Chapter 6

Racism and Health

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Race is a social category that historically and currently captures differential access to power and resources in society (Williams, 1997). The term *racism* refers to an organized system, based on an ideology of inferiority that categorizes, ranks, and differentially allocates desirable societal resources to socially defined “races” (Bonilla-Silva, 1996). The development of racism is typically undergirded by an ideology of inferiority in which some population groups are regarded as being inferior to others. This often leads to the development of negative attitudes and beliefs toward racial outgroups (prejudice), and differential treatment of members of these groups by both individuals and social institutions (discrimination). Racial prejudice and discrimination, measured at the individual level, are often used as indicators of racism in a society, but it is also possible for racism to persist in institutional structures and policies in the absence of racial prejudice at the level of individuals. Moreover, negative racial stereotypes are an additional source of discriminatory behavior even among persons who are not prejudiced. Stereotypes are categorical beliefs about social groups that lead individuals to see members of a group as very similar to each other and as possessing common characteristics.

There is considerable interest among health researchers in cataloguing and quantifying the multiple ways in which racism can adversely affect health. This chapter provides an overview of research on these processes. However, understanding the potential effects of racism on health requires an appreciation of the ways in which racism has operated and continues to operate in society. After an overview of the nature of racism, the chapter describes the multiple ways in which residential segregation, an often-overlooked institutional mechanism of racism, can affect health. Residential segregation shapes socioeconomic status (SES) and thus health by restricting access to educational and employment opportunities, discounting the economic value of a given level of SES and creating health-damaging conditions in residential environments. Racism can also affect health through determining access to desirable services such as medical care, the internalization of racist ideologies, and subjective experiences of discrimination.

A word about terminology. Race is more of a social than a biological category, and members of the major racial/ethnic groups are divided over preferred terminology. A large national study identified the most preferred term for each group. Sixty-two percent of Whites prefer “White” (17% prefer “Caucasian”), 58% of Hispanics prefer “Hispanic” (12% prefer “Latino”), 44% of Blacks prefer “Black” (28% prefer “African American”), and 50% of American Indians prefer “American Indian” (37% prefer “Native American”; Tucker et al., 1996). In an effort to recognize individual dignity, I use the most preferred terms for each group interchangeably.

The Nature of Contemporary Racism

Negative racial attitudes are often used as a societal marker for racism. Some observers believe that there has been a decline in racism in the United States because of the dramatic reduction in the negative racial attitudes of Whites toward Blacks that has occurred in recent decades and broad current support for the principle of equality in virtually every area of evaluation. We consider examples in the area of housing and employment where identical questions were asked of national samples of Whites in various years (Schuman, Steeh, Bobo, & Krysan, 1997). For example, in 1963, 60% of Whites endorsed the view that “White people have a right to keep Negroes out of their neighborhoods if they want to,” but by 1996, only 13% of Whites agreed with that statement. Similarly, in 1944, a majority of Whites supported Affirmative Action in employment for Whites. Specifically, 55% indicated that White people should have the first chance at any kind of job. However, by 1972, only 3% of Whites supported that view, with

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97% indicating that Blacks should have as good a chance as Whites to get any kind of job. This new commitment to racial equality reflected by the positive changes in racial attitudes was institutionalized in the Civil Rights Acts of the 1960s, which removed the legal supports for discrimination.

At the same time, the commitment of many Whites to the principle of equality is superficial, with many individuals who support equal access in principle, unwilling to support policies that would actually implement it (Schuman et al., 1997). For example, in 1973, 67% of a national sample of Whites said that they would support a law that would guarantee a homeowner the right to decide for himself whom to sell his house to even if he preferred not to sell to Blacks. By 1996, one third of Whites would still grant a homeowner that right. In a similar vein, there is only weak support for policies to eradicate employment discrimination. In 1964, 38% of Whites indicated that “the government in Washington should see to it that Black people get fair treatment in jobs,” and 13% indicated that they lacked enough interest in the question to favor one side over another. In 1996, the percentage of Whites supporting federal intervention to ensure fair treatment in jobs declined to 28%, while the percentage expressing no interest in the question increased to 36%.

In addition, national data reveal that Whites continue to hold negative stereotypes of Blacks and other minorities. For example, 56% of Whites believe that Blacks prefer to live off welfare, 51% think that Blacks are prone to violence, 29% view Blacks as unintelligent, and 44% see Blacks as lazy (Davis & Smith, 1990). Comparatively, Whites believe that only 4% of Whites prefer to live off welfare, that 16% are prone to violence, that 6% are unintelligent, and that 5% are lazy. In this study, Whites viewed Blacks, Hispanics, and Asians more negatively than themselves, but Blacks were viewed more negatively than all other groups, and Hispanics twice as negatively as Asians. It is possible that these reported levels of negative stereotypes are understated due to social desirability concerns.

These high levels of negative stereotypes are an ominous indicator of widespread societal discrimination. Research indicates that individuals who hold negative stereotypes of a group will discriminate against members of the stigmatized group (Devine, 1995; Hilton & von Hippel, 1996). Moreover, well-learned stereotypes resist disconfirmation, and their activation is an automatic process with even non-prejudiced individuals spontaneously, and without conscious awareness, discriminating against someone to whom the stereotypes are applicable (Devine, 1989; Hilton & von Hippel, 1996).

Thus, in the United States, the combination of negative racial stereotypes, weak support for policies to eradicate historic racial inequities, and the persistence of institutional mechanisms of discrimination ensures that discrimination is still common-place. For example, based on negative stereotypes of African Americans, the majority of Whites express a strong preference for living in racially segregated neighborhoods (Bobo & Zubrinsky, 1996), and Blacks in search of housing are still systematically steered toward neighborhoods having a greater number of minorities, lower home values, and lower median income (Fix & Struyk, 1993). A review of the data on the persistence of housing discrimination in the United States concluded that, in any given encounter between a Black home-seeker and a real estate agent, the odds are at least 60% that something will happen to limit that Black renter’s or buyer’s access to housing that is available to Whites (Massey, Gross, & Shibuya, 1994).

The employment opportunities for Blacks are also negatively affected by employment discrimination at the level of individual employers. Some of the best evidence of this comes from audit studies in which trained Black and White job applicants with identical qualifications apply for employment. These studies find that discrimination that favors White over Black applicants occurs in one in every five audits (Fix & Struyk, 1993). In these studies, racial differences exist for being allowed to submit an application, in obtaining interviews, and in being offered a job. As painful as it may be to acknowledge, scientific evidence is overwhelming that discrimination is routine and commonplace in society. Racial discrimination is not the aberrant behavior of a few bad apples but a widespread societal problem. Moreover, much discrimination today occurs through behaviors that the perpetrator may not subjectively experience as intentional. The evidence also suggests that one cannot rely on the stated racial attitudes of Whites or the mere existence of laws prohibiting discrimination to ensure that it does not occur.

Racism and Health

The growing literature on racism and health suggests that there are multiple pathways by which racism adversely affects the health of nondominant racial/ethnic groups over the life course. First, and most importantly, institutional discrimination can affect health by creating racial/ethnic differences in residential environments, SES, and access to goods and services. Second, experiences of discrimination may be a neglected psychosocial stressor that adversely affects health. Third, nondominant group members' internalization of society's negative characterization of their group may also have health consequences.

Residential Segregation: The Power of Institutional Discrimination

Observers have long noted the central role played by segregation in creating racial differences in SES.
Historian John Cell (1982) indicates that residential segregation was “one of the most successful political ideologies” of the 20th century and “the dominant system of racial regulation and control” in the United States. Similarly, Massey and Denton (1993) indicated that segregation is “the key structural factor for the perpetuation of Black poverty in the U.S.” and the neglected “missing link” in efforts to understand urban poverty. We now consider evidence that racial residential segregation is the key institutional mechanism of racism on which Black–White disparities in SES have been built in the United States. Segregation is a fundamental cause of differences in health status between African Americans and Whites because it shapes socioeconomic conditions for Blacks at the level of the individual, household, and community (Williams & Collins, 2001). That is, segregation is a key determinant of racial differences in socioeconomic mobility and also creates poor health damaging conditions in the social and physical environment.

**Racism in Action: The Nature and Persistence of Segregation**

Prior to the Civil War, segregation was not a feature of life in the United States (Cell, 1982; Lieberson, 1980; Massey & Denton, 1993). In the late 19th and early 20th century, segregation, rooted in the widely endorsed ideology of White supremacy, was developed and advocated by Whites as a very conscious and deliberate strategy to ensure that Whites were protected from residential proximity to Blacks by physically separating Blacks from Whites in residential areas (Cell, 1982). The legislation that implemented this ideology required Blacks to reside only in restricted (less desirable) areas. These legal restrictions were supported by the banking and real estate industries, incorporated into the housing policies of the federal government, and enforced by the judicial system (Cell, 1982; Jaynes & Williams, 1989). These institutional policies received active support by individuals at the local level. Vigilant neighbors and neighborhood organizations assisted local police in enforcing segregation, real estate agents actively steered Blacks to their designated neighborhoods, and home owners placed restrictive covenants in their property deeds that prohibited their homes from being sold to Blacks. Accordingly, in both Northern and Southern cities, levels of Black–White segregation increased dramatically between 1860 and 1940 and have remained strikingly stable since then (Massey & Denton, 1993).

The segregation of African Americans in the United States is unique, comparable only to the isolation of American Indians on reservations. While most immigrant groups have experienced some residential segregation in the United States, no immigrant group has ever lived under the high levels of segregation that currently characterize the African American population (Massey & Denton, 1993). Interestingly, in the early 20th century, segregation increased for Blacks at the same time that it declined for immigrants. In the late 19th century and up through 1910, Blacks were less segregated than several European immigrant groups (Lieberson, 1980). However, after 1910, segregation for these European groups declined while that of Blacks increased. Accordingly, for European immigrants, the second generation was less segregated than the first. The same is not true for most Blacks.

The Civil Rights Act of 1968 removed the legal support for residential segregation by making discrimination in the sale or rental of housing units illegal in the United States. However, old habits die slowly and studies reveal that explicit discrimination in housing persists (Fix & Struyk, 1993). In addition, research reveals that in a range of more subtle ways Blacks are still discouraged from residing in White residential areas (Turner, 1993). Moreover, Whites prefer neighborhoods with few or no Blacks and move out of communities when the Black population increases. Paradoxically, although African Americans express higher support than other racial/ethnic groups for residence in integrated neighborhoods (Bobo & Zubrinsky, 1996), their residential exclusion remains high and distinctive.

Data from the 2000 Census documented the persistence of extremely high levels of segregation in the United States (Glaeser & Vigdor, 2001). Nationally, the index of dissimilarity for the United States declined from .70 in 1990 to .66 in 2000. A score of .66 means that 66% of Black U.S. residents would have to move to achieve a perfect representation of their group. Generally, a dissimilarity index value above .60 reflects extremely high segregation (Massey & Denton, 1989). In the 2000 Census, some 74 metropolitan areas that contain the majority of the Black population had dissimilarity scores greater than .60. In fact, between 1990 and 2000 there was no decline in the number of census tracts where over 80% of the population was African American (Glaeser & Vigdor, 2001). The small decline in segregation was largely due to the movement of Blacks into formerly all-White census tracts rather than the integration of overwhelmingly Black (over 80%) census tracts. Accordingly, the decline in segregation has not reduced the very high percentage African American census tracts, the residential isolation of most African Americans, or the concentration of urban poverty (Glaeser & Vigdor, 2001). Thus, while ethnic enclaves were temporary in the process of assimilation for immigrants, high levels of segregation have been a permanent feature of the African American experience for almost a century.

**Segregation and SES**

Segregation restricts socioeconomic attainment for African Americans by determining access to
education and employment opportunities. In the United States, the funding of public education is controlled by local government and community economic resources determine the quality of the neighborhood school. In addition, in most areas, residence determines which public school students can attend. Accordingly, residential segregation produces very segregated elementary and high schools, which vary in available resources and educational quality. Some 50 years ago, the U.S. Supreme Court unanimously ruled in Brown v. Board of Education that segregated schools were inherently unequal and unconstitutional. However, because of the persistence of residential segregation, elementary and high school education in the United States remains highly segregated and markedly unequal (Orfield & Eaton, 1996). Moreover, levels of segregation for Black and Latino students are on the increase (Orfield, 1996).

It is the concentration of poverty rather than racial composition that lies at the heart of the problems created by segregation. In many large metropolitan areas, residential segregation and the concentration of poverty overlap considerably. Although two out of three poor persons in the United States are White, poor White families tend to be dispersed throughout the community with many residing in desirable residential areas (Wilson, 1987). Nationally, the correlation between minority (Black and Hispanic) percentage and poverty is .66, and in metropolitan Chicago, the correlation is .90 for elementary schools (Orfield, 1996). Accordingly, in 96% of predominantly White schools, the majority of students come from middle-class backgrounds (Orfield, 1996). In contrast, in public schools where the student body is predominantly Black and Hispanic, most of the children are poor. Because of segregation, many minority students are concentrated in urban schools that have different and inferior courses and lower levels of achievement than the schools attended by White students in adjacent suburban school districts (Orfield & Eaton, 1996). Thus, the high school dropout and graduation rates, the competencies and knowledge of a high school graduate, and the probability of enrollment in college vary by race.

Segregation is also a critical determinant of employment opportunities and thus income levels for African Americans. We earlier noted evidence of discrimination on the part of individual employers. In addition, institutional discrimination, based on residential segregation, severely restricts access to jobs for Blacks. First, residential segregation isolates Blacks in segregated communities from both role models of stable employment and social networks that could provide leads about potential jobs (Wilson, 1987). Second, in recent decades, low-skill, high-pay jobs have moved from the urban areas where Blacks reside to the suburbs (Wilson, 1987, 1996). Some corporations explicitly use the racial composition of areas in determining the sites of new plants and the relocation of existing ones (Cole & Deskins, 1988). Negative racial stereotypes of African Americans and the areas where they are concentrated play an important role in these decisions (Kirschman & Neckerman, 1991; Neckerman & Kirschman, 1991). A Wall Street Journal analysis of more than 35,000 U.S. companies found that Blacks were the only racial group that experienced a net job loss during the economic downturn of 1990–1991 (Sharpe, 1993). African Americans had a net job loss of 59,000 jobs, while there was a net gain of 71,100 for Whites, 55,100 for Asians, and 60,000 for Latinos. Thus, during routine "non-racial" restructuring, relocation, and downsizing, employment facilities are systematically moved to suburban and rural areas where the proportion of Blacks in the labor force is low.

The Consequences of Segregation: Racial Differences in SES and Health

Thus, racial differences in SES are the predictable results of the reduced access to educational and employment opportunity that is produced by segregation. An analysis of the effects of segregation on young African Americans making the transition from school to work found that the elimination of residential segregation would completely erase Black–White differences in earnings, high school graduation rates, and unemployment and would reduce racial differences in single motherhood by two thirds (Cutler, Glaeser, & Vigdor, 1997). Research has identified SES as one of the strongest determinants of variations in health, in general, and the major contributor to racial differences in health, in particular (Williams & Collins, 1995). SES accounts for much of the racial differences in health, and it is frequently found that SES differences, within each racial group, are substantially larger than overall racial ones (Williams, 1999).

Table 1 presents life expectancy differences at age 65 by age and years of education (Lin, Rogot, Johnson, Sorlie, & Arias, 2003). At age 65, White men can expect to live almost one year longer (0.8) than their Black counterparts and White women just over one year longer (1.3) than their Black peers. Racial disparities in health are larger at younger ages, and the higher rates of illness and death among African Americans in the pre-retirement years ensure that markedly fewer Blacks than Whites survive to age 65. National data reveal that for every 100,000 Black and White men born alive (National Center for Health Statistics [NCHS], 1999), 17,000 fewer Black men survive to age 65. Similarly, 10,100 fewer Black than White women reach their 65th birthday from each initial cohort of 100,000. However, Table 1 shows that for both Blacks and Whites, men and women, higher levels of education are associated with longer life expectancy. Moreover, for all groups, the gap in life expectancy between the highest and lowest education category is larger than the racial gap in
health. Instructively for five of the six comparisons in the table, Blacks have a lower life expectancy than comparably educated Whites.

Racial differences in health among minority elders must be understood within a life course framework. The Black–White differentials in SES and health reflect the historical legacy of racism and the unequal educational opportunities and lack of investment in education for Blacks that characterized U.S. society when Black seniors were growing up. Fischer and colleagues (1996) show that the initial efforts to educate Blacks after the Civil War were replaced by Jim Crow laws in the late 19th century that led to a decline in spending on education for Blacks, such that one third of the counties in the South had no high schools for Blacks in the 1930s. In 1911, Atlanta had no high school that would accept African Americans. The schools that did exist for Blacks were inferior in quality. This lack of educational training and opportunity, combined with discrimination in employment, is reflected in the current economic circumstances and health of the Black elderly population.

Nonequivalence of SES

Racial differences in income, education, and occupation do not tell the full story of racial differences in economic circumstances. These standard socioeconomic indicators are not equivalent across race (Kaufman, Cooper, & McGee, 1997; Williams & Collins, 1995). As noted earlier, there are large racial differences in the quality of elementary and high school education, such that Black high school graduates bring fewer basic skills to the labor market than their White counterparts (Maxwell, 1994). In addition, at every level of education Whites have higher median income than Blacks and Hispanics (U.S. Bureau of the Census, 2001). These differences are larger among men than among women. Moreover, even after taking differences in test scores into account, African Americans still earn less than their White peers (Neal & Johnson, 1996). Middle-class Blacks are also more likely than their White peers to be recent and tenuous in that status (Collins, 1997). College-educated Blacks, for example, are more likely than their White peers to experience unemployment (Council of Economic Advisors for the President’s Initiative on Race, 1998). Moreover, employed Blacks are more likely than their White peers to be exposed to occupational hazards and carcinogens, even after adjusting for job experience and education (Robinson, 1984).

Segregation also leads to racial differences in the purchasing power of income. Many commercial enterprises withdraw from segregated urban areas. There are often fewer services in highly segregated Black areas and the available ones tend to be poorer in quality but higher in price. On average, Blacks pay higher prices than Whites for a broad range of goods and services in society including food and housing (Alexis, Haines, & Simon, 1980; Ayres, 1991; Williams & Collins, 1995). Some evidence suggests that it is difficult, even for middle-class Blacks, to escape some of the negative neighborhood conditions associated with segregation. There is increasing segregation in some suburban areas (Reardon & Yun, 2001), and middle-class Blacks are less able than their White counterparts to translate their higher economic status into desirable residential conditions. Although middle-class suburban African Americans reside in neighborhoods that are less segregated than those of poor central city Blacks, they live in poorer quality neighborhoods than middle-class Whites and with White neighbors who are less affluent than they are. A recent analysis of 1990 Census data revealed that suburban residence does not buy better housing conditions for Blacks (Harris, 1999). The suburban locations where African Americans reside tend to be equivalent or inferior to those of central cities. One recent national study found that while residence in the suburbs was associated with lower mortality rates for Whites, it predicted markedly elevated mortality rates for Blacks, especially for Black men (House et al., 2000).

Racial differences in income also provide no information on racial differences in wealth. The racial differences in wealth are much larger than those for income and there are racial differences in the inheritance of wealth and intergenerational transfers of wealth. At every level of income, Black and Hispanic elders have considerably less wealth than their Caucasian peers (Smith, 1997), so that racial/ethnic differences in income understate real racial gaps in economic resources. Racial differences in wealth also link the current situation of Blacks to historic discrimination. For most American families, housing equity is a major source of wealth. Thus, today’s Black–White differences in wealth are, at least partly, a consequence of the institutional discrimination in housing practiced in the past (Oliver & Shapiro, 1997). In addition, residential segregation leads to smaller returns on the investment in real estate for African Americans compared with Whites. That is, the growth in housing equity over time, a major source

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<th>Table 1. Life Expectancy at Age 65</th>
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Source: National Longitudinal Mortality Study (NLMS); adapted from Lin and colleagues (2003). Notes: W = White; B = Black.
of wealth for most American families, is smaller for Blacks in highly segregated areas than for comparable homes in other areas (Oliver & Shapiro, 1997).

**Segregation Can Create Pathogenic Residential Conditions**

High levels of segregation create distinctive residential environments for African Americans. Sampson and Wilson (1995) report that in the 171 largest cities in the United States, there was not even one where Whites lived in comparable conditions to Blacks in terms of poverty rates or rates of single-parent households. These researchers came to the striking conclusion that “the worst urban context in which Whites reside is considerably better than the average context of Black communities” (Sampson & Wilson, 1995).

Racial residential segregation has led to unequal access for most Blacks to a broad range of services provided by municipal authorities. Compared to more affluent areas, political leaders have been more likely to cut spending and services in poor neighborhoods, in general, and African American neighborhoods, in particular (Wallace, 1991). Because poor and minority persons are less active politically, elected officials are less likely to encounter vigorous opposition when services are reduced in these areas. This disinvestment of economic resources in these neighborhoods has led to a decline in the quality of life in those communities (Alba & Logan, 1993). The selective out-migration of many Whites and some middle-class Blacks from cities to the suburbs has also reduced the urban tax base and the ability of some cities to provide a broad range of supportive social services to economically deprived residential areas.

Research reveals that residential segregation is related to elevated risk of adult and infant mortality and tuberculosis (Williams & Collins, 2001). There are multiple mechanisms by which the concentrated poverty created by segregation could adversely affect health (Schulz, Williams, Israel, & Lempert, 2002; Williams & Collins, 2001). First, the conditions created by poverty and segregation make it more difficult for residents of those areas to practice desirable health behaviors. The higher cost and poorer quality of grocery items in economically disadvantaged neighborhoods can lead to poorer nutrition. Both the tobacco and alcohol industry heavily bombard poor minority communities with advertising for their products. The lack of recreation facilities and concerns about personal safety can also discourage leisure time physical exercise.

In addition, given the strong association between SES and the distribution of stress, the concentration of poverty leads to exposure to elevated levels of economic hardship, as well as other types of chronic and acute stress at the individual, household, and neighborhood level. For example, African Americans are much more likely than Whites to be victims of all types of crime (Council of Economic Advisors for the President’s Initiative on Race, 1998). The weakened community and neighborhood infrastructure in segregated areas can also adversely affect interpersonal relationships and trust among neighbors (Schulz et al., 2002). These resources can potentially reduce at least some of the negative effects of stress on health. Fourth, poor, segregated communities are often victims of institutional neglect and disinvestment. The resulting decline in the urban infrastructure and physical environment results in disproportionate exposure to environmental toxins and poor quality housing (Bullard, 1994).

**Discrimination and Medical Care**

Institutional and individual discrimination can also reduce non-dominant groups access to a broad range of desirable goods and services. Medical care is one example. Discrimination can affect access to care, as well as the quality and intensity of medical treatment.

**Discrimination and Access to Medical Care**

As noted, discrimination reduces access to employment opportunities. In turn, access to good jobs determines access to medical care in the pre-retirement years. Compared with Whites, African Americans, Latinos, and some Asian populations have lower levels of insurance coverage, with Hispanics having greater barriers to health insurance than all other U.S. groups (Smedley, Stith, & Nelson, 2003). In the pre-retirement years, Blacks and Hispanics are less likely to have direct private employer-based insurance coverage and to have health insurance coverage indirectly through a spouse’s employment, and are more likely to have public health insurance coverage than Whites (Hogue, Hargraves, & Collins, 2000; NIH, 1998). They are also more likely than Whites to receive care in non-optimal organizational settings (such as the emergency room) and to lack continuity in the health care received. Analyses of racial and ethnic differences in access and the use of health services between 1977 and 1996 concluded that the Black–White gap has not narrowed over time and the gap between Hispanics and Whites has widened (Weinick & Zuvekas, 2000). Moreover, this study found that, even if income and health insurance coverage were equalized, racial/ethnic differences in having a usual source of care and in receiving ambulatory care in the past year would not be eliminated because one half to three quarters of the disparities on these indicators are not accounted for by those factors.

Racial/ethnic differences in access to care persist into the retirement years. In 1965, the Medicare program was established to reduce financial barriers...
to hospital and physician services for persons aged 65 and older. As a prerequisite for participation in this program, hospitals were mandated to be in compliance with Title VI of the Civil Rights Act of 1964, which requires that no one can be excluded from federal benefits based on race, color, or national origin. This requirement played a large role in desegregating hospitals in the United States (Quadagno, 2000). However, although Medicare has improved access to health care for America’s elderly adults, there is evidence that racial differences in access to health services remain within this population (Gornick, 2000). Compared with their White peers, Black and Latino elders are less likely to have private insurance and more likely to receive Medicaid and to have Medicare as their only insurance (NCHS, 2001).

Thus, although many minority elders have greater need for medical care due to higher levels of morbidity, they are more likely than Whites to face economic challenges in accessing medical services. Medicare does not cover some medical needs such as prescription drugs, dental care, and long-term care, and out-of-pocket medical expenses can be substantial. In addition, Medicare requires a copayment on physician charges, an annual deductible for Part A, and the cost of one day of inpatient care. These medical expenses may present additional burdens to elders and especially minority elders who are more likely than Whites to have low household incomes. For example, in 1996, two thirds of White Medicare beneficiaries had incomes of less than $25,000 compared with 90% of Black and Hispanic beneficiaries (Gornick, 2000). Other data reveal that Black, Hispanic, Asian and Pacific Islander, and American Indian elders all have higher rates of poverty than their White counterparts (Williams & Wilson, 2001).

African American Medicare beneficiaries report higher levels of morbidity than their White counterparts. However, they report lower levels of office visits but more inpatient, emergency room, and nursing home visits (Gornick, 2000). Compared with Whites, African American beneficiaries also have markedly lower visits to specialists and receive diagnostic services such as mammography and sigmoidoscopy at much lower rates (Gornick, 2000). For some elderly persons with low income and assets, Medicaid can cover much of their out-of-pocket medical expenses. However, only about 11% of elderly Medicare beneficiaries also receive Medicaid (Feder, Komisar, & Niefeld, 2001).

Residential segregation can affect access to medical care by determining both the particular institutions where minorities access care and the type and quality of their health care providers. Access to high quality medical care is often a challenge in many segregated neighborhoods. Health care facilities are more likely to close in poor and minority communities than in other areas (Whitets, 1992), and pharmacies in minority neighborhoods may be less likely to be adequately stocked with medication (Morrison, Wallenstein, Natale, Senzel, & Huang, 2000). Moreover, Blacks and Latinos are more likely than Whites to be treated at large inner-city urban hospitals that are often the place of final resort for the poor (Smedley et al., 2003). Some evidence also suggests that non-White patients are more likely than their White counterparts to be treated by lower-quality physicians (Mukamel, Murthy, & Weimer, 2000).

Discrimination and the Quality of Medical Care

Research reveals that there are systematic racial differences in the quality of medical care received among Medicare beneficiaries (McBean & Gornick, 1994). In an analysis of racial differences in the rates of procedures performed by hospitals for Medicare beneficiaries in 1992, McBean and Gornick (1994) found that Black Medicare beneficiaries were less likely than their White counterparts to receive all of the 16 most commonly performed procedures. The differences appeared to be largest for referral-sensitive procedures. Further examination of the Medicare files revealed that there were only four non-elective procedures that Black beneficiaries of Medicare received more frequently than their White counterparts. All of these procedures (such as, the amputation of a lower limb and the removal of both testes) reflected delayed diagnosis and/or initial treatment or failure in the management of chronic disease. A greater percentage of Black than White Medicare beneficiaries make out-of-pocket payments for deductibles and copayments for ambulatory care (McBean & Gornick, 1994). This higher financial cost could lead to lower utilization of ambulatory medical care and the postponement and avoidance of treatment.

However, racial differences in the receipt of various procedures among Medicare beneficiaries are consistent with a much larger literature that finds systematic racial differences in a broad spectrum of therapeutic interventions (Mayberry, Mili, & Ofili, 2000). A recent Institute of Medicine (IOM) report entitled Unequal Treatment documents that there are large racial/ethnic differences in the quality and intensity of medical care in the United States (Smedley et al., 2003). For a diverse range of therapeutic procedures, ranging from high technology interventions to basic diagnostic and treatment procedures, Blacks and other minorities are less likely to receive medical procedures and to experience poorer quality medical care than Whites. This pattern of differences is robust even in studies that adjust for differences in health insurance, SES, stage and severity of disease, comorbidity, and the type of medical facility.

Several lines of evidence suggest that discrimination based on negative stereotypes of minorities is likely to play a role in encounters between patients and providers in the United States. First, health care
providers are a part of the larger society that views racial/ethnic minorities negatively on multiple social dimensions. Second, research on stereotypes indicates that encounters in the health care setting contain ingredients that enhance the likelihood of the use of stereotypes. Stereotypes are more likely to be activated when there is time pressure, the need to make quick judgments, cognitive overload, and task complexity, and when the emotions of anger or anxiety are present (van Ryn, 2002). The typical health care encounter is often characterized by time pressure, brief encounters, and the need to manage complex cognitive tasks.

Third, the few studies that have examined how physicians perceive their patients indicate that Black patients are viewed more negatively than their White counterparts (Finucane & Carrese, 1990; van Ryn & Burke, 2000). For example, van Ryn and Burke (2000) found that even after adjustment for patient age, sex, SES, sickness/frailty, overall health status, patient availability of social support, and education level, physicians viewed Black patients (compared with their White counterparts) as less likely to adhere with medical advice and to be kind, intelligent, and educated, and more likely to lack social support and to abuse alcohol and drugs. Moreover, African American patients were two thirds less likely than Whites to be perceived as the kind of person the physician could see himself or herself being friends with. In an experimental design, Abreu (1999) found that health professionals “primed” with African American negative stereotypes were more likely to view the same hypothetical patient negatively than therapists primed with neutral words. Other experimental studies of physicians (Schulman et al., 1999; Weisbe, Sorum, Sanders, & Syat, 2001) and medical students (Rathore et al., 2000) provide further evidence that the manipulation of demographic variables such as race can lead to variations in provider perceptions.

Internalized Racism and Health

Negative images of Blacks are pervasive in American culture. Moore (1988), for example, documents the widespread use of blatant and subtle racist stereotypes, images, and symbols in the English language. Categorical beliefs about the biological and/or cultural inferiority of some racial groups can attack the self-worth of at least some members of stigmatized racial groups and undermine the importance of their very existence. Internalized racism refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves. One response of populations defined as inferior would be to accept as true the dominant society’s ideology of their inferiority (McCarthy & Yancey, 1971; Pettigrew, 1964). For example, for some African Americans, the normative cultural characterization of the superiority of Whiteness and the devaluing of Blackness, combined with the economic disadvantages of Blacks, can lead to the perception of self as worthless and powerless.

The internalization of negative cultural images by stigmatized groups appears to create expectations, anxieties, and reactions that can adversely affect social and psychological functioning. Fischer and colleagues’ (1996) review of research from several countries indicates that groups that are socially regarded as inferior have poorer academic performance than their more highly regarded peers. Examples include Koreans versus Japanese in Japan, Scots versus the English in the United Kingdom, and Eastern European origin versus Western European origin Jews in Israel. Research in the United States reveals that when a stigma of inferiority is activated under experimental conditions, performance on an examination was adversely affected (Steele, 1997). African Americans who were told in advance that Blacks perform more poorly on exams than Whites, who were told that they perform more poorly than men, and White men who were told that they usually do worse than Asians, all had lower scores on an examination than control groups who were not confronted with a stigma of inferiority (Fischer et al., 1996; Steele, 1997). Several studies have empirically examined the association of internalized racism with health. In a study of 289 African American women, Taylor and Jackson (1990) found a positive association between a scale capturing internalized racism and alcohol consumption. Internalized racism was also positively related to psychological distress even after adjustment for stress, social support, religious orientation, SES, marital status, and physical health (Taylor, Henderson, & Jackson, 1991; Taylor & Jackson, 1991).

Experiences of Discrimination and Health

There is growing research interest in the extent to which subjective experiences of discrimination may be an additional mechanism by which discrimination affects health. National data reveal that one third of the population reports exposure to major acute experiences of bias and 60% report that they have experienced chronic, everyday experiences of discrimination (Kessler, Mickelson, & Williams, 1999). Everyday discrimination includes perceptions of being treated with less courtesy than others and receiving poorer service than others in restaurants and stores. Unfair treatment experiences based on race is the most common type of bias in society (Kessler et al., 1999), and African Americans and other minorities report much higher levels of racial/ethnic bias than Whites (Williams, 2000). These experiences are viewed as an important domain of stressful life experience that has not been captured by
traditional measures of stress (Clark, Anderson, Clark, & Williams, 1999; Williams et al., 2003).

Several laboratory studies have found that exposure to racist experiences leads to increased cardiovascular and psychological reactivity (Harrell, Hall, & Taliaferro, 2003). Similar findings come from non-experimental settings (Krieger, 1999). The brief overview here, with illustrative examples, highlights the findings of a recent review of population-based empirical studies that examined the association between perceptions of racial, ethnic discrimination and health and identified 53 published studies (Williams, Neighbors, & Jackson, 2003).

Mental health status is the most frequently assessed indicator of health in studies of discrimination. The mental health outcomes that have been examined include well-being, self-esteem, perceptions of control, psychological distress, and anger, as well as specific psychiatric disorders such as major depression, generalized anxiety, and substance use. Eighty percent of the 47 associations examined in the literature between measures of discrimination and an indicator of mental health found that higher levels of discrimination were associated with poorer mental health status (Williams et al., 2003). For example, a national study of more than 3,000 American adults found that perceptions of acute and chronic discrimination were positively related to psychological distress, major depression, and generalized anxiety (Kessler et al., 1999).

Most of the research studies in this area have been U.S.-based, and the majority have focused on the African American population. However, several studies have documented similar patterns of associations for all of the other major minority groups in the United States. Similarly, recent studies have found inverse associations between discrimination and mental health among Asian immigrants in Canada, as well as multiple immigrant and other nondominant populations in the Netherlands, the United Kingdom, and Finland.

Multiple measures of physical health status have been examined (Williams et al., 2003). Six studies using a single-item global self-rated health measure have all found a positive association between discrimination and ill health. Nine of the 11 additional studies using other self-ratings of health or checklists of chronic illnesses documented that discrimination was related to poorer health status, at least under some conditions. For example, one recent study found perceived discrimination to be predictive of self-rated ill health and a composite measure of chronic health problems in a sample of 3,012 Mexicans in California (Finch, Hummer, Kolody, & Vega, 2001). Similarly, in a probability sample of more than 1,106 adults in Michigan, both chronic and acute discrimination were positively related to reports of ill health and chronic conditions for Blacks but not for Whites (Williams, Spencer, & Jackson, 1999). Eleven studies have examined the association between discrimination and hypertension, and the findings are mixed (Williams, Neighbors, & Jackson, 2003). Three studies have documented a clear positive association between discrimination and elevated blood pressure; in an additional five, this effect exists conditional on coping style, sex, SES, or race; and three studies find no association between discrimination and blood pressure. The findings for blood pressure are complex. For example, Krieger and Sidney (1996) found, in a sample of more than 2,000 African Americans, that blood pressure levels were higher for women and working-class men who reported no discrimination and who reported discrimination in three or more social situations, compared with those with discrimination in one or two situations. Among professional men, discrimination was positively related to systolic and diastolic blood pressure.

Other health outcomes have also been examined (Williams et al., 2003). Perceptions of discrimination were unrelated to self-reported heart disease in two studies, but a recent study found that perceptions of chronic discrimination were positively related to the onset of subclinical disease in the carotid artery for Black but not White women (Troxel, Matthews, Bromberger, & Sutton-Tyrrell, 2003). Two studies have examined the association between perceived discrimination and low birth weight, and the findings have been inconsistent. An additional study found that perceived discrimination was associated with an elevated mortality risk but only among adults with certain psychological orientations (LaVeist, Sellers, & Neighbors, 2001). Five studies have found a positive association between discrimination and cigarette use or alcohol consumption. Moreover, two studies have found that discrimination makes an incremental contribution above SES in explaining Black–White differences in self-reported health (Ren, Amick, & Williams, 1999; Williams, Yu, Jackson, & Anderson, 1997).

**Research Issues**

Research on racism and health must continue to monitor the changing nature of racism, and the multiple pathways by which racism especially in its institutional manifestations, can adversely affect health. Such research needs to utilize longitudinal designs and a life course perspective so that the accumulation of the multiple effects of racism can be assessed. Few studies of residential segregation and internalized racism have focused on the elderly population, and there is an urgent need for rigorous research that relates these aspects of racism to the health status of older persons.

Research is needed to identify the relative contribution of racism to racial/ethnic disparities in health care access and quality, especially for racial and ethnic minority populations other than Blacks and
Whites. To date, most of the research on this topic has focused on Blacks and Whites. A small number of studies have identified disparities in quality and intensity of care for diverse racial and ethnic populations, but the extent of disparities faced by Hispanics, American Indians, Asian Americans, and Native Hawaiians and other Pacific Islanders is unclear (Smedley et al., 2003). A related and potentially promising area of investigation is the identification of the specific characteristics of health care institutions and/or systems, some of which may be shaped by institutional racism, that can affect the presence and/or the magnitude of racial/ethnic disparities in the quality of care. At the present time we do not know the extent to which specific financial, structural, and institutional aspects of health care systems can determine variations in racial/ethnic disparities in care.

In order to shed light on how perceptions of discrimination may be related to health, advances are needed in the conceptualization and measurement of discrimination and in the theoretical identification and the empirical verification of the plausible pathways by which this stressor can affect various health outcomes. Studies to date have not given sufficient attention to capturing exposure to discrimination comprehensively and to assessing the cumulative burden of such exposure over the life course (Kreiger, 1999; Williams et al., 2003). Research efforts are needed that would comprehensively characterize discrimination in multiple areas of social life. Like other stressful experiences, discrimination is multidimensional and its assessment should provide coverage of all relevant domains: major and minor, traumatic and routine, acute and chronic, and specific and globally embedded. Importantly, the various types of experiences may have independent effects on health such that an evaluation of the full impact of this stressor may require the inclusion of all relevant classes of experience (Wheaton, 1999).

One of the most critical research needs is for more careful attention to the specific mechanisms by which perceptions of discrimination might adversely affect health. The literature on stress and health indicates that stressors can influence physical illness primarily through causing negative emotional states, such as anxiety and depression, which in turn can have direct effects on biological processes or patterns of behavior that affect disease risk (Cohen, Kessler, & Underwood, 1995). Experiences of discrimination and the negative emotional states created by them may also lead to changes in health-related behaviors and in lower levels of compliance with medical recommendations (Cohen et al., 1995). Researchers should also give attention to assessing the contribution of discrimination not only to the onset of disease but also to its severity and course.

Racism is one of several factors linked to the organization of society that shapes health status over the life course. This review suggests that its effects on health are pervasive and that they operate through diverse mechanisms to influence health risk. Importantly, some of the most important mechanisms by which racism influences health (institutional racism) are imperceptible to many researchers and challenging to study. However, success in eliminating racial/ethnic disparities in health is contingent upon clearly identifying the spiders that produce the complicated webs that create ill health and identifying effective strategies to eradicate these root causes of disease (Kreiger, 1994).

References


