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Racial inequalities in health: Framing future research

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Introduction

Substantial time and resources have been devoted to the study of racial inequalities in health. Indeed, the public health and social science literatures have documented racial inequalities across numerous health behaviors, including mental and physical health outcomes (Beck et al., 2014; Bollini & Siem, 1995; Cardoso et al., 2005; Chor, 2013; Fiscella et al., 2000; Yin Paradies et al., 2008; Smith et al., 2000; David R. Williams, 2008; David. R. Williams et al., 1997; Winkleby et al., 1998). However, empirical research examining the root sources of these inequalities is still in its infancy (Phelan & Link, 2015). While a growing literature considers the link between racism – broadly conceptualized – and health inequalities, much of this work focuses on discrimination or prejudice in interpersonal interactions as the primary driver of these inequalities (Harris et al., 2006; Krieger, 2014; Lewis et al., 2015; Priest et al., 2013; David R. Williams & Mohammed, 2009). There has been and continues to be a need for more research on cultural and structural forms of racism as fundamental drivers of racial health inequalities (Bailey et al., 2017; Dressler et al., 2005; Essed & Goldberg, 2002; Gee & Ford, 2011; Mullings, 2005; Nazroo, 2003; Phelan & Link, 2015; Viruell-Fuentes et al., 2012; David R. Williams & Mohammed, 2013).

This Special Issue on Racism and Health Inequalities provides a sample of innovative work and empirical evidence from Australia, Brazil, New Zealand, and the United States. The 23 papers in this collection encompass qualitative and quantitative methods and multiple scientific disciplines. Furthermore, they collectively underscore the potential for innovative public health research on cultural and structural racism, but also highlight a number of challenges to confront as we continue to advance scientific knowledge within this area.

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This introduction will synthesize the ways in which this collection advances understanding of the importance of cultural and structural racism for racial health inequalities. While public health scholars have also recently written on this topic (Bailey et al., 2017; Gee & Ford, 2011; Viruell-Fuentes et al., 2012), we integrate multiple social science literatures to emphasize that *all* research on racial health inequalities must be founded upon sound guiding frameworks. Specifically, we synthesize the evidence from conceptual and empirical models that: (a) indicate structural racism as the actualization of cultural racism (Dressler et al., 2005; Fassin, 2004; J. M. Jones, 1997; Lamont et al., 2014; Mullings, 2005; Silverstein, 2005); and (b) employ approaches consistent with critical race theory (Bell, 1987, 1992; Ford & Airhihenbuwa, 2010b). Because these components are crucial to yet often missing from racial health inequalities discourse, we outline two recommendations for future work that stem from these two areas of emphasis. These recommendations aim to continue and strengthen the shift from a biomedical/risk factor model that documents the health behaviors, experiences, and outcomes of marginalized racial groups, to a broad, systemic view that situates these inequalities within the social, economic, and political structures of societies that maintain the dominance of a single racial group.

We will begin with a discussion on cultural and structural racism, including our working definitions and the processes through which they are related. We will then discuss our two recommendations for future research on racial health inequalities, using arguments from papers in this collection to support them. We will conclude with a call to action for the future of racial health inequalities research that challenges scholars to move toward a "reconstruction of knowledge" (Desmond & Emirbayer, 2010) about the root causes of these inequalities to then work toward their elimination. In this introduction, we will not emphasize individual-level factors and interpersonal processes as we wish to focus on largely-missing components of the discourse in this field and therefore direct attention to cultural racism and the ways in which cultural processes may link social structure to structural racism (Dressler, 2001; Dressler et al., 2005; Fassin, 2004; Lamont et al., 2014; Silverstein, 2005; Thomas & Clarke, 2013).

Racial inequalities in health as the embodiment of cultural racism

The importance of structural racism to racial health inequalities has been described in the public health literature (Gee & Ford, 2011; Viruell-Fuentes et al., 2012). We build on this to integrate notions of cultural racism, which at once dynamically maintains structural racism over time and serves as a "cloak of invisibility" that renders racialized and racially-hierarchical structures as racially-neutral and rational (Dressler et al., 2005; Lamont et al., 2014; Silverstein, 2005). Consider the following working definition of racism that, while developed in psychology, integrates notions of sociological structure and anthropological culture. Racism refers to:

> "a system of dominance, power, and privilege based on racial group designations; rooted in the historical oppression of a group defined or perceived by dominant-group members as inferior, deviant, or undesirable; and occurring in circumstances where members of the dominant group create or accept their societal privilege by maintaining structures, ideology, values, and behavior that have the intent or effect

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> of leaving non-dominant-group members relatively excluded from power, esteem, status, and/or equal access to societal resources" (Harrell, 2000, 43).

We further specify that a society's structures (e.g., economic stratification, social networks) can be can be considered manifestations or actualizations of a society's culture. Acknowledging that there are multiple working definitions of culture, we define a society's culture broadly for our purposes as its values and belief system. A society's culture defines its shared social meanings; its culture is drawn from its history but is dynamic over time and is extrasomatic, passed through generations by learning. A society's culture influences which formal and informal institutions are created and how these institutions operate. These interrelated institutions, in turn, provide and maintain social structure and include, for example, its media, its justice, educational, economic, and political systems, and the institutions overseeing family and community formation and maintenance (Carmichael & Hamilton, 1992; Hing, 2009).

These institutions and the resulting social structure may not inherently support a racialized, racially-hierarchical society. It is through cultural racism that the values and belief system of a dominant racial group are perpetuated as the norms through which institutions are created and by which all racial groups are judged (Dressler, 2001; Dressler et al., 2005; J. M. Jones, 1997; Link & Phelan, 2001; Silverstein, 2005). Through cultural processes that adapt to spatial and temporal contexts, institutions and the social structure are created to be racialized and racially-hierarchical. Through institutional racism, organizational policies and practices (whether de jure or de facto) privilege the dominant group. Because it is often reinforced through shared cultural processes, institutional racism is not easily associated with malicious intent on the part of specific individuals or groups. Furthermore, while the cultural processes are shaped and driven by historical pressures, historical accounts of the roots of inequality are often erased (Farmer, 2004) and this erasure leaves contemporary racial health inequalities without a clear link to structural forces.

Just as a society's culture maintains its structure, cultural racism maintains structural racism through specific interrelated cultural processes. With respect to the link between cultural and structural racism, scholars have divided these cultural processes into two broad categories which interweave different components of the social structure to ultimately create and maintain these societies (see Lamont et al., 2014 for a full discussion). First, identification, for the purposes of our discussion, is the process by which social actors define and characterize themselves and others (Brubaker & Cooper, 2000). Importantly, the development and iterative maintenance of these social boundaries (e.g., us and them) and their meanings (e.g., dominant and marginalized) generally occur within a shared social subconscious (Silva, 2010). Second, rationalization is the process by which institutions and social rules are motivated by apparently neutral and objective factors rather than tradition. A feature of rationalization is that the rules are generally deemed to be fair across social groups, but in actuality, have been developed and then institutionalized based upon historical inequities (Farmer, 2004; Lamont et al., 2014). With a lack of historical consciousness, the institutionalization of these so-called rational and fair rules means that there are no identifiable racially-prejudiced or discriminatory actors on which structural racism can be blamed. That these cultural processes operate throughout racialized and racially-hierarchical

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societies in a cloaked manner highlights the importance of and challenges associated with explicating the mechanisms linking structural racism to health inequalities among racial groups.

We focus on two types of identification processes that are most relevant for structural racism and racial health inequalities. Racialization is the process by which social meanings are attached to a constellation of biological, phenotypic, or otherwise observable features (e.g., skin tone, clothing) (Omi & Winant, 2014). Both the observable features which are deemed important and the social meanings are re-classified and re-interpreted over time and across space (Omi & Winant, 2014; Telles, 2004) to maintain the power of the dominant group (Bell, 1992; Bonilla-Silva, 2010). Shared definitions of racialized groups can operate to support or constrain access to material and non-material resources for members within the various groups (Fassin, 2004). In addition to setting different racialized groups on different (and generally unequal) paths of access to resources, racialization can also operate to devalue those in non-dominant groups (Lamont et al., 2014). Stigmatization, then, is the process by which crude, generalizing stereotypes are attached to racialized groups. While there may be stereotypes about the dominant power group in a given context, it is specifically the power differentiation and degree of inequities between racialized groups that link stigmatization processes and stigmatized groups to structural inequities (Link & Phelan, 2001). Thus, stigmatization processes become important for racial health inequalities when they operate within a racialized power structure. Together, racialization and stigmatization continually adapt to fit socio-spatial and temporal contexts and operate to maintain racial hierarchies.

Rationalization, the second category of cultural processes, includes two processes of particular importance to racial health inequalities. First, standardization is the process by which social actors “construct uniformities across time and space through the creation of agreed upon rules” (Timmermans & Epstein, 2010, 71). Notably, while the creation of these standards may comprise efforts to prevent unequal access to resources, it is often the socially advantaged groups that already possess those resources that facilitate meeting those standards (Link & Phelan, 1996; Phelan & Link, 2015). Second, evaluation is the process by which social and economic value or merit is assigned. At its core, evaluation processes demarcate those who are worthy of access to power (Lamont, 2012) (see also the notion of commensuration (Espeland & Stevens, 1998)). As with the identification processes we have outlined, rationalization processes often operate at a shared social level but without conscious awareness. Furthermore, while the rationalization processes are often intended to create fair and neutral institutions, the effect of the identification processes result in institutions that maintain racial hierarchies.

From this discussion on the linkages between cultural and structural racism and the cultural processes that maintain racialized and racially-hierarchical structures, we provide two foundational recommendations for future research on racial health inequalities.

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Recommendation 1: Develop guiding frameworks and empirical models based on cultural and structural racism

Based on an understanding that the root causes of racial health inequalities stem are founded upon cultural and structural racism (Dressler, 2001; Dressler et al., 2005; Geronimus & Thompson, 2004; Phelan & Link, 2015), we recommend that all work on racial health inequalities be situated within a framework of cultural and structural racism. While the specific conceptual and empirical models that guide specific research questions may not make cultural and/or structural racism explicit, we recommend that there is, nonetheless, an underlying framework based on cultural and structural racism that are guiding these models. There is no one single framework recommended here, but numerous disciplines have provided the information for scholars to develop their own. Table 1 outline the primary themes regarding cultural and structural racism that have been discussed with anthropology, sociology, law studies, and the humanities. While many of these features are discussed across these literatures, several noted works are referenced.

Studying the connection between cultural and structural racism

Cultural racism operates with institutional racism to maintain a racial hierarchy in racialized societies. A number of manuscripts in this issue point to the ways in which these two forms of racism may affect health inequalities. In a mixed methods study of the politics of race, sickle cell disease, and health care in Brazil, Creary explicates her framework of biocultural citizenship that simultaneously considers the cultural context of race and the institutional context of health care (Creary, 2017). Within the skin-tone-and socioeconomic-based racial hierarchy, Brazilians, particularly those with darker skin tone, living with sickle cell disease actively claim both biological and cultural notions of race in order to access necessary health care. While those living with the disease are using the tools of biological race to access care, it is the State that has created the conditions that require this adaptation through the narrative of a racial disease (e.g., cultural racism) and racialized health care systems (i.e., institutional racism).

Two studies in this special issue have outlined how cultural racism may transform institutional policies and practices into contemporary institutional racism in the US (Asad & Clair, 2017; Philbin et al., 2017). Specifically, American cultural racism that builds upon the racialization and stigmatization of Black Americans and *certain* immigrant groups drive institutions to enact policies to control these groups. While the narrative behind the policies targets specific members within the racialized groups (e.g., Black Americans who have engaged in illegal activity, undocumented immigrants from Latin America, etc.), the crude stereotyping inherent in cultural racism provides for “spillover effects” that adhere to other members of the larger racialized group. Thus, for example, while most Latino men and women in the US are not undocumented immigrants, they risk negative social and health consequences that result from racialized employment and educational policies that target undocumented immigrants. These studies in Brazil and the US suggest different ways that racialized institutions are informed by cultural racism. Because the cloak of cultural racism can render institutions and structure as neutral and rational, more work explicating the role

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of cultural racism is needed to clarify the ways in which we can intervene on racialized institutions.

The need for frameworks on cultural and structural racism with micro-level models

Even in circumstances where a cultural or structural framework is not explicitly or immediately related to empirical research, situating research questions on racial health inequalities within such a framework may prevent mis-specified analytic models, inadequate measures, and misinterpretation of results. For example, there is a large literature on the association of individual-level factors and interpersonal processes with health, including interpersonal discrimination experienced by non-White individuals (either personally- or vicariously-experienced) and implicit bias on the part of White individuals. Two systematic reviews in this special issue (Heard-Garris et al., 2017; Maina et al., 2017) assess specific areas within these large literatures, and while each covers a very different aspect (i.e., vicarious discrimination and child health; healthcare provider implicit bias and patient health), they report fundamentally similar results highlighting the equivocal literature. For example, vicarious racism (most often measured as discrimination reported by a caregiver) was not related in the same way across studies to measures of child mental health (Heard-Garris et al., 2017). In general, the papers included in this review measured whether caregiver-experienced discrimination was linked to child health outcomes without considering how cultural or structural racism may affect child health through educational (Monroe, 2005; Morris, 2016; Skiba et al., 2002), family (Collins, 1998; Roberts, 1999; Taylor et al., 1997), or community organizations (Lawrence et al., 2010).

Future research using an explicit cultural/structural framework might integrate the cultural process of identification and rationalization that maintain the institutional features of structural racism. Research in the US, for example, suggests that Black children bear the burden of stereotypes of violence and limited learning capacity (i.e., identification processes and cultural racism) which are related to their educational experiences (i.e., rationalization processes and institutional racism) (Monroe, 2005; Morris, 2016; Skiba et al., 2002). Alternatively, future research on vicarious racism specifically might examine how caregiver stress and family dynamics and socialization within Black families in the US setting, for example, are altered after events such as police killings of Black and Latino children. These caregiver vicarious experiences are not the result of interpersonal interactions but of the structural racism maintained by the cultural processes we have described. For research specifically on the interpersonal experiences of caregivers, future research might model discrimination within family or community contexts that account for contemporary features of structural racism (Krieger, 2012; Priest et al., 2010).

Using frameworks on cultural and structural racism using micro-level models

While the literature reveals a relation between interpersonal discrimination and health (mental health, in particular) (Gee et al., 2009; Y. Paradies, 2006; David R. Williams & Mohammed, 2009) and while many hypothesize that interpersonal discrimination is an important driver of health *inequalities*, there is little empirical evidence to support this latter notion (Krieger, 2014). Two studies in this special issue situate their empirical models on interpersonal discrimination within a broader context of cultural or structural racism and

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show that in certain settings, discrimination may play an important role. First, researchers (Colen et al., 2017) build from previous work within a structural racism framework indicating that upward socioeconomic mobility does not translate into better health to the same extent for Black, compared to White, adults (Colen et al., 2006). Due to employment and neighborhood racial segregation and inequality, upwardly-mobile Black adults may need to navigate White social spaces more often and in qualitatively different ways than their non-upwardly-mobile counterparts. Because of this, the former group may experience greater interpersonal discrimination as they encounter more Whites while bearing the stigma burden (i.e., identification cultural processes) of the Black American racial group. Indeed, the authors report that when measures of interpersonal discrimination were included in models linking race to self-reported health, this race-health association was substantially attenuated for upwardly-mobile adults (Colen et al., 2017).

Second, using data from Chicago in 2000, researchers (Hicken et al., 2017) explicitly framed interpersonal discrimination along with vigilant coping style within a cultural racism framework and reported that, without vigilant coping, both Black and White women exhibited an association between discrimination and weight-related measures. However, when vigilant coping style, as a marker of the burden of cultural identification processes, was modeled, an association between vigilance and health – but not discrimination – was found among Black women; while among White women, an association was found between discrimination – but not vigilance – and health. Using a cultural racism framework, the authors were able to reconcile the equivocal literature on discrimination and weight-related measures. The levels and potential outcomes of interpersonal processes are not universal across space and time. This means that researchers need to carefully consider using a framework of structural racism to clarify how interpersonal processes may be operating within their particular studies. Together, the studies in this issue illustrate that situating evidence of individual-level factors and interpersonal processes within a structural and cultural racism framework may provide a clearer picture of their relation to health inequalities.

Using frameworks on cultural and structural racism with macro-level measures

While it may be tempting to simply use macro-level measures to capture cultural or structural processes, we caution that this does not mitigate the need for a carefully-considered racism framework. For example, community violence has generally been racialized so that research focuses particularly on violence within poor communities with large concentrations of Black, Latino, and/or immigrant residents (Sampson & Wilson, 1995). However, there continue to be challenges in clarifying the root causes, critical to identifying points of intervention in reducing community violence. Without a structural racism framework, history is erased and scholars and policymakers may point to cultural deficits on the part of such neighborhoods in community violence interventions (Small et al., 2010). Using a framework of structural racism that explicitly addresses historical patterns of urban planning and civic disinvestment, Jacoby and colleagues report that the geographic patterns of violence match those of historical "red-lining" in which members of stigmatized social groups were distributed into defined geographic areas through real estate policies and practices (Jacoby et al., 2017). In the "Chronicle of the Black Crime Cure", Bell discusses

the root sources of violence within Black communities as the systematic disinvestment in racial, economic, and educational equity (Bell, 1987). Since then, sociologists have worked to clarify the link between disinvestments in these institutions and violence (Sampson et al., 2005; Sampson & Wilson, 1995). Future work in public health could integrate this work in sociology and build on the results of Jacoby and colleagues to examine specific disinvestment policies and practices across historically red-lined areas. Furthermore, future research might work to clarify the ways in which cultural process described above have guided institutional practices that resulted in the systematic disinvestment in racialized communities. This type of research may then remove the "cloak of invisibility" and demonstrate the ways in which seemingly neutral and rational policies stem from cultural racism.

Others have examined residential segregation more explicitly which can contribute to racial health inequalities in different ways depending on socio-spatial and temporal contexts. For example, in the first large-scale study of residential segregation and racial health inequalities in Brazil, researchers in this special issue situated their study within the historical context of racialized geospatial development (Barber et al., 2017). The authors examined neighborhood socioeconomic segregation in relation to racial health inequalities as neighborhoods demonstrate the inextricable and mutually dependent link between race and socioeconomic status in Brazil. The authors showed that socioeconomic segregation is indeed racialized, as Black and Brown Brazilians were more likely that White Brazilians to live in poor neighborhoods. That socioeconomic segregation had developed and is maintained through de facto rather than de jure mechanisms suggests that cultural racism that racializes poverty may work in concert with informal institutions and future quantitative work can incorporate ethnographic and other qualitative work to better understand these institutional mechanisms in order to develop effective interventions.

Other research in this special issue suggests that the health impact of racial residential segregation may not have been universally detrimental for Black Americans, but does depend on the other contemporaneous features of structural racism. Specifically, researchers used a novel measure of segregation of Black residents that allowed for measurement even in rural areas and reported that in the US south throughout the early- to mid-20th century, the clustering of Black residents was related to a *later* age of mortality for Black adults and children (Logan et al., 2017). On the other hand, the clustering of Black residents was related to *earlier* mortality for White Americans, particularly White adults (Logan et al., 2017). The authors hypothesized that the apparent protective role of Black segregation for Black Americans needed to be understood against the backdrop of poor access to healthcare during a time of prevalent infectious diseases and other more universal threats to health for Black Americans in the US south, no matter their residential location. On the other hand, for White Americans in the US south who were not burdened with these same universal risks, the potential lack of resources within residential areas with high clustering of Black residents may have played an important role in mortality.

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The need for innovative measures of cultural and structural racism

We have noted that every study of cultural and structural racism does not necessarily require macro-level measures. However, in order to move the science forward, the literature will need to include empirical tests linking measures of macro-level factors and processes to racial health inequalities. While still in its infancy, there has been growing interest in capturing social sentiments using “big data”, including social media (e.g., Twitter, Facebook) or user-generated data from online activity (e.g., Yelp, Google). Researchers in this issue use geospatially-located Google search terms in the US context to capture area-level racial prejudice and report that living in areas with greater racial prejudice is related to greater risk of poor birth outcomes for Black mothers (Chae et al., 2017). Furthermore, in an innovative use of the probability-based General Social Survey, researchers linked area-level measures of attitudes on immigration within the US to individual-level mortality (Morey et al., 2017). They report that greater area-level anti-immigrant prejudice is linked to greater mortality risk for those in the racial category composed primarily of Asian and Hispanic Americans, but not for those in either White or Black racial groups (Morey et al., 2017). Both studies point to the potential for innovation when examining the link between cultural racism and health. While each of these studies situates their questions within the appropriate contemporary aspects of cultural racism, we reiterate that the use of macro-level measures does not eliminate the need for a guiding framework on cultural and structural racism, as the measureable face of racism shifts and adapts over time to different contexts (Bonilla-Silva, 1997, 2010; Bonilla-Silva & Baiocchi, 2001).

Standardized measures may also provide researchers with the ability to capture structural factors and processes. For example, the US Department of Labor has created standardized measures of workplace environments within occupational categories. Researchers in this special issue have linked these innovative measures to the probability-based sample of older adults in the Health and Retirement Study to examine whether the influence of workplace environments on racial health inequalities requires one to perceive that environment as stressful (McCluney et al., 2017). They report that racial inequities in the workplace environment (e.g., opportunities for advancement, autonomy), as captured by standardized measures, were related to racial inequalities in health. Notably, neither individual perceptions of these aspects of the workplace environment nor reports of workplace discrimination predicted health inequalities. This work suggests that institutional factors, regardless of whether one consciously perceives these factors, contribute to health inequalities. We note that while standardized measures may provide one avenue for capturing structural factors, the cultural processes of identification and rationalization can alter the utility of these measures. Therefore, we recommend that researchers understand how these measures were constructed, particularly the ways in which dominant cultural frames may have shaped their formulation (Darian-Smith, 2016; Devlin, 1997).

Recommendation 2: Employ critical race theory approaches

In addition to applying a framework of structural racism, we recommend that scholars studying racial health inequalities use a critical race lens when developing their framework and conceptual and analytic models. Critical race theory (CRT), developed in law studies

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(Crenshaw, 1995), is a constellation of principles that form an approach to the interpretation of structural factors, and more recently, to scientific inquiry of racial inequities, including health inequities (Ford & Airhihenbuwa, 2010a, b). In fact, Ford and Airhihenbuwa (Ford & Airhihenbuwa, 2010b) provide a thorough description of these principles (see Table 2) and a roadmap for the application of CRT to public health questions. Essentially, CRT challenges scholars to understand the permanence and ubiquity of cultural and structural racism. This means that while specific aspects of racism may shift and adapt to fit the sociopolitical climate, fundamentally, cultural and structural forces continue to ensure that a new equilibrium is reached that favors the dominant racial group (Bobo et al., 1997; Bonilla-Silva, 2010; Fields & Fields, 2014; Haney-López). This also means that cultural and structural racism are infused throughout racialized and racially-hierarchical societies – racism is ordinary rather than the exception.

Using CRT to clarify paradoxes and other ambiguities

A critical race lens can also help explain apparent paradoxes. For example, a study in this special issue used a structural racism framework with the understanding that racialization, rather than race, is the driver of racial health inequalities (Malat et al., 2017). They developed a conceptual model from the extant literature to explain how the dominant cultural racism of whiteness in the US context drives White Americans to reject policies from which they would benefit. Specifically, racialized social safety net policies, particularly those associated with undocumented immigrants or poor Black Americans would benefit many poorer White Americans as well. Furthermore, Whites continue to comprise the largest racial group of adults in poverty and a large portion of the children in poverty (Semega et al., 2017). Thus, these policies would mostly help White Americans; yet, as these policies run counter to the dominant White narrative, White Americans reject them (Malat et al., 2017). Future research using a CRT lens might clarify how to frame policies and programs that will both benefit socially-disadvantaged members of the dominant racial group and reduce racial health inequalities as well.

Using a critical race lens may also help to clarify a confusing literature. Returning to the systematic reviews on individual-level factors in this special issue (Heard-Garris et al., 2017; Maina et al., 2017), we recommend that researchers view discrimination and implicit bias, along with their relationships to health, through a critical race lens which dictates that racism is ordinary and ubiquitous and will adapt to fit specific social contexts. When reviewing the literature on implicit bias and healthcare outcomes, the authors noted a stark difference in study results based on study design (Maina et al., 2017). Because study design can impact the results of any study, a careful consideration of design is necessary to ensure that it does not interfere with the research question. The research included in the review generally showed an association between implicit bias and healthcare outcomes when real-world but not vignette-based study designs are used. It may be that, while it was possible to capture implicit bias, it was more difficult to capture the resulting actions stemming from implicit bias in a hypothetical setting. To the extent that healthcare providers wish to appear race neutral, they may consider their healthcare decisions in vignette settings in ways that are not possible or otherwise do not happen in real-world settings.

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Using CRT to uncover the relation between cultural and structural racism

In this issue, researchers in New Zealand set out to assess institutional inequities within the healthcare system, drawn from a framework in which historical and contemporary cultural and institutional racism had created multiple institutional privileges for Whites over Maori (Came et al., 2017). They report that although the healthcare system was designed to address historical inequities, institutional practices burdened Maori providers (who generally provide service to the Maori population) while privileging general providers. This supports the CRT notion that racism is persistent and, while certain aspects of structural racism may appear to be addressed, the system will move to an equilibrium that continues to privilege the dominant group.

When using a critical race lens, the ways in which cultural racism informs institutional practices become clearer. For example, in this issue, researchers used qualitative data on a large multiracial sample of prison-based drug rehabilitation program participants in the US to examine their experiences and opportunities to become successfully “rehabilitated”, a label that confers access to multiple resources (Kerrison, 2017). They report that rather than a neutral and rational program, the prison-based treatment programs operate through a White racial frame (Feagin, 2013) that may not be appropriate across racial groups. By privileging White values, ideologies, and behaviors in program development, White participants reported relative ease progressing through this program to achieve the “rehabilitated” label, whereas Black participants did not. This differentially-applied label, then, may result in unequal access to the resources linked to this label including parole, early release, and employment.

Using CRT to understand intersections

Using a critical race lens can also clarify how multiple social identities intersect (Crenshaw, 1993) to produce health inequalities. Researchers conducted qualitative interviews with Brazilian women of childbearing age to examine the ways in which race, gender, and class intersect in a society where notions of race are often fluid and involve combinations of skin tone, social class, and ancestry (Hogan et al., 2017). The authors discuss how the boundaries of racial group membership are crossed when gender and class are also considered. Traversing these racial boundaries allows for new oppressions (e.g., gendered roles for Black women versus White women) and privileges (e.g., professional Black women, low-income White women) (Hogan et al., 2017). By understanding the ways in which multiple social identities intersect, researchers can explain within-racial group variation in health to better identify the root causes of racial health inequalities.

Using CRT to act to eliminate health inequalities

Inherent in CRT approaches is the movement from documentation of structural racism to action (Ford & Airhihenbuwa, 2010b). Indeed, in an international collaboration, researchers in this special issue explicitly use CRT approaches to discuss the ways in which allies (those who are not the target of structural racism) can change the institutions they inhabit (e.g., healthcare system) to redress racialized and unequal policies and practices (Came & Griffith, 2017). The authors explicate the ally-based activities required to change systems ranging from continual deep self-reflection to structural power analyses to monitoring and evaluation

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of intervention progress and impact (Came & Griffith, 2017). Researchers in this special issue have empirically tested interventions within the healthcare educational system from pre-health educational training (Metzl et al., 2017) to medical training (Chapman et al., 2017) to shift individual-level knowledge in institutionalized settings. Collectively, the research suggests that it is possible to increase the knowledge and understanding of individuals about the structural roots of racial health inequalities (Chapman et al., 2017; Metzl et al., 2017). However, it may be particularly challenging to overcome the continual cultural processes that inform our implicit biases (Came & Griffith, 2017; Chapman et al., 2017). Future intervention research might focus on education for both those who comprise institutions (e.g., healthcare providers within the medical system) and those who hold power within institutions (e.g., healthcare policy makers) – coupled with opportunities to act on "the better angels of our nature". In other words, for example, it may be possible to delink implicit bias (stemming from shared social cultural understandings of different racial groups) from healthcare access and quality by educating healthcare professionals and allowing them more time with patients to apply this new education in their decision-making.

A call to action

In this introduction to the Special Issue on Racism and Health Inequalities, we have discussed a part of a framework linking cultural and structural racism and health inequalities that is too often ignored in public health, particularly epidemiology and biomedical, discussions. Specifically, we discussed the ways in which cultural racism drives structural racism to maintain the privileged positionality of the dominant racial group. Finally, we provided two foundational recommendations for all researchers conducting work on racial health inequalities, whether they focus on individual-level factors, interpersonal processes, or institutional-level policies.

To reiterate, we recommend that all research on racial health inequalities be founded upon a guiding framework of cultural and structural racism using approaches consistent with critical race theory. There are many scholars trained in the social sciences, legal studies, and humanities who have set the example for scholars in public health, particularly in epidemiology and the biomedical sciences. Importantly, however, we are not suggesting that all those interested in clarifying the root causes of these inequalities acquire new methodological training or change disciplines. Indeed, building a strong foundation of evidence to clarify the ways in which racism operates to maintain health inequalities will require multiple methodological and interdisciplinary – preferably transdisciplinary – approaches.

Woven through our two recommendations is a call to action about knowledge production and the public health scholarship on racial health inequalities. Speaking of the field of anthropology, Mullings called for an anti-racist anthropology (Mullings, 2005) and here, we extend her agenda as the call to action toward an anti-racist public health that is consistent with CRT. First, we call on public health scholars to continually scrutinize our field, to ask which voices are privileged when discussing racial health inequalities. Are the dominant voices from the West? The US? Are they primarily White? The field would benefit from more work outside the US as well as more comparative, cross-cultural research. Second, we

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must continually name racism (with precision) and explicate the mechanisms that maintain the link between racism and health inequalities. As Mullings stated,

> "[We] must resist using the passive exonerative voice and name racism and the forces that reproduce it. This requires moving beyond noting that race is socially constructed to confront forthrightly the extent to which structural racism is pervasively embedded in our social system." (Mullings, 2005, 685)

Finally, we call for public health researchers to move our research founded upon CRT-based cultural and structural racism frameworks from academic discussions to public discourse. This means we must seek opportunities to engage with the public but also speak with precision (as racism has many lay as well as scientific meanings) and communicate our research in lay terms. In sum, we call on public health scholars to follow the examples of our allied social science scholars and move beyond the conventional public health/biomedical/risk factor model, with its focus on behavioral and medicine-based changes for marginalized groups, toward CRT-consistent frameworks based on cultural and structural racism to highlight the racialized and racially-hierarchical power systems. We urge the field to reconstruct the knowledge (Desmond & Emirbayer, 2010) around racial health inequalities so that it can be used as the tool in the struggle to dismantle racism and eliminate racial inequalities in health.

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Table 1

Features of structural racism important for racial health inequalities

1	Structural racism can be considered the actualization of cultural racism as the latter determines the interdependent formal and informal institutions that comprise the former (Alexander, 2010; Dressler et al., 2005, see "Structural-Constructivist Model").
2	Cultural racism can render the linkages between structural factors and racial health inequalities invisible (Bonilla-Silva, 2010; Fassin, 2004).
3	Structural racism is maintained by multiple, simultaneously-acting, and interdependent formal and informal institutions (Powell, 2007).
4	Structural racism is inextricably linked to nation-building and global capitalist markets (Mullings, 2005; Thomas & Clarke, 2013), and these linkages may place economic concerns over human rights concerns making effective intervention challenging (Farmer, 2004; Farmer & Castro, 2004).
5	Structural racism includes the erasure of historical processes that could clarify the link between racialized groups and health (Farmer, 2004).
6	As a fundamental cause of racial health inequalities, structural racism continually changes to adapt to contemporary and spatially-specific social norms (Mullings, 2005; Silverstein, 2005).
7	Structural racism does not require malicious intent on the part of specific individuals or groups (Harrell, 2000; C. P. Jones, 2000).
8	Structural racism does not require explicit action, as it is often maintained through inaction (Bobo et al., 1997).

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Table 2

Critical race theory principles of the Public Health Critical Race praxis (See also Baer et al., 1986 for a related discussion on critical medical anthropology.; List adapted from Ford & Airhihenbuwa, 2010b)

1	Race is a social construct.
2	Racialization, rather than race, is the fundamental source of racial health inequalities.
3	Racism is ordinary, not exceptional, and embedded in the social fabric of society.
4	Structural factors are the fundamental mechanism linking racial group membership to health inequities.
5	Scholars must move beyond surface understandings of racial health inequities.
6	Multiple social identities may intersect to impact health inequities within and across racial groups.
7	Knowledge is socially constructed.
8	Marginalized voices must be prioritized.
9	Scholars must be deeply aware of their own racial position.
10	Disciplinary norms may limit knowledge production about racial health inequities.