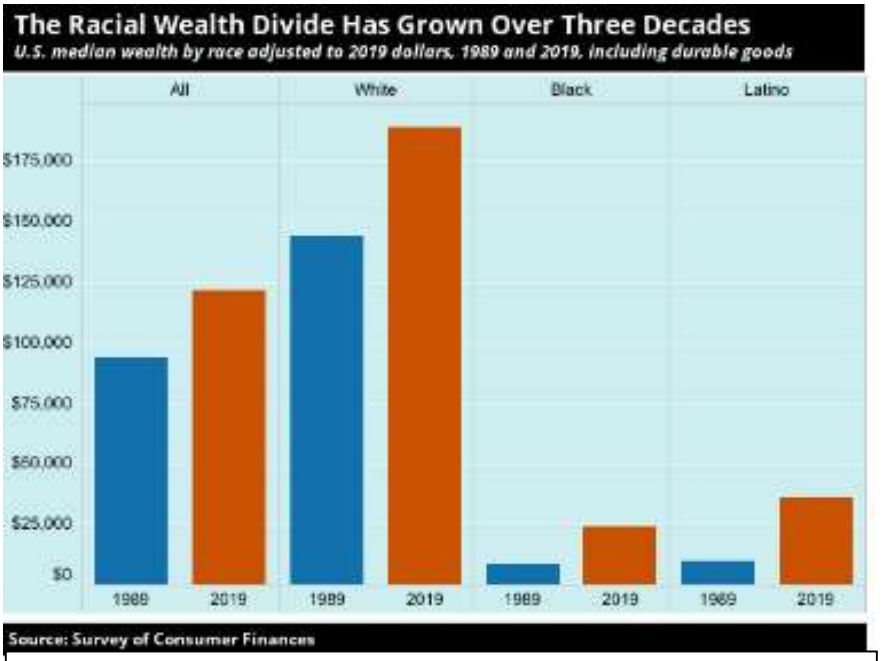
Racism as a Cause of Health Disparities

Large socioeconomic inequalities in health and mortality have persisted at similar levels over time. Since the 19th century, the developed world has eradicated major diseases and risk factors that appeared to account for health inequalities among lower income groups (e.g. deadly infectious diseases fueled by poor sanitation and overcrowding). Today we have inequalities in health outcomes among lower income groups for cancers and cardiovascular illnesses fueled by poor diet, lack of exercise, and stress.



https://inequality.org/facts/racial-inequality/

Resources of power, prestige, education, and beneficial social connections allow people to avoid risks and adopt protective strategies, but their use highly depends upon wealth. For example, when new knowledge about a health problem and effective treatment or protective strategies emerge, wealthier people use their resources to harness the benefits of that new knowledge. People with more resources can benefit more, thus creating persistent disparities in health outcomes income groups.

Research shows that those with more education and income will take advantage of screens for cervical and breast cancer. Access to life-saving screen has emerged to link social conditions to health outcomes. Educated smokers changed their smoking behavior first. Other examples are access to the best doctors, knowing about and asking for beneficial health procedures, having friends who support healthy lifestyles, getting flu shots, wearing seat belts, eating fruits and vegetables. The list goes on to include living in neighborhoods with low crime and lead-free housing, working in safe occupational jobs, and taking restful vacations.

Differences in access to resources of wealth, prestige, power, and beneficial social connections result in unequal disease outcomes. Blacks have elevated death rates for 8 of the 10 leading causes of death in the US, a disturbing reality which holds true even when levels of wealth are controlled. While wealth narrows the unequal outcomes, the disparities between Black and white health outcomes persist.

Non-Occupational Prestige is defined as respect or deference attached to a person or social status. Much of the prestige hierarchy is embodied within occupational structures, and thus derives from income status. Systemic racism, however, produces inequalities in the resources of race-specific prestige beyond occupation. Negative stereotypes, devaluation of personhood, and disrespectful treatment result in whites perceiving Blacks as unworthy of their respect.

Racial Stereotypes: Researchers have found persistent beliefs among whites that Blacks are less intelligent and lazy; that they prefer to live off of public assistance; and that they are prone to violence.

Implicit Racial Bias: Whites reveal a significant implicit or unconscious but visceral preference for whites over Blacks.

Power. Within a racially diverse goal-oriented cooperative group, researchers repeatedly find that Blacks have less influence within a group than whites in decision-making.

Beneficial social connections. Racial segregation is a major source of inequalities in social connections. Neighborhoods consist of various resources: stores, schools, gyms, parks, street lights, fire and police protection, health care. Neighborhood resources are in large part spillover effects in which individuals benefit from collective resources without their active participation. They essentially are born or move into an affordable neighborhood.

Blacks, regardless of their income, live among neighbors with poorer socioeconomic resources and who are less likely to provide beneficial connections for things such as jobs, admission to college, or access to political power holders. Collective resources that may affect health, such as stores and parks, are also inferior in neighborhoods with more Black residents.

Freedom, the ability to control one's own life circumstances and action, allows us to protect our health in a variety of circumstances. Enslaved or imprisoned people do not have the freedom to avoid the harmful conditions of their situation, to relocate to escape infectious disease, or control their access to health care. They do not have the freedom to avoid brutalization, to benefit from the support of family and friends, or to eat a healthy diet. In 2017, Blacks represented 12% of the U.S. adult population but 33% of the sentenced prison population. Whites accounted for 64% of adults but 30% of prisoners.

Other examples of unfreedom include official and unofficial harassment, discrimination and threat of harm that thwarts freedom of movement and behavior, which places limitations on how one dresses and behaves and where one walks, shops, eats, or drives. Blacks do not have the freedom to live and work where they want.

Stress and Health Outcomes

Social stress, a response to threatening or burdensome situations, induces physiological response that can harm health. Both acute and chronic stress have been linked to mortality and to numerous health outcomes. A number of different stressors connect racism to health outcomes.

Stressor: Experience of discrimination. Discrimination acts as a particularly harmful stressor because Black people cannot predict or control it. It spans the life course, and Blacks experience it in multiple contexts, inducing a psychically painful state of vigilant anticipation. Researchers find that the association between discrimination and harmful health outcomes is independent of income.

Stressor: Weathering. Blacks experience early physiological and health deterioration as a consequence of the cumulative stress of living in a society that stigmatizes and disadvantages them. The wear and tear of stress on the body accumulates as an individual is exposed to repeated stress. At all ages, Blacks have a higher stress load scores than whites that income alone cannot explain.

Stress: Medical Care. Blacks receive lower-quality health services than whites. These inequalities remain remarkably consistent across a range of illnesses and health care services. Blacks are less likely to undergo coronary artery bypass surgery, less likely to receive a kidney transplant, and more likely to receive a lower quality of basic clinical services such as intensive care, and experience greater delays in transfer from hospitals to nursing homes even when such factors as insurance status, income, age, and symptoms are taken into account. These and other instances lead to a greater mortality among Black patients.

Stress: Neighborhood effects. Neighborhoods bundle together beneficial or harmful sets of circumstances, such as availability of healthful foods and good medical care. The importance of neighborhoods in understanding racial differences in health is hard to overstate. It alone may be its own fundamental cause of racial disparities in health.

A wealthy person with many resources can afford to live in a high-status neighborhood with others also of high status. Through no personal effort, that person now lives in the cultural habitat of an advantaged neighborhood and has access to multiple health-enhancing circumstances. The high status neighbors collectively have enormous political clout to exert pressure to maintain what they have. Together they exert pressure on local government to keep crime, noise, violence, pollution, traffic, and vermin at a minimum. They have the best health-care facilities, parks, playgrounds, along with food stores and other amenities conveniently located nearby.

Recreation: Segregated Black neighborhoods have fewer recreational outlets than white neighborhoods. A strong relationship exists between neighborhood recreational resources and physical activity. Inactivity is associated with obesity, diabetes, hypertension, heart disease, and cancers.

Nutrition: Segregated Black neighborhoods contain two to three times as many fast-food outlets as white neighborhoods of comparable income. Blacks consume more fast food, which contributes to racial disparities in obesity and diabetes. Predominantly Black neighborhoods have two to three times fewer supermarkets than white neighborhoods of comparable income. Consumption of fresh fruit and vegetables depends upon access to them. Those who eat fresh produce have lower rates of obesity, diabetes, and other conditions.

Harmful substances: Tobacco and alcohol industries target minority neighborhoods for advertising and sales. Controlling for income and family history of alcoholism, researchers find an association between exposure to alcohol advertising and problem drinking in a predominantly Black community.

Protection and crime: Segregated Black neighborhoods have poorer fire and police protection and higher crime rates. Blacks have an age-adjusted death rate from homicide that is more than five times as high as that for white Americans. In addition, the perception of unsafe neighborhoods leads to reduced levels of exercise.

Toxic environmental exposures: Minority neighborhoods are 5 to 20 times more exposed to toxics and harmful emissions than are white neighborhoods, after controlling for income. Toxic exposures contribute to disease and poor birth outcomes.

Medical care: Hospitals in neighborhoods with more Black residents have fewer technological resources, specialists, and board-certified physicians, and higher rates of negligent adverse events and mortality for both Black and white patients.

Researchers have identified racism as a fundamental cause of health inequalities above and beyond income inequalities. Advantages denied Blacks by whites include non-occupational prestige, power, beneficial social connections related to neighborhood segregation, and freedom.

Resources.

Gramlich, John, "The gap between the number of blacks and whites in prison is shrinking*", Pew Report.* (April 30, 2019): https://www.pewresearch.org/short-reads/2019/04/30/shrinking-gap-between-number-of-blacks-and-whites-in-prison/

Link, B. and J. Phelan 2010). "Social Conditions as Fundamental Causes of Health Inequalities." In C. Bird, P. Conrad, A. Fremont, and S. Timmermans (Eds.*). Handbook of Medical Sociology, Sixth Edition. Nashville, Vanderbilt University Press,* (2010).

McCartney, Gerry, et al, "Health inequalities, fundamental causes and power": *Sociology of Health and Illness*, Vol. 43 No.1 (2021).

Phelan, J. and Bruce Link "Is Racism a Fundamental Cause of Inequalities in Health?": *Annual Review of Sociology,* 41:311-330, (2015).

Prepared by Louise Gorenflo, lgorenflo@gmail.com
September 2023