

INTRODUCTION

RACISM AND HEALTH: A RESEARCH AGENDA

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Racial and ethnic minority populations experience unequal results across a broad range of societal indicators. Health status is one such area of persistent and pervasive racial disparities. Higher rates of disease, disability, and death for blacks (or African Americans) compared to whites have been documented for over a century. Hispanics,¹ Asian and Pacific Islander Americans,² and American Indians³ also have elevated rates of disease and death for several health status indicators. However, knowledge of the specific factors responsible for racial disparities in health is limited. Of particular current concern is the growing evidence of a widening gap in health status between blacks and whites driven, in part, by the worsening health status of blacks.⁴ Moreover, the repeated empirical observation that racial differences in health status frequently persist even after adjustment for socioeconomic status (SES)^{4,5} emphasizes that race is more than SES and that renewed efforts are needed to identify the unique factors linked to race that affect health outcomes. A growing number of researchers suggest that racism is a neglected pathogenic factor in studies of the health status of racial and ethnic minority populations.⁵⁻⁸

The set of papers in this special issue reviews the current state of thinking on the major ways in which racism might affect

health and point to promising directions for the needed studies that would elucidate these relationships. Figure 1, based on earlier models of the association between race and health,^{7,8} provides a framework for understanding the relationship between racism and health. It gives centrality to racism as a major societal force that affects health status. Although racism includes negative attitudes and beliefs about outgroups (prejudice), and differential treatment of members of those groups (discrimination), the model argues that fundamental to racism is an ideology of superiority that categorizes and ranks human population groups into races. Racism was created by larger macrosocial factors as they focused on the phenotypic characteristics and/or geographic origins of certain population groups. Race is one of several social status categories created by macrosocial factors and racism that shape individual values and behavior in ways that can enhance or impair health status.

Racism developed in a dynamic process in which racist ideologies and practices were supported by, and in turn, reshaped societal institutions and structures. That is, beliefs about race have been fundamental to the determination of societal policies in a surprisingly broad range of areas.⁹⁻¹⁰ The papers by Herman and LaVeist in this issue review the conceptual basis for the use of

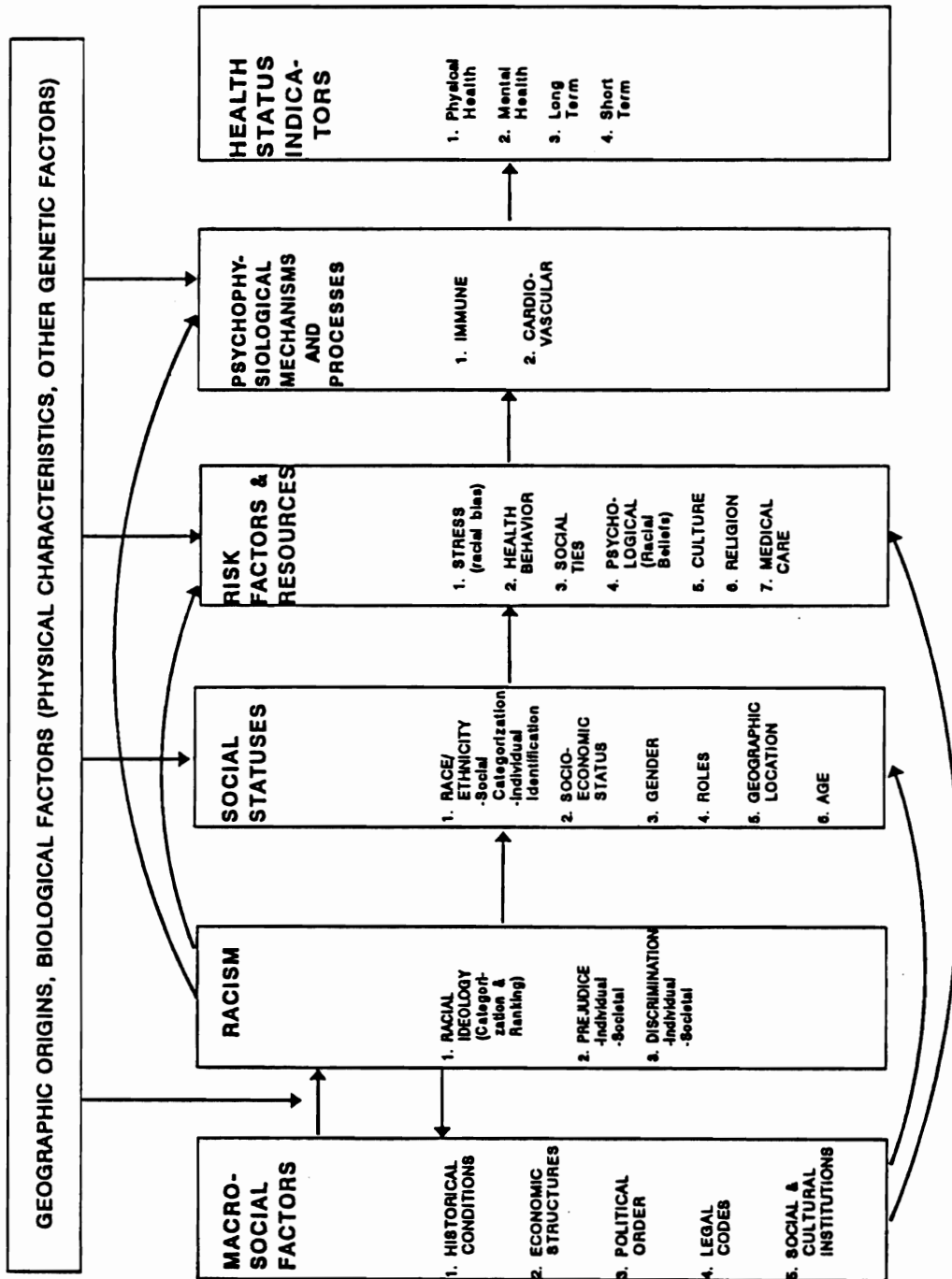


FIG. 1.—A framework for understanding the relationship between race and health.

race in health research. A researcher's beliefs about race will shape the research questions that are asked and the potential research issues that are neglected. Historically, limited or inappropriate conceptualizations of race have led to misguided research, reinforced racial prejudices and perpetuated racist stereotypes in both research and health policy. For example, because they believed that blacks were so biologically different from whites that diseases would manifest themselves differently in blacks, researchers who were against studies of untreated syphilis initiated the Tuskegee Syphilis Study.¹¹

RACISM AND SOCIETAL INSTITUTIONS

Given the centrality of racism to larger social structures and processes, there are multiple ways in which racism can affect health status.⁵⁻⁷ However, the most profound impact is at the level of societal institutions. The paper by King illustrates how racism in medical institutions can affect minority health status. The organization of medical services affects access to care for vulnerable populations and the quality and outcomes of care that these groups receive. There are large racial differences in access to medical care,¹²⁻¹³ and a pervasive and disturbing pattern of racial differences in the receipt of a broad range of medical procedures, even in settings where persons, at least in theory, have similar access to care.¹⁴⁻¹⁶ King highlights the importance of focusing on institutional racism in medical care and not limiting analyses of racism to individual actions and behavior.

King's analysis suggests that a given societal institution should be viewed not in a vacuum but in the context of its interactions with other institutions. Neuspiel's paper illustrates this point by showing how the racism inherent in U.S. drug policy not only affects access to medical care services for vulnerable populations but also shapes the creation of health knowledge, medical dis-

course, and the public images surrounding drug use. Menefee's paper considers the legal environment in which medical institutions operate. His analysis illustrates that because macrosocial factors and racism are the basic causes of racial differences in health, intervention efforts should not primarily focus on individual risk factors. Intervening in some of society's fundamental social structures, such as the legal system, can importantly alter the exposure of an entire group to risk factors for disease.

Figure 1 suggests that the racism that is embedded in our social and cultural institutions can adversely affect the health of minority group members. It indicates that race-related risk factors and resources such as racial beliefs and racial bias are potentially important but neglected influences on health. The paper by Williams-Morris documents this neglect in the field of developmental psychology and outlines numerous ways in which the racism in the larger culture can adversely impact the psychological well-being of minority children. Members of minority populations will vary in the extent to which they internalize the societal prejudice and racial ideology about the inferiority of their group. Future research needs to identify the critical aspects of culture that may be most pernicious and the conditions under which those effects are most likely to be observed.

There is a larger body of literature that suggests that the internalization of cultural stereotypes can lead to negative self-evaluations that adversely affect psychological well-being. A growing number of studies indicate that African Americans who internalize society's negative evaluations of blacks have elevated rates of substance abuse, and physical and mental illness.¹⁷⁻¹⁹ An important priority for future research is more systematic attention to the ways in which racial belief systems affect health status. This should include analyses of the extent to which holding racist beliefs is related to the health of majority group members,²⁰ as well as the ex-

tent to which believing the larger society's negative evaluation of one's group by minority group members is adversely linked to health.

Economic institutions can also play a role in adversely affecting the health status of minority populations. Moore and his colleagues show how the disproportionate targeting of minority consumers by large scale economic interests (the tobacco and alcohol industries) can have a disproportionate adverse impact on the health status of these groups. The line between good business practices and racism is often blurred and unclear but these authors propose criteria that can be used to make the distinction. Other research indicates that racial minority populations in the United States are also affected by disproportionate exposure to environmental risks in residential environments.²¹

Residential racial segregation is one of the fundamental mechanisms by which racism has operated in American society.²² Historically, government agencies, banking institutions and the real estate industry have worked together to ensure that blacks were concentrated in the least desirable residential areas. Racial segregation probably has its largest impact on health status by shaping socioeconomic outcomes for minority group members. Once in place residential segregation triggers a number of mechanisms to restrict educational and employment opportunities for blacks. African Americans experience higher levels of segregation²² and more difficulties in socioeconomic mobility²³ than any other racial and ethnic group in the U.S. Moreover, there has been little decline over time in the level of racial segregation for blacks.²⁴ Health researchers have given little attention to documenting the ways in which residential segregation can affect health status. Polednak's paper reviews the available evidence and outlines important directions for future research.

RACE-RELATED STRESS AND COPING

In addition to processes of racism at the societal level, experiences of racial bias in the everyday lives of minority group members can have deleterious health consequences. The courts have recognized that discriminatory practices can cause emotional distress and have allowed plaintiffs to receive compensatory damages for these experiences.²⁵ Similarly, the stress literature has long recognized that the stress linked to racial minority status is an important but neglected form of socially induced stress,²⁶ but stress researchers have not incorporated experiences of racial discrimination in the content areas of the standard stress inventories. The studies by Jones et al. and Prather et al. document that there are measurable physiological responses to exposure to racism under laboratory conditions. The findings of Jones et al. clearly indicate that researchers should attend to the specific characteristics of the experience of racism since some types of experiences may have more adverse effects on victims than others. Moreover, the Prather et al. study's finding that the race of the perpetrator had no effect on blood pressure responses, suggests that experiences of unfair treatment, irrespective of their source, may have adverse health consequences. Future research should explore the extent to which perceptions of injustice negatively affect health regardless of the race of the victim. Although minority group members may experience higher levels of unfair treatment than non-minorities, the health impact of such experiences may be similar across racial and ethnic categories.

The papers by Jackson et al. and Broman assess the association between racial discrimination and health, not under laboratory conditions, but in the real world. Jackson et al. report that although experiences of discrimination are strongly related to health status in cross-sectional data, these relationships are weaker in longitudinal

analyses. They also document that the level of racial discrimination varies over time and highlight the importance of identifying the determinants of its intensity over time. Broman found relatively high levels of discrimination but no relationship between racial discrimination and health. This study was conducted in Detroit, where some 60% of the population is black. Does this larger racial ecological context make a difference? Both of these studies highlight the fact that improvement is needed in the assessment of racial discrimination. This improvement must include expansion of the scope of phenomena considered, and the precision of the measurement, and it should pay greater attention to the strategies used to elicit race-related stressors. Some evidence suggests, for example, that generating contextual cues can facilitate more accurate recall of stressful experiences.²⁷

The paper by McNeilly et al. describes a scale that seeks to comprehensively measure race-related stress. It assesses the levels of racism and the emotional and behavioral coping responses to it in different societal contexts. The situational context and the subjective appraisal of a racial incident can affect both the range of coping responses and the perceived stressfulness of the experience. Documenting the place in which particular experiences of discrimination occur is also important from a policy making perspective because it identifies potential areas of intervention. The perceived racism scale, like most of the papers in this special issue, heavily focuses on the experiences of African Americans. Recent studies reveal that Latinos²⁸ and Asian Americans²⁹ also routinely encounter racial discrimination. Research is needed to address the extent to which exposure and adaptation to racial/ethnic bias vary for major socio-cultural groups.

The stress literature suggests that the persistence of a difficult situation and its resolution or lack thereof are important determinants of its adverse impact.³⁰ Researchers

need to give more attention to identifying the duration and timing of race-related experiences. Future research must also assess the ways in which racism combines with other types and sources of stress to create new chronic strains or to alter the meaning of existing stressors. Understanding the stress process also requires the identification of intervening variables that may mediate or moderate the effects of stress on health. The papers by Neighbors and colleagues and Dressler outline the ways in which the health impact of racism may be contingent on processes of attribution and social identity. These papers suggest several intriguing hypotheses for identifying the mechanisms by which racism affects health.

The study of racism and health is in its infancy, but the evidence presented in this special issue suggests that racism may be a pervasive influence on health. This collection of papers provides ways in which to think about racism, directions for measuring it, historic examples of its impact, laboratory findings and epidemiologic studies that suggest its potential importance, and most importantly, numerous directions for future research. In order to move the field forward, more attention needs to be given to the development of conceptually based, empirically validated measures of racism and the initiation of well-designed empirical research that evaluates theoretical ideas about the relationship between racism and health. This is indispensable for the development of confidence in both the theory and the measures employed.

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