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THE IMPACT OF RACISM ON HEALTH DISPARITIES.

AUTHORED BY - PRAPTI JALPAN SHAH

Abstract:

Race functions as an essential health disparity creator between various communities of different ethnicities. This study investigates the connection between system-based racism and health inequalities through research about how institutional barriers and structural inequalities with interpersonal discrimination affect health service access and healthcare delivery effectiveness and result outcomes. The study conducts a literature review which emphasizes both socioeconomic position and environmental contamination and stress-caused medical conditions in addition to medical sector discrimination. The study presents policy solutions for eliminating health inequalities alongside advancing racial health equality. Racism is not always conscious, explicit, or readily visible— often it is systemic and structural. Systemic and structural racism are forms of racism that are pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of colour, with adverse health consequences. Examples include residential segregation, unfair lending practices and other barriers to home ownership and accumulating wealth, schools' dependence on local property taxes, environmental injustice, biased policing and sentencing of men and boys of colour, and voter suppression policies. This article defines systemic and structural racism, using examples; explains how they damage health through many causal pathways; and suggests approaches to dismantling them. Because systemic and structural racism permeate all sectors and areas, addressing them will require mutually reinforcing actions in multiple sectors and places; acknowledging their existence is a crucial first step.

Keywords: Racism; Discrimination; Health Disparity; Race; Ethnicity; Immigrant; Social Determinants; Inequity.

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Introduction

Health discrepancies exist throughout worldwide societies because of the long-lasting and structural social inequalities that persist. Racism, as a social determinant of health, influences multiple facets of healthcare access, delivery, and outcomes. This research examines how racism affects health inequalities and proposes governmental approaches to lessen its negative effects. Health inequities among racial minorities are pronounced, persistent, and pervasive (Sondik et al., 2010). Racism may be one cause of these inequities. Studies find that individuals who report experiencing racism exhibit worse health than people who do not report it (Williams and Mohammed, 2009). While this line of research has been invaluable in shifting the discussion from innate differences in biology or culture to social exposures, it is limited by inadequate attention to the multiple dimensions of racism, particularly structural racism. Theories of institutional racism give preminence to racism that is embedded within normed and often overlooked policies and practices of organizations and structures, and structural racism expands upon this perspective to consider how the interactions among institutions produce racialized outcomes (Bailey, Krieger, Agenor, Graves, & Bassett, 2017; Williams and Collins., 1995; Williams et al., 2019). Despite evidence of narrowing in recent years (Cunningham et al., 2017), the racial mortality gap remains large, with life expectancies for black males and black females 4.4 years and 2.9 years lower than their white counterparts (NCHS 2018).

METHODS

Critical Review Methodology:

We conducted a broad-scope critical review of the extant health disparities literature across three areas of clinical pathology interest: communicable diseases; non-communicable conditions; and injuries. The review was conducted through a race-conscious lens to examine the impact of race on health outcomes and inform a conceptual framework for the development of actionable steps and practice recommendations.

Critical reviews include “a degree of analysis and conceptual innovation” resulting in a product capable of launching a new phase of evaluation.[11] According to Grant and Booth, the critical review does not call for a systematic evaluation of all the literature related to a topic, but rather the emphasis is on the contribution of each piece of evidence included to the review’s conceptual product.[11] As described by the Search, Appraisal, Synthesis, and Analysis framework, critical reviews are designed to identify key findings in the field of interest (health

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disparities literature), evaluate the evidence in accordance with its contribution (racial health disparities attributable to SDoH), synthesize the evidence in organized fashion (clinical pathology interests relevant to EM), and provide a conceptual output of analysis that contributes to the literature (actionable steps and practice recommendations).

Results

Final structural racism model:

The model with the best fit was a single factor model that contained seven indicators (one from each domain) and one correlated error term. The final model is displayed in figure. The fit statistics for the final model were excellent, with a root mean square error of approximation of 0.049, a confirmatory fit index of 0.984, a Tucker-Lewis fit index of 0.974, and a standardized root mean square residual of 0.073. All factor loadings were statistically significant at the $p<0.06$ level. The final standardized factor scores can be interpreted as the number of standard deviations a state's structural racism score is from the mean for all states.

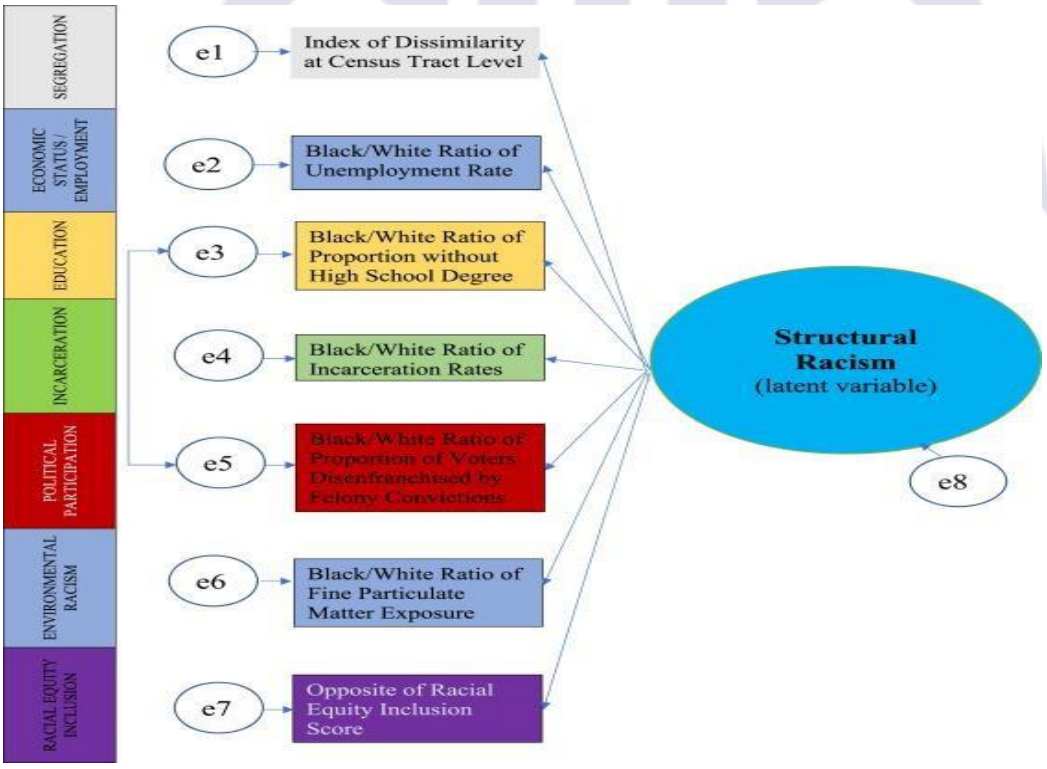

Figure 1. Diagram of final factor analysis model. Oval shape indicates the latent variable of structural racism. Rectangular boxes represent the exogenous variables, in this case, indicators covering each of the seven domains of structural racism considered in this model.

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Case study: negative race-exposure interaction terms

The four examples provided in are not exhaustive of all possible race-exposure interaction scenarios. These relatively simplistic examples miss other nuances that health disparities researchers may encounter. Consequently, we will discuss a particular scenario we have observed in the literature that often confuses researchers investigating racial health disparities. When the more socially advantaged group is the referent, presence of negative interaction indicates that a deleterious exposure-outcome relationship is stronger among the more advantaged group, as was the case in scenario C (interaction present, but exposure does not contribute to the disparity). However, the higher exposure and outcome burden may still be carried by the disadvantaged group. One such example of this has emerged from the cardiovascular health literature. In a sample of 6134 individuals recruited from 50,844, Liu et al. aimed to evaluate the relationship between diabetes mellitus and uncontrolled blood pressure. Although this study contrasted Mexican Americans, blacks, and whites, for consistency with our previous examples, we will focus specifically on the black and white comparison. In this article, the authors introduced an interaction term between diabetes and race into their model and found a significant interaction; the association between diabetes and uncontrolled blood pressure was stronger among whites than among blacks. From these results, the authors concluded that "health providers need more efforts to weaken the association of diabetes with uncontrolled blood pressure outcomes by further improving care for diabetes and blood pressure in non-Hispanic whites." In a health disparities context, such a suggestion should give one pause and warrants further investigation.

Using our initial guiding questions, Tables 1 and 2 provided by Liu et al., and outside literature regarding uncontrolled blood pressure, we see that uncontrolled blood pressure is more prevalent among blacks than whites, diabetes prevalence is higher among blacks than whites, and there is an overall association between diabetes and uncontrolled blood pressure that is positive in both race groups but varies in magnitude. The information gained from asking these questions illustrates the scenario depicted in. Although the presence of negative interaction indicates that the association may be stronger in non-Hispanic whites, blacks suffer the greater burden of both exposure and outcome. Thus, from a health disparities standpoint, the assertion that the white sample population should be targeted over the black sample population is troubling as it could lead to inappropriate redistribution of intervention resources and widening of racial disparities in uncontrolled blood pressure prevalence. This example further

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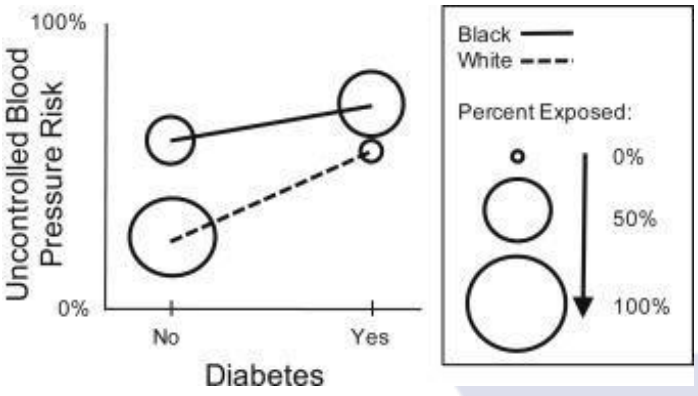
demonstrates the danger of drawing conclusions regarding health disparities based on interaction term significance alone and highlights the importance of additionally considering the exposure and outcome distributions in a health disparities context.



Case study of a racial health disparity interaction analysis found in the literature, examining the relation between diabetes mellitus and uncontrolled blood pressure and whether this association varies by race. This represents a scenario where the interaction term indicates that the exposure-outcome relationship is stronger among the more advantaged group (captured by the steeper slope of the dashed line), yet the high exposure prevalence among the more disadvantaged group suggests that the exposure may be disparity-producing nonetheless. The exposure is indicated along the x-axis and the outcome along the y-axis. The simplified, dichotomous race classification is denoted by a solid line for the black sample and a dashed line for the white sample. The circles represent the proportion of each racial group at each level of exposure so that equally sized circles indicate that equal proportions of the racial group are exposed and unexposed. Larger circles represent a larger proportion exposed (or unexposed).

Discussion

To our knowledge, this is just the second paper to use a latent measure of structural racism at the state level and to examine the relationship between this measure and a wide array of racial health disparities. It expands on the previous paper by examining the association of structural racism with Black-White racial disparities in documented mortality outcomes, rather than subjective measures of general and mental health. It also advances our own previous research that examined the link between structural racism and racial health disparities at the state level, but used an index that merely averaged indicators across domains of structural racism, arbitrarily assuming equal weights for each indicator. We found a significant relationship

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between higher levels of the latent structural racism measure and greater disparities between non-Hispanic Black and non-Hispanic White people in age- adjusted death rates from firearm homicide, infant mortality, HIV, obesity, and asthma, but not in death rates from hypertension, stroke, diabetes, and kidney disease.

These results are consistent with our previous paper, which found a significant relationship between structural racism and state-level racial disparities in death from firearm homicide, infant mortality, HIV, obesity, and asthma, but not for diabetes or kidney disease. However, that paper did find a small but significant relationship for hypertension and stroke which we do not find here.

The magnitude of the observed association between structural racism and Black-White racial health disparities was greatest for firearm homicide and HIV mortality. Our regression model predicts that holding all other variables constant, as a state's structural racism factor score increases from one standard deviation below the mean to one standard deviation above the mean, its Black-White firearm homicide rate ratio increases from approximately 5 to 15.

Similarly, as a state's structural racism factor score increases from one standard deviation below the mean to one standard deviation above the mean, its Black-White HIV death rate ratio increases from approximately 7 to 10.

The implications of these findings can perhaps be appreciated best by a comparison between New Jersey (the state with the highest standardized structural racism factor score [+2.2]) and Georgia (the continental state with the lowest standardized structural racism factor score [-1.2]). Although compared to Black people in Georgia, Black people in New Jersey have a higher median household income ($55,453 vs. $46,964), a lower poverty rate (16.4% vs.

20.1%), and a lower incarceration rate (673 vs. 866), the Black firearm homicide rate in New Jersey is nearly five times higher than in Georgia, and the Black HIV death rate is twice as high.

Connecticut has the second highest standardized structural racism score at +2.04. This is primarily a result of its extremely high incarceration ratio of 10.1 and its voter felony disenfranchisement ratio of 11.6. In fact, Connecticut has the highest Black-White ratio of

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felony disenfranchisement of any state along with the fourth highest Black-White incarceration ratio. The ACLU of Connecticut writes that: "Because of systemic racism, Connecticut's incarceration and policing systems most harm Black and Latinx people, its budgets invest in over-policing and prisons at the expense of opportunity, and barriers to voting access most disenfranchise Black and Latinx voters." Connecticut has a long history of disenfranchisement of people who are Black. The original state Constitution in 1818 only allowed voting by white males. Connecticut did not in fact grant the right to vote to Black people until 1876, after the 15th Amendment was ratified. This stands in contrast to laws in every other New England state, which allowed Black people to vote as of 1855. Connecticut has the highest incarceration rate of any New England state, and three-fourths of its inmates are either Black or Latinx.

The 'subjectivist' way of dealing with the topic of racism in discussions leads to problems because the objective existence of racism is called into question when habitual expectations for clear-cut textbook knowledge, criteria and definitions are not met. Additionally, the empirical findings connected to the 'subjectivist' approach point to several difficulties that medical students encounter regarding the understanding and use of racialised categorisations such as 'Rasse', 'race'. Problems connected to the wide range, vagueness and inadequacy of human categorisations are not specific to medical students but are also described for the general context of life sciences in Germany [127]. Regarding the relation of racialised categorizations and racism, the use of racialised categorisations such as 'race' or 'Morbus mediterraneus' is seen as somehow problematic and vaguely associated with racism.

However, due to uncertainty about what racism is, who is affected by racism and how to deal with racialised categorisations in the clinical environment, the evaluation of the whole topic is afflicted with uncertainty and subjectivism. This mirrors knowledge gaps among medical students about the concept of racism and other forms of discrimination.

Furthermore, our results can help to understand difficulties that may arise when different ways of dealing with the topic interact in medical students' discussions of racism. Opposing or even conflicting orientations can lead to controversial discussions. However, they may also impede the development of a collective conclusion or even the achievement of a mutual understanding. Discussions then take more parallel patterns of shared opinions and lack true interaction between participants. In our groups, we observed that some medical students were not used to being considerate regarding potentially discriminating or devaluing effects of their statements

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on people who personally experience racism. In particular, this holds true for objectivistic views on racialised groups like the ones promoted by 'scientistic' arguments, or the handy heuristics employed in the 'pragmatic' approach. The somewhat naïve do-gooder attitude of the 'interculturalist' perspective can also effectively prevent critical self-reflection and a considerate habitus in discussions of racism. Such ways of dealing with the topic often caused indignation and were vehemently criticised by other participants in our groups.

However, there were also insecure students who were self-conscious and had difficulties expressing their thoughts about racism out of fear of saying something wrong or hurting somebody. Especially in interactions between 'subjectivist' and 'critical' attitudes, the inhibitions of the former can be intensified. Students displaying a 'critical' approach sometimes claimed for themselves a superior moral ground and referred to unconscious and structural aspects of racism that are often beyond the reach of individual (self-)awareness and intentional change. This way of dealing with the topic of racism can intimidate other participants in discussions. Yet, there might also be a productive aspect in the irritations that arise when habitual ways of dealing with racism collide. Especially the 'subjectivist' wish to learn more and reduce uncertainty and ambivalence about the topic of racism points to the potential of anti-racist medical education.

Limitations

Several important limitations of this study should be noted. First, in order to generate stable rate estimates for the health outcomes, we had to combine data for multiple years. In addition, we measured structural racism based on its consequences, as manifested currently. We did not measure structural racism over time nor use variables that directly measure historical structural racism (such as redlining maps, for example). Therefore, the study is cross- sectional, precluding us from establishing a causal relationship between structural racism and racial health disparities. An important area for future research is to examine the longitudinal relationship between structural racism and racial health inequities. In fact, our current work is attempting to do this by measuring changes in levels of racial segregation over time and relating those patterns to changes in the magnitude of racial health disparities over time.

Being white raised the question of how we as white student/faculty can implement effective anti-racism teaching that also addresses institutional and structural aspects without reproducing

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racism. Impressions from clinical health care practice brought in by SG indicated the need to study not only medical students' theoretical views on racism but also their ways of dealing with the topic in practice-related situations such as discussions. The aims of our study were shaped by our perspectives as a white medical student and as ethicists in medical education because we are concerned with understanding the preconditions and obstacles of teaching and learning about racism and anti-racism in medicine and health care and their connections to professional socialization in the medical context. We studied perspectives of diverse students with and without personal experience of racism and their interactional dynamics in discussions laden with power relations stratified by racism.

"Strategies to dismantle systemic racism must give high priority to addressing inequities in the key determinants of health".

CONCLUSION

To investigate racism seriously as a fundamental determinant of health disparities requires attending to the multiple manifestations of racism. Structural racism operates on the macrolevel of the socioecologic framework; therefore, it more fundamentally influences outcomes than do proximal factors. To date, research has focused on the relatively narrow band that emphasizes self-reported racism and residential segregation. We encourage research on additional forms of racism, including other dimensions of social segregation, immigration policy, and the intergenerational transfer of assets and liabilities. There are many other forms of racism that we did not have space to discuss, including the prison industrial complex, historical trauma, emotional rules, and media portrayals. Some of these ideas are developed more fully elsewhere in this issue of the journal. Research on structural racism should not only focus on independent effects but also should address interactions among multiple forms of racism. Further, it is likely that forms of racism may reinforce one another, and efforts to dismantle one system may yield little effect without simultaneous efforts on another system. For example, part of the segregation that occurs across and within occupations is related to immigration policy (Catanzarite 2000). The study of single forms of racism would lead to an incomplete understanding and, potentially worse, biased estimates.

For instance, assume that five forms of racism fully account for health disparities, but an intervention only targets one form. That intervention may show no effect simply because it is incomplete, and potentially lead to the erroneous conclusion that anti-racism efforts fail.

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Hence, it is absolutely critical to consider the multiple forms of racism. Further, our analysis highlights the importance of time and its dimensions—historical period, age, cohort, and placement in the life course. Given this complexity, conventional tools of regression analyses, and even their extensions such as multilevel analysis, would likely be inadequate.

Such study may benefit from simulation models, such as agent-based modeling (Bruch and Mare, 2006). We can, however, look to history as a guide. Notably, the handful of studies on the impact of the abolition of Jim Crow laws have consistently shown improvements in mortality in the black community, and converging mortality between black and white communities in the 15 years after the passage of the 1964 Civil Rights Act.53–56 We recognise that efforts to implement reforms to dismantle structural racism have repeatedly encountered serious obstacles and backlash from institutions, communities, and individuals seeking to preserve their racial privilege.8,20,26,30 However, as Frederick Douglass famously said in his 1857 address on the struggle against slavery in the USA, the West India emancipation, and the backlash that ensued: “Power concedes nothing without a demand.” For example, ways of dealing with the topic that tend to normalise racism may require a focus on teaching knowledge about racism and competencies that help to identify racism in practice and in internalised habits and thoughts . This might pose particular difficulties as thorough self-reflection is required, and habitual perspectives on racism and the moral evaluation of one’s own habits may have to change. The ‘subjectivist’ way may be addressed by providing access to knowledge about racism, and by empowering critical reflection to overcome feelings of ambivalence and ambiguity connected to the topic of racism. The ‘critical’ way might benefit from expanded knowledge and discussions about racism.

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the Census data web site was down.

References

1. World Medical Association. WMA Declaration of Geneva. Chicago: 68th WMA General Assembly, 2017.
2. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. New York: Oxford University Press; 2013
3. Osei-Tutu K, Duchesne N, Barnabe C, Richardson L, Razack S, Thoma B, et al. Anti-racism in CanMEDS 2025. Can Med Educ J. 2023; 14(1). https://doi.org/10.36834/cmej.75844 PMID: 36998489
4. World Medical Association. WMA Declaration of Berlin on Racism in Medicine Berlin: 73rd WMA General Assembly, 2022.
5. Liebow NK, Rieder TN. "What can I possibly do?: White individual responsibility for addressing racism as a public health crisis. Bioethics. 2022; 36(3):274–82. https://doi.org/10.1111/bioe.13004 PMID: 35060163
6. University Health Network.Administrative: Anti-Racism & Anti-Black Racism. 2021 Jan [Cited 2023June 19]. Available from: https://www.uhn.ca/corporate/AboutUHN/Governance_Leadership/ Policies/Documents/1.20.019_Anti_black_Racism_policy.pdf.
7. Sim W, Lim WH, Ng CH, Chin YH, Yaow CYL, Cheong CWZ, et al. The perspectives of health professionals and patients on racism in healthcare: A qualitative systematic review. PLoS One. 2021; 16
8. 8 e0255936. https://doi.org/10.1371/journal.pone.0255936 PMID: 34464395 8. Maina IW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Soc Sci Med. 2018; 199:219–29. https://doi.org/10.1016/j.socscimed.2017.05.009 PMID: 28532892
9. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health. 2000; 90 (8):1212–5. https://doi.org/10.2105/ajph.90.8.1212 PMID: 10936998
10. Bailey, Z., Krieger, N., Agenor, M., Graves, J., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. Lancet, 389, 1453–1463.