The Lived Experience of Race and Its Health Consequences

A growing body of research illuminates the mechanisms through which racism and discrimination influence the health status of people of color. Much of the focus of this research, however, has been on individually mediated racism (i.e., acts of discrimination and racial bias committed by White individuals against people of color).

Yet research literature provides numerous examples of how racism operates not just at individual levels, but also at internalized, institutional, and structural levels. A more comprehensive model of the lived experience of race is needed that considers the cumulative, interactive effects of different forms of racism on health over the lifespan.

Such a model must facilitate an intersectional analysis to better understand the interaction of race with gender, socioeconomic status, geography, and other factors, and should consider the negative consequences of racism for Whites. (*Am J Public Health*. 2012;102:933–935. doi:10.2105/AJPH.2011.300643)

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IN MARCH OF 2002, THE IN-stitute of Medicine (IOM) released a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* that rekindled a national debate about race and medicine. Prepared by Congressional request, the report sought to address the question of whether a patient's race matters when seeking medical care. It was well established that patients' insurance status and income determine the timeliness and quality of health care. But the question posed by Congress was even more challenging: Do patients of color receive a lower quality of health care than Whites even when access-related factors, such as insurance status and income, are comparable?

What the IOM found shocked many: An overwhelming body of evidence in the peer-reviewed literature demonstrates that many minority patients receive a lower quality of health care than Whites, even when access-related factors are controlled. These disparities are associated with poorer health outcomes, and therefore, the study committee asserted, are unacceptable. The IOM concluded that many factors are complicit in health care disparities, including policies and practices of health care systems and the legal and regulatory climate in which they operate. But the report also found strong evidence that racial bias, discrimination, stereotyping, and clinical uncertainty also play a role.[1]

In retrospect, while the report was one of many important developments in the late 1990s and in the early 2000s that focused attention on the problem of health care disparities, the public conversation that followed *Unequal Treatment* may have hindered broader understanding of how racism operates at many levels to increase risk for poor health for many people of color. News media coverage of the report's findings tended to focus on the question of whether physicians or other health care providers could be biased against minority patients, thereby obscuring the report's emphasis on the role of structural factors, such as policies and practices of health care systems, as well as the ways in which health care is financed and delivered in the United States. These structural factors directly contribute to health care disparities, in that they lead to "tiered" systems with unequal health care quality. They also indirectly contribute to disparities, in that they create many of the conditions–such as time pressures and resource constraints—that are likely to activate biases and stereotypes on the part of many actors within the system, including providers and health systems administrators.[1]

Since 2002, research has greatly expanded our understanding of how health care disparities arise. It has confirmed that many factors play a role, including patients' and providers' biases, stereotypes, attitudes, and expectations; geographic inequities in the availability and accessibility of high-quality care; and institutional and systemic issues, such as policies and practices that contribute to cultural and linguistic barriers to care.

Perhaps more importantly, a growing body of research has also increased our understanding of the array of determinants of health inequities, many being rooted in the inequitable distribution of access to political power, resources, and social status. What has emerged is a growing consensus that we must look beyond the traditional understanding of racism as largely an individually mediated phenomenon to understand the health consequences of the lived experience of race in the United States, and how race intersects with other factors such as gender, socioeconomic status, and geography.

Racism, as defined by Jones, is a system of structuring opportunity and assigning value based on phenotypic properties (i.e., skin color and hair texture associated with "race" in the United States) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and ultimately undermines the full potential of the whole society through the waste of human resources.[2]

Most Americans understand racism, however, as a "bad apple" problem: an individual with racial bias treating individuals from other racial groups poorly or in a discriminatory manner. Indeed, the research literature is replete with studies of the noxious effects of perceived racially motivated animus for the health of people of color, many of which are reviewed elsewhere in this special issue. For example, perceived race-based discrimination is positively associated with smoking among African Americans, and smokers find the experience of discrimination more stressful. Repeated subjection to race-based discrimination is associated with higher blood pressure levels and more frequent diagnoses of

hypertension.[3] In another study, Black women who reported that they had been victims of racial discrimination were 31% more likely to develop breast cancer than were those who did not report racial discrimination.[4] Experiences of racial discrimination also are associated with poor health among Asian Americans. A recent national survey of Asian Americans found that everyday discrimination was associated with a variety of health conditions, such as chronic cardiovascular, respiratory, and pain-related health issues.[5] Filipinos reported the highest level of discrimination, followed by Chinese Americans and Vietnamese Americans.

But research must also consider the broader consequences of discrimination as a determinant of health inequities. A large body of literature demonstrates that racial and ethnic minorities face persistent discrimination in housing, employment, and mortgage lending. For example, large federally sponsored audit studies—which match pairs of testers, one White and one minority, on a variety of personal characteristics, and assign equivalent "background" information—have found that racial and ethnic discrimination in housing markets remains significant and pervasive. A 2000 US Department of Housing and Urban Development study found that Whites were favored over identically qualified African Americans in 22% of rental housing test cases, and were favored over Hispanics in 26% of cases. In housing sales, Whites received favorable treatment over African Americans in 17% of tests and were favored over Hispanics in nearly 20% of housing sale tests conducted in 2000.[6] The same study also found that Asian-American testers received poorer treatment relative to White testers in 21% of tests of rental markets and 20% of housing sales markets.[7] Audit studies of employment discrimination consistently find that job applicants of color are more likely than are Whites to face unfair and discriminatory treatment. An audit study that matched African American and White college students posing as job seekers found that even White auditors who presented criminal records were more likely to receive callbacks than were African Americans who did not present criminal records.[8] These forms of discrimination have significant health consequences, given the relationship between socioeconomic status and health.[9]

Research has also illuminated how internalized racism operates to damage the self-esteem of some among stigmatized groups. Internalized racism refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves—beliefs which reinforce the superiority of Whites and devalue people of color, and which can lead to the perception of oneself as worthless and powerless.[10] For example, internalized racism among Blacks who exhibit racial prejudice toward other Blacks is positively associated with alcohol use and psychological stress.[11] Self-reported experiences of racial discrimination and the internalization of negative racial group attitudes are both found to be risk factors for cardiovascular disease among African American men, and the combination of internalizing negative beliefs about Blacks and the absence of reported racial discrimination are associated with particularly poor cardiovascular health.[12]

A significant body of research also demonstrates how racism operates at institutional and structural levels. Institutional racism results from policies, practices, and procedures of institutions that have a disproportionately negative effect on racial minorities' access to and quality of goods, services, and opportunities.[13] Structural racism results from a system of social structures that produces cumulative, durable, race-based inequalities.[14] One of the most significant examples of a form of structural racism that harms the health of people of color is residential segregation: many racial and ethnic minorities live in majority-minority communities that, on average, suffer from a disproportionate concentration of health risks (e.g., environmental degradation, an abundance of unhealthy foods, tobacco and alcohol products) and a relative lack of health-enhancing resources (e.g., geographic access to health care providers, full-service grocery stores, safe parks and recreational facilities).[15] These neighborhood factors influence health in several ways. They exert effects on both physical and mental health through conditions such as levels of crime and violence, overcrowding, and environmental exposures. Neighborhood conditions also influence health, in that they can either support or discourage healthy behaviors, such as exercise, proper nutrition, and the development of strong social supports. While some forms of segregation, such as ethnic enclaves among new immigrants, can foster positive mental health though social support, much of the residential segregation in the United States is associated with institutional discrimination in the real estate and housing finance market in addition to individual interpersonal discrimination.[16]

What's needed now is a more comprehensive and sophisticated understanding of the cumulative, interactive effects of the different forms of racism on health as they operate over the life course. Given evidence that racism operates at many levels—individual, internalized, institutional, and structural—it seems evident that these levels are unlikely to affect health in isolation or intermittently. For example, low socioeconomic status and social isolation associated with residential segregation may increase vulnerability to the negative health consequences of stress associated with the experience of racism and discrimination. And the negative health and behavioral health effects of internalized racism, constantly reinforced by examples of institutional racism, may help explain why relatively advantaged people of color are found to have poorer physical health along many measures than Whites with lower socioeconomic status.[17] Because racism and efforts to cope with its effects vary considerably in different sociocultural contexts and across developmental stages, comprehensive approaches should consider how ethnic identify and socialization may moderate these influences.[18]

Such a model must facilitate an intersectional analysis to better understand the complex dimensions of race, gender, socioeconomic status, geography, and other factors. Racism, gender and class exploitation, and other forms of oppression do not act independently of each other; rather, they act on multiple and often simultaneous levels.[19] Stresses arising from gender role strain, limited economic resources, and negative community conditions such as high levels of environmental degradation and limited nutritional options exert a toll on

human health but may be experienced more profoundly in communities of color.

More recently, public health scholars are exploring transdisciplinary methodologies, such as Critical Race Theory, to help understand and address the many forms of structural inequality and their intersectional effects on health. Ford and Airhihenbuwa, for example, offer an application of Critical Race Theory to illustrate the complex ways in which racism operates at the individual, clinical, and neighborhood levels to understand how these contexts influence African Americans' perceptions of and attitudes regarding HIV testing.[20] Similarly, Thomas et al. propose a fourth generation of health equity research, grounded in Critical Race Theory, to help develop and test multilevel interventions that address the complex interplay of race, gender, class, and other forms of oppression. They offer an example of mixed-methods quantitative and qualitative research, applied at individual and institutional levels, to address some of the challenges and complexity of evaluating comprehensive, multilevel interventions. These challenges include the difficulty of teasing out specific impacts of interventions at multiple levels. However, Thomas et al. argue that Critical Race Theory principles such as the social construction of knowledge, critical approaches, and disciplinary self-critique promote an integrated understanding of how social forces structure health in ways that avoid simplistic parsing of effects.[21]

A comprehensive model of how the lived experience of race shapes health must also consider the impact of racism on White Americans. White Americans are harmed by racism against people of color in multiple ways. Racism damages social trust and cohesion, limits the potential societal contributions of marginalized groups, and drains social resources.[10] The health consequences of racial inequality present a significant economic burden for the nation: one estimate indicates that $1.24 trillion were drained from the economy between 2003 and 2006 as a result of the higher direct medical costs and indirect costs associated with health inequalities (e.g., lost productivity and tax revenue when people are too sick to work or die prematurely).[22] And with growing evidence that inequality harms even advantaged groups, it is clear that racism has imposed health and economic burdens across all US communities. This is not to suggest that Whites do not suffer from other forms of oppression, including class exploitation, or that all Whites enjoy potential health-enhancing effects of social and economic advantage. But racism imposes a human, social, and economic cost to all in the United States. Advances in our understanding of these burdens—and more importantly, ways to ameliorate them—will therefore yield significant benefits for the US population as a whole. ■

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