Conceptual and Methodological Challenges for Health Disparities Research and Their Policy Implications

Brian D. Smedley*

*The Joint Center for Political & Economic Studies

Hector F. Myers

Vanderbilt University

This special issue of the Journal of Social Issues contributes to a growing body of research that illuminates the mechanisms through which racism and discrimination influence the health status of people of color. Importantly, this special issue attempts to connect research examining how racism operates at the interpersonal, internalized, institutional, and structural levels, and points to a number of policy strategies to mitigate the racism–health relationship. Going forward, a comprehensive model of the lived experience of race is needed that considers the cumulative, interactive effects of the different forms of racism and related risk factors on health as they operate over the lifespan. Such a model must facilitate an intersectional analysis to better understand the interaction of race with gender, socioeconomic status, sexual orientation, geography, and other factors, and should also consider the negative consequences of racism for Whites (e.g., poorer health of a growing share of their neighbors, coworkers, customers, and congregants).

In the United States, race and ethnicity powerfully shape the opportunity for good health. A large and growing body of evidence demonstrates that people of color receive a lower quality of health care than Whites even when access-related factors, such as insurance status and income, are comparable. 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 there

*Correspondence concerning this article should be addressed to Brian D. Smedley, The Joint Center for Political & Economic Studies, 805 Fifteenth Street NW, Second Floor, Washington, DC 20005 [e-mail: bsmedley@jointcenter.org]. This research was supported by grant P3022041 from the W.K. Kellogg Foundation and by NIMH Grant #5P50MH73453.

© 2014 The Society for the Psychological Study of Social Issues
is also strong evidence that racial bias, discrimination, stereotyping, and clinical uncertainty also play a role (Smedley, Stith, & Nelson, 2003).

Perhaps more importantly, research has increased our understanding of the array of determinants of health inequities, many of which are rooted in the inequitable distribution of access to political power, resources, and social status. A growing body of literature argues that we must look beyond the traditional understanding of racism as largely an individually mediated phenomenon to understand the cumulative, interactive effects of the different forms of racism on health as they operate over the lifespan, and how race intersects with other factors such as gender, socioeconomic status, sexual orientation, and geography (Smedley, 2012).

This special issue of the *Journal of Social Issues* adds depth and dimension to the existing research on racism and health. The objectives of this issue are to (1) publish new research that assesses the relationship between racism and health, with attention to how racism operates at multiple levels and on multiple health outcomes; and (2) identify the implications of this research for public policy and practice to eliminate health inequities (Rivera & Beatty, 2014). The first objective is well addressed with a rich collection of papers that explore intrapersonal, interpersonal, and intergroup processes shaped by race and ethnicity, as well as gender and sexual orientation. The second objective is also well addressed with each paper offering specific policy suggestions that should encourage researchers and policymakers to establish collaborations to develop and test conceptual models and identify and evaluate policy strategies that can mitigate the negative effects of racial hegemony on health. This article summarizes the major conceptual and methodological challenges for health disparities research and their policy implications.

Several terms are used in this special issue to describe systems of racial advantage and disadvantage. In the introductory article of this special issue, Rivera and Beatty (2014) refer to stigma and prejudice, which, in this issue, are based on race and/or ethnicity. We believe the term racism is appropriate to describe the phenomenon under study. Racism, as defined by Camara Jones (2003), 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). This “system”—which ranges from daily interpersonal interactions shaped by race/ethnicity to racialized opportunities for good education, housing, employment, etc.—unfairly disadvantages racial and ethnic minority individuals and communities, unfairly advantages European-American individuals and communities, and “ultimately undermines the full potential of the whole society through the waste of human resources” (Jones, 2003).

Several articles in this special issue build on the existing literature examining the racism–health relationship. The existing evidence base is rich and growing. 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 (Mays, Cochran, & Barnes, 2007). In another study, Black women who reported that they had been victims of racial discrimination were 31% more likely to develop breast cancer than those who did not (Taylor et al., 2007). 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. Filipinos reported the highest level of discrimination, followed by Chinese Americans and Vietnamese Americans (Gee, Spencer, Chen, & Takeuchi, 2007).

But research has also examined the broader consequences of racism and 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—find that racial and ethnic discrimination in housing markets remains significant and pervasive. A 2000 U.S. 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 (U.S. Department of Housing and Urban Development, 2005). 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 (Turner & Ross, 2003). Audit studies of employment discrimination consistently find that job applicants of color are more likely than 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 African Americans who did not present criminal records (Pager, 2003). These forms of discrimination have significant health consequences, given the relationship between socioeconomic status and health (Williams, Neighbors, & Jackson, 2003).

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, devalue people of color, and can lead to the perception of oneself as worthless and powerless (Jones, 2001). For example, internalized racism among Blacks who exhibit racial prejudice toward other Blacks is positively
associated with alcohol use and chronic psychological stress (Taylor & Jackson, 1990). Self-reported experiences of racial discrimination and the internalization of negative racial group attitudes are both 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 (Chae, Lincoln, Adler, & Syme, 2010). Several studies in this issue also show that self-stereotyping depletes self-esteem and contributes to overweight and obesity in adult Hispanics, but not in Whites (Rivera & Paredez, 2014), and that negative perceptions of the neighborhood (i.e., neighborhood disorder and safety issues) also contribute to central body adiposity (Rooks et al., 2014). Both studies identify important group- and community-level targets for interventions to reduce adverse health outcomes.

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 (Randall, 2011). Structural racism results from a system of social structures that produces cumulative, durable, race-based inequalities (The Kirwan Institute, 2011). 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, community violence, limited opportunities for meaningful employment, 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) (Williams & Collins, 2001). 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 exposure to environmental toxins. 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 (Rooks et al., 2014). While some forms of segregation, such as ethnic enclaves among new immigrants, can foster positive mental health through social support, much of the residential segregation in the United States is reliant on both institutional discrimination in the real estate and housing finance market and individual interpersonal discrimination (Massey & Denton, 1993).

What’s needed now is a more comprehensive and sophisticated understanding of the cumulative, interactive effects of the different forms of racism and related risk factors 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 they 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 (Wyatt et al., 2003). 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 identity and socialization may moderate these influences (Hughes et al., 2006).

Such a model must facilitate an intersectional analysis to better understand the complex dimensions of race, gender, socioeconomic status, sexual orientation, 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 (Crenshaw, 1991). 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 (CRT), to help understand and address the many forms of structural inequality and their intersectional effects on health. Ford and Airhihenbuwa (2010), for example, offer an application of CRT 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. Similarly, Thomas and colleagues propose a “Fourth Generation” of health equity research, grounded in CRT, 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, CRT principles such as the social construction of knowledge, critical approaches, and disciplinary self-critique, Thomas and colleagues argue, promote an integrated understanding of how social forces structure health in ways that avoid simplistic parsing of effects (Thomas, Quinn, Butler, Fryer, & Garza, 2011).

In order to fully appreciate the impact of racism on health require comprehensive, multidimensional, reciprocal models of health risks and resources over the life course that correctly situate the role of racism in the complex interplay
of factors that result in cumulative vulnerability to adverse health outcomes in populations of color (see Myers, 2009 for such a model).

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 (Jones, 2001). The health consequences of racial inequities 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) (LaVeist, Gaskin, & Richard, 2009). And with growing evidence that inequality harms even advantaged groups, it is clear that racism has imposed health and economic burdens across all U.S. 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 unique 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 U.S. population as a whole.

To tackle these challenges, policies must be crafted that mitigate the impact of racism on health at multiple levels of influence, ranging from public and individual awareness and education to school and residential desegregation. One of the most important and enduring contributions of psychological research to federal policy was that of Drs. Kenneth and Mamie Clark, whose classic studies of internalized self-hatred among African-American schoolchildren in the 1940s contributed to the U.S. Supreme Court’s finding in the 1954 Brown v. Board of Education decision that separate educational facilities for African-American children were inherently unequal, and that segregation damaged children’s racial identity formation (Philogene, 2004). The court ordered U.S. public schools to desegregate, and while the nation has failed to fully do so (disturbingly, in recent years schools have tended toward resegregation, eliminating gains made in the last quarter of the 20th century), desegregation remains an important structural-level policy objective that can have significant implications for the racial identity formation of children of color, as well as to ensure equal access to the educational resources necessary for social mobility in an increasing complex and competitive global society. More research is needed to understand how desegregation and effective integration efforts can mitigate internalized racism, but the research presented in this issue by Page-Gould, Mendoza-Denton, and Mendes (2014), Sanders-Phillips (2014), Brady (2014), and LaVeist, Thorpe, Pierre, Mance, and Williams (2014) will be critically important to achieve this objective.
Critical to school desegregation is housing segregation. As noted above, neighborhoods with high concentrations of poverty can impair the health and human development of their residents. Efforts to deconcentrate poverty, such as by assisting those who seek to move out of high-poverty communities, should therefore be considered from a health equity and social justice perspective. Housing mobility entails the use of housing assistance to help families in high-risk neighborhoods move to communities with better opportunity structures and, therefore, better conditions for health and well-being. Recent findings from the federal Moving To Opportunity program suggest that families who moved out of distressed neighborhoods and into lower-poverty communities experience better mental health, lower rates of risky health behaviors, and modest reductions in obesity and diabetes compared to a randomly assigned control group of families who also sought housing assistance but did not move out of distressed communities. While the results of this longitudinal study have not been uniformly positive (adolescent boys did not benefit as much as adolescent girls), the findings nonetheless suggest that housing mobility, when combined with other family support strategies and investments in distressed communities, can reduce the concentration of poverty and associated health risks that are among the root causes of health inequities (Ludwig et al., 2011). More research is needed to understand the potential of housing mobility to address intrapersonal, interpersonal, and intergroup stigma.

Research is also needed to assess the impact of antiracism public awareness and public education campaigns. While there have been few coordinated federal efforts to address racism since “One America”—President Clinton’s Initiative on Race in America, which sought to engage a national dialogue on race and racial reconciliation—local, state, and federal agencies can collaborate with a range of public sector partners to encourage communities to examine how racism is expressed in daily life, both in visible (e.g., discriminatory treatment) and less-visible (e.g., discrimination in home mortgage lending) ways. Yet strong data are lacking evaluating the impact of such large-scale initiatives on public awareness, attitudes, and knowledge about race and racism. Should current or future administrations “grab the baton” from the Clinton Administration and the recent election and reelection of President Obama and extend the conversation, a strong base of knowledge from One America and other grassroots racial equity efforts can help to inform research and practice.

Finally, more research is needed on the potential benefits of training for professionals in health, social service, and educational sectors regarding implicit biases and stereotypes. The large body of research on implicit bias—revealing that a significant majority of people succumb instantaneously, automatically, and often unwittingly to racial, gender, sexual orientation and other group stereotypes and biases—is being used by trainers working in an array of sectors to educate professionals who interact across racial/ethnic and socioeconomic lines. Trainees can learn more by taking the Implicit Association Test online, and within 15 minutes
learn about how widely held social stereotypes about and biases against racial, sexual, and religious minorities, overweight people, older people, people with disabilities, and other groups automatically shape their ability to make positive and negative associations. Such tools offer great promise to help target audiences understand the salience of race in daily life. Government can stimulate the use of antiracism training by encouraging accrediting bodies to adopt cross-cultural education standards that utilize implicit bias theory, research, and educational tools.

More policy strategies to address racism and its health consequences will emerge as research and theory embrace the complexity of the problem. Racism is a persistent and ubiquitous aspect of American life that will require a coordinated response aimed at multiple levels, including the intrapersonal, interpersonal, and intergroup (i.e., structural and institutional). Theory, research, and policy analysis must also conform to this approach, which will require interdisciplinary and intersector (e.g., faith, education, business communities) collaboration and strong community leadership and engagement. Given the nation’s movement toward a population majority of people of color, these sectors can be among the most persuadable and vital partners in the effort to advance health equity.

References


BRIAN D. SMEDLEY is Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. Formerly, Smedley was Research Director and cofounder of a communications, research, and policy organization, The Opportunity Agenda (www.opportunityagenda.org). Prior to helping launch The Opportunity Agenda, Smedley was a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as Study Director for the IOM reports, *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce* and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, among other reports on diversity in the health professions and minority health research policy. Smedley came to the IOM from the American Psychological Association, where he worked on a wide range of social, health, and education policy topics in his capacity as Director for Public Interest Policy.

HECTOR F. MYERS is a Professor in the Center for Medicine, Health & Society and the Department of Psychology at Vanderbilt University, Nashville, Tennessee. He earned his PhD in Clinical Psychology at the University of California, Los Angeles, in 1974. He has published extensively on biobehavioral and psychosocial factors contributing to ethnic disparities in health & mental health. He has investigated questions related to racial/ethnic differences in exposure to stress in diverse health outcomes, including essential hypertension, heart disease, depression, HIV/AIDS, and on the impact of trauma exposure on mental health status. He has also collaborated in testing for ethnic differences in response to pharmacotherapy for depression, as well as testing the efficacy of community-based interventions for HIV/AIDS risk reduction. Dr. Myers is also interested in developing and testing multidimensional lifetime conceptual models to account for the persistent ethnic health disparities.