EDITORIALS

Investigating the Role of Racial/Ethnic Bias in Health Outcomes

Although legalized segregation and discrimination have been eliminated in the United States, bias against people of color exists in many sectors of our society. Discrimination based on race/ethnicity is detrimental to the individuals who experience discrimination as well as to society at large. It has also been suggested that there are serious mental and physical health consequences for people who routinely live with discrimination.[1–3] However, the scientific evidence underlying these beliefs needs to be carefully examined to determine the weight of the evidence and where gaps exist.

Toward this end, in April 2002 the Office of Behavioral and Social Sciences Research of the National Institutes of Health convened a meeting of approximately 100 leading scientists to present scientific evidence of the effects of racial/ethnic bias on health and to identify areas for future research to further explicate the relationship. We intentionally chose the term "racial/ethnic bias" instead of "racism" to reflect our desire to address a wide range of types of discrimination that may affect health, including bias against populations that do not define themselves based on race. The Office of Behavioral and Social Sciences Research and its 3 cochairs (James Jackson, David Williams, and Nancy Krieger) designed the conference to consider the historical and contextual factors relating to racial/ethnic bias in the United States today, and the evidence relating various forms of bias and the well-documented disparities in health that are found among the various racial/ethnic groups in US society. One panel examined pathways through which racial/ethnic prejudice acts on the individual, creating a psychophysiological response that can ultimately result in a negative health outcome. Another panel examined how racism and ethnic prejudice operate within the structures of our society to produce inequalities in employment, housing, and the environment that may translate into differential health outcomes among diverse racial/ethnic populations. Special emphasis was given to racial/ethnic bias in the medical care system, an area in which it has been repeatedly demonstrated that certain racial/ethnic minority patients receive diagnoses and treatment recommendations differing from those for similar White patients.[4] This issue of the Journal presents the conference papers.

WHY STUDY RACIAL/ETHNIC BIAS?

Reducing or eliminating the disparities in health found among the various racial/ethnic groups in the United States has become a priority of the National Institutes of Health and the Department of Health and Human Services. Any effort to eliminate health disparities will be hindered by an incomplete understanding of the social context of the individuals. Because of societal racial/ethnic relations, past and present, an individual's race/ethnicity has an impact on all aspects of social and economic life, leading to different sets of opportunities for housing, education, employment, and health care, to name a few of the social institutions affected.[5] Although biased policies of major societal institutions affect the opportunities available to both individuals and communities, perceptions and experiences of racial/ethnic bias leading to unfair treatment can result in personal negative emotional and stress responses, which in turn have been shown to be related to hypertension, cardiovascular disease, mental health, and other negative states of health.[3,6,7] The ways in which racial/ethnic bias can affect health range from limits on access to quality medical care and economic deprivation to the physiological responses to the experience of chronic discrimination and to inequitable exposures to occupational and environmental hazards.

WHAT CAN BE DONE?

Some people have questioned the benefit of studying racial/ethnic bias with respect to health, perhaps because of the belief that dramatic social change is necessary to produce any positive results. Clearly, considerable social change has already occurred, with legal and broad societal and cultural changes over the past 40 years making segregation illegal and expanding the scope and enforcement of civil rights. Of course, a change in legislation does not automatically produce a change in ideology or resultant behaviors. Changing the

attitudes and beliefs of the population is a long and difficult process. However, there is evidence that change is occurring and that there is greater acceptance of diverse groups within American society.[3]

Attitudes, beliefs, and behaviors are amenable to change through interventions. The variety of evidence demonstrating the differences in health services offered and provided to patients of color suggests that the training of health care professionals may be an important avenue for intervention.[4] Additionally, patients can be trained to have a more effective doctor-patient interaction. Some research has suggested that Black and economically disadvantaged patients benefit by increased assertiveness in their interactions with physicians.[8]

Waiting for societal change, even change hastened through intervention, is not the only option for members of racial/ethnic groups who live within a discriminatory society. Research has pointed to possible areas for intervention. A strong sense of racial/ethnic identity and self-worth may have a protective effect against perceptions of racism/ethnic prejudice and the stress that results.[9] To the extent that racism/ethnic prejudice is a major source of stress, individuals can be taught stress-reduction techniques and to draw on the strength of their communities.[10] Moreover, to the extent that research provides insight into the additional physical and economic pathways by which racism/ethnic prejudice harms health (e.g., via residential and occupational segregation), it will generate evidence necessary for informed action and policy change to reduce—and ultimately eliminate—racial/ethnic disparities in health.

CONCLUSION

The conference showcased the high quality of research that is currently examining the relationship between racial/ethnic bias and health. It also pointed to the many areas that are in need of further development. The vast majority of empirical research on prejudice and discrimination has been conducted among African Americans. Few studies have systematically addressed how prejudice and discrimination affect other racial/ethnic minority groups such as Native Americans, Asian Americans, and Latinos. Racial/ethnic bias has affected the social position of each racial/ethnic group in the United States, and thus bias may have unique associations with health for each group.

The case for intervening to prevent or ameliorate the effects of racial/ethnic bias on physical and mental health outcomes will be strengthened by continued research on racism/ethnic prejudice. We need to be able to better characterize such prejudice, understand how it operates within society and affects health. New and improved methods and measurements will help advance the field of study. Although several areas have been suggested as possible points of intervention, there is a clear need for development and testing of evidence-based interventions. Finally, training is crucial for students and young investigators, as well as for more senior scientists, who wish to embark on a program of research examining health disparities and the role that racial/ethnic bias may play in disparate health outcomes.

The papers presented at the conference, and the subsequent workshop discussions with the participants, resulted in some clear directions for a program of research to expand our understanding of the effects of racial/ethnic bias on health and to develop interventions to prevent racism/ethnic prejudice and ways of implementing effective strategies for coping with their deleterious effects. ■

Virginia S. Cain, PhD,
Raynard S. Kington, MD, PhD

About the Authors

The authors are with the Office of Behavioral and Social Sciences Research, National Institutes of Health, Bethesda, Md.

Requests for reprints should be sent to Virginia S. Cain, PhD, deputy director, Office of Behavioral and Social Sciences Research, National Institutes of Health, 1 Center Dr, Bldg 1, Room 256, Bethesda, MD 20892 (e-mail: virginia_cain@nih.gov).

This editorial was accepted November 26, 2002.

References

1. Krieger N, Rowley DL, Herman AS, Avery B, Phillips MT. Racism, sexism, and social class: implications for studies of health, disease, and well-being. *Am J Prev Med.* 1993;9(suppl 6):82–122.

2. LaVeist TA. Why we should continue to study race . . . but do a better job: an essay on race, racism and health. *Ethn Dis.* 1996;6:21–29.

3. Williams DR, Williams-Morris R. Racism and mental health: the African American experience. *Ethn Dis.* 2000;5;243–268.

4. van Ryn M. Research on the provider contribution to race/ethnicity disparities in medical care. *Ethn Health.* 2002;40(suppl 1);140–151.

5. Jaynes GD, Williams Jr RM. *A Common Destiny: Blacks and American Society.* Washington, DC: National Academy Press; 1989:71–100.

6. Finch BK, Hummer RA, Kolody B, Vega WA. The role of discrimination and acculturative stress in the physical health of Mexican-origin adults. *Hisp J Behav Sci.* 2001;23;399–429.

7. Karlsen S, Nazroo JY. Relation between racial discrimination, social class, and health among ethnic minority groups. *Am J Public Health.* 2002;92:624–631.

8. Krupat E, Irish JT, Kasten LE, et al. Patient assertiveness and physician decision-making among older breast cancer patients. *Soc Sci Med.* 1999;49;449–457.

9. Williams DR, Spencer MS, Jackson JS. Race, stress and physical health: the role of group-identity. In: Contrada RJ, Ashmore RD, eds. *Self, Social Identity and Physical Health: Interdisciplinary Explorations.* New York: Oxford University Press, 1999:71–100.

10. Bowen-Reid TL, Harrell JP. Racist experiences and health outcomes: An deaminization of spirituality as a buffer. *J Black Psychol.* 2002;28;18–36.