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FRONT PAGE

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RACISM & HEALTH: A public health perspective on racial discrimination

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RACISM & HEALTH
A public health perspective on racial discrimination

ABSTRACT. Racial discrimination has been increasingly reported to have a causal link with morbidity and mortality of Black Americans, yet this issue is rarely addressed in a public health perspective. Racism affects health at different levels: institutional racism is a structural and legalised system that results in differential access to health services; cultural racism refers to the negative racial stereotypes, often reinforced by media, that results in poorer psychological and physiological wellbeing of the minorities. Lastly, interpersonal racism refers to the persistence of racial prejudice that seriously undermines the doctor-patient relationship. After analysing these concepts with examples and relevant studies, this paper explores current literature. *Racism as a Determinant of Health: A Systematic Review and Meta-Analyses* (Paradies et al., 2015) is the most recent and comprehensive research on the issue, yet it cannot be used to base public health interventions as it contains several limitations. *Forward Through Ferguson: A Path Toward Racial Equity* (Ferguson Commission, 2015) is a report that identifies four priority areas for framing public health interventions: Racial Equity, Justice for All, Youth at the Centre and Opportunity to Thrive. This study represents an important milestone in the application of public health on racial injustices, yet racism must be tackled with a sustained, multilevel and interdisciplinary approach. In conclusion, this paper addresses how public health interventions can empower Black minorities and bring forward long-term policies. Racism is a structural and long-standing system that can be eliminated only with the collective effort.

KEYWORDS: Racism, public health, racial discrimination

In 1963, Dr Martin Luther King Jr., in the very famous speech delivered at the Lincoln Memorial, dreamed of a Nation where people "will not be judged by the colour of their skin, but by the content of their character" (1). Yet, over half a century later, police brutality is still a major issue: Philando Castle, Alton Sterling and Michael Brown Jr. are just few of the countless people killed unjustly by the police, with the only fault of being Black (2). Police brutality is only one form of racism; Black Americans deal with the implications of their skin colour in very different ways. Racial discrimination has been widely discussed, yet not much has been done to systematically eradicate the problem. However, this issue can be tackled in a public health perspective as there is a growing literature reporting a causal link between

racism, morbidity and mortality (3). Indeed, public health has been defined as "the science and art of preventing disease, prolonging life and promoting health" (4) and as such, addressing inequalities and injustices is a fundamental corollary to its defining goals. This paper will firstly define racism and explain how its institutional, cultural and interpersonal forms affect health at different levels. It will then appraise current evidence available and suggest possible interventions and policies. Finally, it will look at potential challenges and possible recommendations.

Racism is a system of structuring opportunity and assigning value based on race that unfairly disadvantages some individuals (5). Therefore, racial minority populations have lower levels of access to medical care, higher morbidity and mortality rates and poorer quality of care (6). Although most people have a basic understanding of racial discrimination and White privilege, it is important for the purposes of this paper to give a deeper explanation. Racism can be thought about as institutional, cultural and interpersonal. Institutional racism is the structural and legalised system of policies, practices and norms that results in a differential access to goods and services (5). Although segregation was officially abolished in the 20th century, Black Americans still live in separated neighbourhoods where they have limited access to quality education, gainful employment and appropriate medical facilities. The higher rates of violent crimes and incarceration further exacerbates the situation. Indeed, incarcerated adults leave their families in financial instability and social stigma and return to their communities with limited access to housing, employment opportunities, voting rights and health services (6). Cultural racism refers to the negative racial stereotypes associated with minorities. Centuries of systematic oppression, slavery and genocide have led to the internalised belief that Blacks are inferior, worthless, poor, lazy and ignorant. Moreover, media and television always portray them as drug-dealers, criminals or buffoons and are rarely given important roles. Therefore, even the minorities interiorize the beliefs of the dominant society and think about themselves as biologically and culturally inferior. This results in lower self-esteem and psychological wellbeing, but also higher risks of cardiovascular disease, respiratory illness and other physiological effects (3). Moreover, the activation of a negative stigma creates anxiety and expectations that impair social and psychological functioning (5). Finally, interpersonal racism refers to the persistence of racial prejudice that negatively affects the doctor-patient relationship. Indeed, on the one side the Black patient, facing a mostly non-Black

health care system, feels uncomfortable and not understood; on the other, the doctor thinks of the patient as inferior and therefore provides care of less quality. This implicit bias makes it harder to detect disease and leads to higher mortality rates. For example, although Black women are less likely to contract breast cancer, once contracted, they are more likely to die from it as there is less screening available and they are treated less effectively (7).

Institutional, cultural and interpersonal racism have been described to affect health of Black Americans at different levels. It is important to highlight that they are not isolated systems, but rather interdependent phenomena each strictly related to the other. For instance, the higher rates of incarceration discussed in institutional racism are a consequence of the shared cultural stereotype of minorities as criminals and prone to violence that exposes the youth to a thug lifestyle and makes them more likely to get arrested. All racial minorities are vulnerable to systemic White racism, although Americans of colour are the most affected (6).

Systematic reviews and meta-analyses are a workhorse of evidence-based public health (8). Since the early 1980s there has been a growing literature of studies looking at the impact of racism on health. *Racism as a Determinant of Health: A Systematic Review and Meta-Analysis* (9) is the most recent and comprehensive research on the issue. This study reviews articles published in English between 1983 and 2013 focusing on the relationship between reported racism and mental and physical health outcomes. The 293 studies considered include as health outcomes negative mental health (depression, distress, anxiety…), positive mental health (self-esteem, wellbeing, life satisfaction…), physical health (diabetes, blood pressure…) and general health. Three methods were used to assess publication bias. The studies used instruments of exposure to racism such as the Schedule of Racist Events and the Racism and Life Experience Scales. The results, combined per each outcome, show a stronger association between racism and mental health outcomes, compared with physical health.

Although this systematic review is the most important research on racism and health, it includes several limitations (9). Firstly, the population considered is very heterogeneous. It focuses on adults 18 and older, but it also includes children and adolescents (16%); the participants are of both sexes (60% females), from very different ethnic groups (largest subgroup is African Americans, 37%) and level of education. Indeed, these variables modify the impact of perceived racism and how

4

people cope with it. Secondly, as the authors themselves recognise, there needs to be more longitudinal analyses to assess the causality and examine the possibility of development of physical health problems in longer terms. Finally, racism is a difficult parameter to measure. It is different from randomized controlled trials where a group uses a placebo and the other tests for the new intervention. Racism is based on beliefs, prejudice and subjectivity and, although there are several instruments of measure, it is difficult to be fully translated into quantitative data. Indeed, even the most accurate studies, use self-reports as an assessment method and experiences cannot be examined objectively. Undeniably, a particular experience is considered racist only if race is a salient feature if compared to someone else's experience (10).

Therefore, public health interventions cannot be based on systematic reviews due to the methodological limitations. However, the recent report *Forward Through Ferguson: A Path Toward Racial Equity* raises many issues that can be addressed in public health (11). The report was ordered by Missouri Governor Jay Nixon in November 2014 to examine the root causes underlying the death of Michael Brown Jr., who was shot and killed by police officer Darren Wilson. The Governor appointed an independent body of 16 commissioners, the Ferguson Commission, to conduct the study. The commission operated till December 2015, hearing subjective accounts from hundreds of community members about the systemic disparities they were suffering: Black children in the area were more likely to be suspended, Black drivers more likely to be pulled over and searched and at its extreme, there was a 40-years gap of life expectancy between a predominately White suburb and a Black neighbourhood (12). The Ferguson Commission clearly focused on the underlying infrastructure that feed disparities and identified four signature priority areas for framing public health interventions: Racial Equity, Justice for All, Youth at the Centre and Opportunity to Thrive (13). Racial Equity refers to the structural racism previously discussed, which can be dismantled by developing policies across multiple social identities. For example, in December 2010 the Department of Health and Human Services launched Healthy People 2020 (14), which include health equity among its overarching goals; this represents a fundamental step to eliminate disparities. Justice for All highlights the inequities in law enforcement practices. In the US, there isn't a comprehensive record of number of people killed by "justifiable homicides"; epidemiology could be applied to understand the trends in incidence and prevalence, which can help in developing public health policies. A first attempt was

made by the American Public Health Association by releasing a statement in 1998 against the impact of police violence on Black communities (15). However, there is no record available on whether it was implemented (16). Public health could use the civil rights framework to develop policies that can improve trust in the police force and therefore the collective wellbeing. The third priority area, Youth at the Centre, focuses on the crucial need to develop a healthy environment for these vulnerable generations. Indeed, higher suspension rates among Black students lead to poor academic performance, higher dropouts and delinquency rates. As previously explained, a criminal record seriously undermines the ability to access certain facilities. Therefore, public health interventions can battle educational injustices. Finally, Opportunity to Thrive highlights the issues of segregation explained with institutional racism. Public health scholars can propose housing policies from a health equity perspective.

The Ferguson Commission report constitutes an important milestone in the application of public health on racial injustices. Firstly, it suggests a full understanding of the mechanisms of racism by adopting an unflinching and determined approach when asking uncomfortable questions about racialized health disparities and institutional inequalities (16). Furthermore, it proposes the use of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, colour or national origin, as a legal reinforcement of long term policies. Fifty years on, this serves to illustrate the failures of implementing this landmark legislation. The report has led to the initiative "Regional School Assembly- Keeping Our Kids in the Classroom", which aims to eliminate out-of-school suspensions till third grade (17). However, although very promising, it is very ambitious and much work has to be done to implement the calls for action.

Racism tackled with a sustained, multilevel and interdisciplinary approach cognisant of the pathogenic impact of race discrimination on the distribution of the social determinants of health(16). Institutional racism can be fought by eliminating the differential access to goods (18). Improving neighbourhood and housing conditions, providing additional money to poorer households and enhancing employment opportunities can reduce the rates for violence and incarceration and ultimately improve health. Childhood academic intervention and psychological support to younger students can eliminate the educational inequalities. Social media and television are powerful tools when facing cultural racism. Systematic campaigns

6

and other educational initiatives can raise awareness about the nature of discrimination. There is also the need to empower Black communities and address barriers to healthy choices. The recent movement #BlackLivesMatter represents a collective effort to recognize the equal value of all lives. Health equity can be reached by raising awareness among the wider health professionals, integrating race conscious curricula in public health programs and promoting a person-focused primary care. Health professionals should also be encouraged to report unfair practices around treatment options (12).

The Patient Protection and Affordable Care Act 2010 (20), commonly known as the Obamacare represents the first step to eliminate health inequalities in the US, but much more has to be done and many are the potential challenges. Firstly, public health institutions remain substantially White-run and White-oriented with no apparent interest in improving the minorities' conditions (7). Moreover, to effectively eliminate racism, there must be the eradication of an established system. It requires the collective effort to subvert the legal, social, economic and political systems, currently entrenched with racism. Finally, and most importantly, public health professionals should not limit to document health disparities, but also start bringing forward possible interventions, raise awareness of inequalities and work to influence policy for change

In conclusion, this paper has explored how institutional, cultural and interpersonal racism affect the wellbeing of Black Americans. After defining these terms, it was discussed that systematic reviews are not appropriate to tackle this issue. Therefore, the Ferguson Commission report, providing subjective accounts of lived experiences of racism represented a more powerful and significant study. The signature areas identified were Racial Equity, Justice for All, Youth at the Centre and Opportunity to Thrive and each can be targeted by public health interventions. There are many potential challenges, but a call to action has been made. Public health interventions should be twofold: empowerment and acknowledgement on one side and long-term policies on the other. Recognizing the equal value of all lives is the only way to build a healthy, united and prosperous society.

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