When working-age (i.e., 18–64 years old) Medicaid beneficiaries are mandated to adhere to work requirements, Black and Latinx people will have more significant barriers to complying given the continued reality of racial discrimination in hiring.

Compounding racial inequities, labor market outcomes are also significantly worse for people with criminal records.[75]Moreover, in large part because of racism, Black and Latino men are substantially more likely to be incarcerated in their lifetimes.[30,76–79] As a result, they expe-

rience weakened employment prospects.[75,80] Indeed, even when information about criminal records is withheld (e.g., "ban the box" policies), racialized stereotypes about Black male criminality can lead employers to treat Black men that do not have criminal records as though they do, further exacerbating the labor market penalties that stem from racism.[81]

The cascade of disadvantage does not end there. Experiences with both the criminal legal system and the labor market are conditioned by neighborhood context. Residents of low-income, racially segregated neighborhoods are more likely to have contact with the criminal legal system and more frequently experience joblessness.[82–85] In these and other ways, "the cumulative operation of disadvantage and the close connection between race and vulnerability" trigger dominoes of disadvantage that ultimately make work requirements disproportionally deleterious for Black and Latinx Medicaid beneficiaries.[68] Living in racially segregated neighborhoods predisposes Black and Latinx people to criminal legal contact and dampens their likelihood of employment. A criminal record further diminishes prospects for employment. Even without a criminal record, racism in the labor market hinders chances for finding gainful work–and with such a record, it intensifies the problem. Through these connected processes in the labor, legal, and housing domains, employment becomes less accessible to Black and Latinx denizens. Given this context, tethering employment to health insurance via work requirements proliferates the policy domains that act as a conduit for racism. Understanding racism in health compels close attention to the processes by which racial disadvantage accumulates across spheres of life. Similarly, addressing racism through policy and practice requires action that deliberately disrupts ongoing processes of cumulative racial disadvantage.

Racism and Power

One of the most prevalent contemporary tenets about "race" holds that it is a social construct rather than a biological fact. This rendering of race is meant to undercut racial essentialism and biological determinism, which together assert "the biologically extant reality of race alongside the contention that different racial groups possess different traits and characteristics that…result in racially varied social outcomes."[86] Notwithstanding the widespread rejection of racial essentialism, it is still

common for scholars to study "race" as if it is an essential human characteristic that exerts an independent influence over social and economic outcomes.[87] But "race" does not innately or inherently influence health outcomes. Instead, racism is a bundle of processes that operate through social, economic, and political systems. The varied elements of "race"—including unequal health outcomes across groups that are socially defined in terms of racial categories—are "forged and challenged in historical and present-day struggles over power" that are part and parcel of the processes of racism.[88] Put most straightforwardly, "race" is produced, and racism is enacted via complex relations of power. It is not possible to make sense of "race"—to grasp its meaning, grapple with its history, or account for its enduring significance—without attending to power.[87]

Power has been theorized across vast and varied scholarly terrain.[89–93] We follow Rosino[94] in defining political power as "the capacity to influence social and structural conditions…the capacity for political action through the state and political sphere." More specifically, we draw two insights from Rosino's theorization of the racialized dynamics of power.[94] First, Rosino describes such dynamics as dually characterized by both *boundaries* and *barriers*[94]:

> Boundaries restrict groups from benefitting from the state via the construction of categories and the distribution of resources and penalties according to those categories. Barriers, on the other hand, restrict groups from influencing the state via the enactment of rules and structures that constrain and enable participation in political life.

Again, the example of Medicaid work requirements is instructive. Scholars have usefully charted the negative and racially disparate effects of Medicaid work requirements.[95,96] Work requirements are a state erected boundary that disproportionately restricts Black Americans from access to a vital benefit. Notably, such boundaries can create barriers to political inclusion. A substantial body of research suggests that experiences with Medicaid affect political participation.[97–101] More generous and expansionary Medicaid policies draw people into the political process, whereas more restrictive and punitive policies alienate people from political engagement.[98,99,101] Given this evidence, Medicaid work requirements are both a boundary (cutting off access to health insurance) and a barrier (constraining participation in political life). Health scholars too often focus exclusively or disproportionately

on the former while paying insufficient attention to the latter.[18] Taking power seriously means considering both.

The second insight we draw from Rosino underscores the political agency of racially marginalized populations: "the state and political sphere are not simply institutional mechanisms for reinforcing domination and oppression; they are also sites of contestation."[94] This observation is crucial for avoiding a deficit-based framing of racism and health. Such a frame focuses exclusively on the health resources that communities of color *lack*, the disadvantages they are burdened with, and the processes that disempower them. Although such emphases reflect important realities, they only depict one dimension of health–racism power dynamics. Power is constantly contested. Racially marginalized communities have a long and storied history of struggling for the power to transform their lives and health.[102–106] Scholars, policymakers, and advocates who are oriented toward change should assess processes of racism with an eye toward the power resources and political assets of racially marginalized populations.

There is an important and growing corpus of research focused on the politics of health and health policy.[18,101,104,107–114] Still, a comparatively small subset of work directly attends to power.[107,109,115,116] Research on racism and health equity stands to benefit from more consistently and thoroughly incorporating analyses of power. Attentiveness to racialized power relations as a structural determinant of health means examining the role of the state in enforcing boundaries and erecting barriers that shape both health and political voice across racialized groups.

Implications for Policy and Change

The key points in this piece call for engagement in research and policymaking processes that attend to (1) overlapping systems of oppression, (2) multiple policy domains along the life course, and (3) redistribution of power resources. With these principles in view, we conclude with thoughts on how researchers, health advocates, social movement organizations, government, and funders might advance health equity. We do not propose specific policies (e.g., expand Medicaid in all states, permanently eliminate work requirements for social policies). Instead, we offer insights on how to structure the processes for determining policy priorities and pursuing transformative change. Among the principles we have

laid out above, we are most emphaticabout the redistribution of power. We stress power because we believe that when the people most affected by health inequity have the capacity to shape policy processes, their lived experiences and tangible needs will point to the realities of racism that we delineate above (e.g., placing racism within overlapping systems of oppression, naming the multiple domains along which racism operates).

Build and Share Power

Research and policymaking for health equity must support power building and power sharing by reconfiguring power relationships to center the voices of racially marginalized people.[87,117] There is a storied and traumatic history of race-class subjugated people and communities being "included" in everything from health research to housing policy on harmful and predatory terms.[118,119] Notwithstanding blatant examples of racism in research and policy, even well-intentioned efforts to partner with marginalized people can become exploitative if there are insufficient resources available to do so ethically. For example, when asking a low-income person to participate in research or provide public testimony, the researcher or advocate might inadvertently be asking that person to incur the cost of travel to the location and childcare during the session alongside potentially uncompensated time off work, even if the person is being compensated for their time during the session. To forfend against the unequal costs of participation in research, policymaking, and participatory processes, some states are considering how they might more equitably engage with marginalized communities. In 2022, Washington State legislators passed a bill that aims to increase the participation of people with lived experience on boards, commissions, councils, committees, and other groups by allowing low-income and underrepresented community members to be compensated for their participation and related expenses.[120] Section 1 of the bill reads as follows[120]:

> The legislature finds that equitable public policy discussions should include individuals directly impacted by that policy. In order to do so, the legislature supports removing barriers to that participation. The legislature finds that asking community members with lower financial means to volunteer their time and expertise while state employees and representatives of advocacy organizations receive compensation from their respective agency or organization for their time and experience ultimately hinders full and open public participation. As a result, the legislature finds that removing financial barriers for those

> individuals fosters increased access to government and enriches public policy discussions and decisions, ultimately leading to more equitable and sustainable policy outcomes.

The bill includes a stipend of up to $200 per day as well as expenses to cover travel, lodging, and child/elder care. Minimizing the burden of participation in research and political life for marginalized people and further institutionalizing these efforts helps to ensure that the most impacted communities are placed at the center of the health research and policymaking processes.

Work Collaboratively

The programs and systems designed to help people meet their social needs are largely isolated from those designed to meet health needs, despite the evidence that social factors play a critical role in health outcomes.[121] Because racism accumulates across various life domains, health researchers and practitioners must be intentional about working outside of existing silos to address systemic inequality in health along the life course. This may mean engaging in collaborations that bring people together from distinct disciplines (e.g., public health, public policy, urban planning), across sectors (e.g., academia, government, movement organizations), and with varying capabilities (e.g., public writing, direct action, community organizing, legislative agenda setting). Such multisectoral collaboratives must center actors, institutions, and networks that are chronically excluded from policymaking efforts.[117] Put most broadly, addressing racism in health should not only be oriented toward "reducing disparities" but should place priority on shifting existing power dynamics through people-powered collaboratives and coalitions that position people frommarginalized communities to exert control over the outcomes that shape their own lives.

It is worth noting that efforts to advance change that include a wide range of actors and institutions are bound to face conflicts and tensions around funding, organizational practices, communication, values, and more.[122] For example, philanthropic or government funding mechanisms that require money to be spent on specific populations in explicit ways to produce strictly circumscribed "deliverables" within narrow time horizons can limit the scope of possibilities for change, undermine the ability to experiment and learn from failure, exclude the most marginalized and stigmatized populations, and undermine power

building processes that unfold in complex ways over long time frames. Additionally, administrative rules that prohibit health programs from using government issued funds to address nonmedical services limits the innovation that could be generated by having non–health actors at the table.[123] To better encourage collaboration, government agencies and other funders invested in addressing racial inequality in health should consider requests for proposals that fund multiyear efforts with more flexible interventions. Most critically, they should cede substantial decision-making power to the people and communities most affected by racial health inequities to ensure that they can determine what should be funded, for how long, and in relation to what kinds of outputs/outcomes.

Acknowledge and Measure Heterogeneity

Data and measurement are another key arena in assessing and addressing racism in health. In another essay in this issue, Ponce and colleagues argue that data equity is essential to health equity.[124] They define data equity as the process and outcome of allowing marginalized community members to "shape how data are collected, analyzed, interpreted and distributed such that is meaningful and can be easily accessed by and for their communities."[124] This process rightfully centers the voices of oppressed people in defining appropriate metrics to capture essential research constructs, developing research questions that uncover how inequality operates, and guiding ethical data collection and data use strategies. Complementing this, we add that capturing the ways racism operates in conjunction with interlocking forms of oppression in society also requires attentiveness to the heterogeneity within broad racial categories.[18] In bringing together data on the diverse health experiences of racialized people—data that should be both quantitative and qualitative in nature—health scholars and practitioners must better see and communicate the interconnectedness of heterogeneous experiences.[39]

Conclusion

The health–racism nexus is (rightly) impossible to ignore. But centering racism in research on health involves more than adding "race" variables to statistical models, examining subgroup heterogeneity, or even systematically charting racial inequities. All these things matter. But

none are sufficient. Carefully grappling with racism in relation to health requires process-oriented thinking about how racism works in the world. We offer three insights to that end. We emphasize (1) how racism operates across multiple interlocking systems of oppressions, (2) how its repercussions build across numerous cumulative policy spheres across the life course, and (3) how the structures maintaining it (e.g., policies, rules, regulations, norms, ideas) are a function of power relations. We surface these principles to advance the imperative of crafting more thoughtful, resonant, and impactful research and policy on health and racism. We implore scholars, policymakers, and other change agents to integrate these principles into their analyses and practices.

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Address correspondence to: Jamila Michener, 123 Central Ave, 214 White Hall, Ithaca, NY 14850 (email: jm2362@cornell.edu).