



UNIVERSITY OF DELAWARE

COMMUNITY ENGAGEMENT INITIATIVE

PARTNERSHIP FOR HEALTHY COMMUNITIES

**Structural Racism as a Fundamental
Cause of Health Inequities**



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STRUCTURAL RACISM AS A FUNDAMENTAL CAUSE OF HEALTH INEQUITIES

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Purpose & Executive Summary: This policy brief describes the role of racism in creating and perpetuating inequities in health among Black communities in the United States. It defines structural racism within a social determinants of health framework and highlights ways in which residential segregation is connected with poor living, working, and social conditions that threaten good health. This brief concludes with recommendations for advancing health equity through more concerted attention to structural racism.

Health and Health Inequities in the United States (US)

Despite being one of the wealthiest countries in the world with an abundance of health-related resources, the US has poor health compared to other countries. Life expectancy and infant mortality are two important measures used to describe the health and well-being of a community or population. On both indicators, the US ranks poorly: 45th in life expectancy and 170th in infant mortality.¹ Notably, these indicators are also generally moving in the wrong direction, with the US falling in the rankings in recent years.

Differences in health among different groups of people, often referred to as **health inequities**, are well documented, persistent, and even increasing for some health conditions across the US. Health inequities may be viewed in the context of race, gender, sexual orientation, income, education level, disability status, or geographic location, among others. For example, sexual minorities tend to have poorer physical and mental health than heterosexual men and women² and individuals with disabilities are likely to have higher rates of chronic diseases, unrelated to

their disability, compared to individuals without disabilities³. We also see persistent health inequities by socioeconomic status (e.g., income, occupation, and education level) and research documents a social gradient in health, such that as socioeconomic status improves, so does health status. For example, the gap in life expectancy between individuals in the top and bottom 1% of the income distribution in the US is 15 years for men and 10 years for women.⁴ The social gradient in health means that inequities affect virtually everyone.⁵

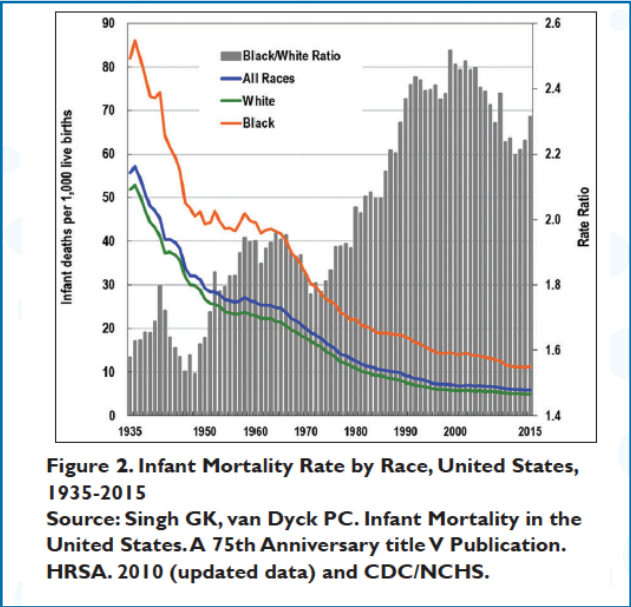
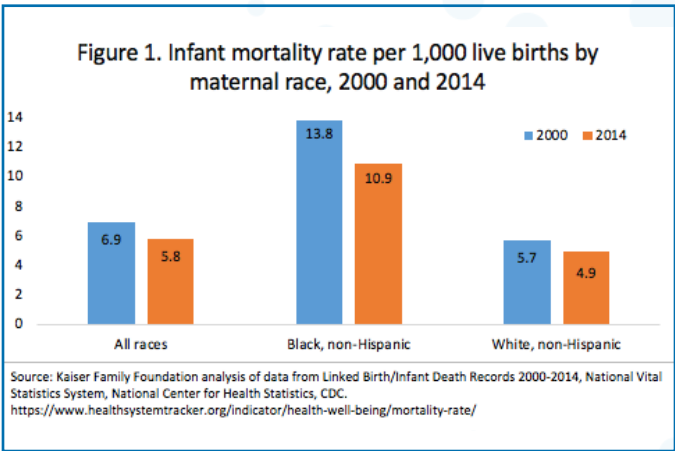
Further, when it comes to health, people are often disadvantaged by more than one type of oppression based on their identity or class (e.g., “black” and “gay”). This concept of **intersectionality**, originally described by Crenshaw⁶, is important for understanding how groups of people with overlapping identities and experiences may be discriminated against in many ways.

Because these are socially constructed categories related to social hierarchy, and related differences in health do not derive from biology or genetics, experts consider such health

differences to be socially produced. As such, we can conclude that “health inequities are not only unnecessary and avoidable, but in addition, are considered unfair and unjust”.⁷

Among the most pervasive and persistent health inequities are those experienced by people of color in the US. While we recognize the importance of health inequities that exist across various racial and ethnic groups, including Native people, Latinos, and others, we believe that the historical context of slavery and persistent oppression among Black individuals in the US warrants particular focus. Using life expectancy and infant mortality as a snap shot, one can get a sense of the magnitude of health inequities experienced by Black individuals in the US. Figure 1 highlights that while infant mortality rates have fallen among all racial and ethnic groups since 2000, the gap between groups persists, with Black, non-Hispanic women experiencing an infant mortality rate of 10.9 deaths per 1000 live births in 2014, compared with a rate of 4.9 per 1000 among White, non-Hispanic women.

Another way to look at the inequity in infant mortality is to examine the ratio of infant deaths across racial groups. Figure 2 highlights how this ratio (i.e. Black infant mortality divided by White infant mortality) has changed over the past 80 years. As seen in this figure, the Black-White infant mortality ratio reached a low of approximately 1.5 in 1948 and stayed below 2.0 prior to the mid-1980s, when it began to climb steadily until reaching a peak over 2.5 in 2000. This Black-White ratio has remained well above 2.0 in recent years and the most recent data from the Centers for Disease Control and Prevention indicate that the infant mortality rate for Black mothers is 2.3 times that of White mothers in the US.

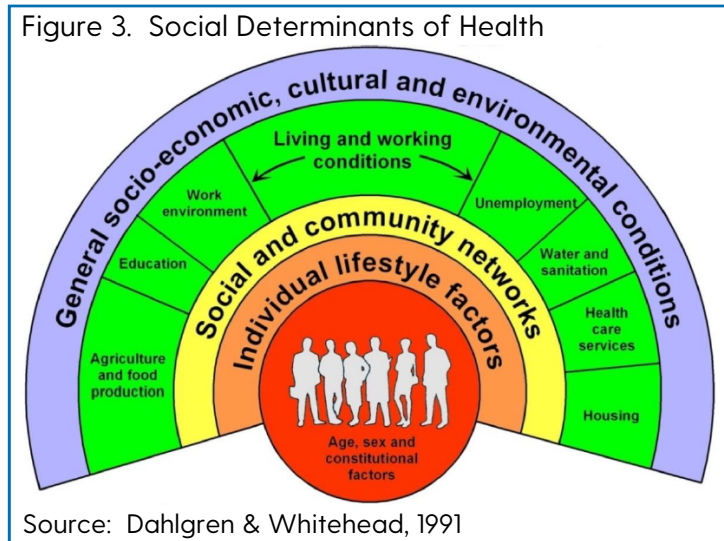


Health inequities experienced by Black individuals in the US can be seen across a range of other health indicators. Despite recent progress, especially among Black males, the gap in life expectancy between Blacks and Whites was still 3.4 years in 2015.⁸ Further, a recent analysis of health status and outcome measures across different racial and ethnic groups found that **Blacks fared worse than Whites on 24 out of 29 indicators**, including rates of asthma, diabetes, heart disease, HIV, and cancer.⁹ Among these findings is evidence that Black children also have higher rates of asthma, teen pregnancy, and obesity.

The Importance of Social Determinants of Health

Health is a result of a complex web of influences, including social, economic, political, physical, behavioral, and biological factors. Figure 3 is a model often used to illustrate how various factors operate on different levels to influence health and health inequities.¹⁰ As seen in this figure, health is influenced at a fundamental level by our innate constitutional factors, such as age, gender and genetic predisposition or family history (red circle). Health is also influenced by individual behaviors and lifestyle factors, such as tobacco use or physical activity (orange band). However, we know that lifestyle choices are made within the context of one’s social and community networks (yellow band) as well as the broader social, economic and physical environment (green band). Often referred to as the “social determinants of health (SDH)”, these are widely understood as the conditions in which people live, learn, work, play and pray. **SDH are believed to be the most important determinants of health; and differences in these conditions result in health inequities.**

Communities often experience cumulative health burdens grounded in inequities in these social determinants. For instance, communities that experience low economic and employment opportunities, may also have underfunded education systems, inadequate access to health and social services, lack of healthy food retailers, unstable housing, and a lack of safe recreational spaces. Finally, these conditions are themselves influenced by larger structural forces, such as economic, education, and political systems, social norms, culture and power (purple band).



Structural Racism as a Fundamental Cause of Health Inequities

Racism is a complex social phenomenon that can be defined in many different ways and is frequently expressed on different levels. It involves individual and collective attitudes, actions, processes and unequal power relations.¹¹ On an **individual** level, racism can be expressed as intentional or unintentional acts of commission or omission, based on assumptions that one race is superior to another. For example, a restaurant owner who refuses to serve a Black patron is committing an intentional act of racism, while a doctor who neglects to recommend the same surgery for a Black patient that is recommended for a White patient with identical symptoms may be unintentionally committing an act of omission. On an individual level, racism may also be internalized, such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth.¹² Internal racism may be expressed by Black individuals dropping out of school or referring to themselves using negative stereotypes.

Institutional or systemic racism can be defined as differential access to the goods, services and opportunities of society by race, which is often codified in our institutions as customary practice or even law.^{12, p1212} The historic practice of redlining, such that Blacks were systematically denied mortgages in certain

neighborhoods, or charged higher insurance premiums, are expressions of institutional racism. A subtler, but potentially just as serious, form of institutional racism may be seen in the content of public school curricula, or images in the media, that are biased towards the culture and experiences of the majority population. Institutional racism in one area or sector may reinforce or interact with racism in another, such as the ways in which discrimination in housing perpetuates problems with underfunded schools and limited educational opportunities for Black children living in segregated neighborhoods.¹³

Institutional racism is interconnected with individual forms of racism and often serves to reinforce discriminatory beliefs and values.¹⁴ For this reason, the concept of **structural racism** has been suggested as a way to reflect the “totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice”.^{14, p1454}

Another way to think about structural racism is as:

*“A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time”.*¹⁵

Conceptually, we can think about this definition of structural racism in the context of the determinants of health rainbow (figure 3). Specifically, we can see how negative aspects of living and working conditions in Black communities are largely the result of structural racism, where historical and contemporary policies, practices, beliefs and attitudes have resulted in an unequal distribution of resources across communities. More specifically, structural racism has led to many Black neighborhoods characterized by a lack of employment opportunities, underfunded public schools, substandard housing, inadequate access to health insurance and healthcare, lack of greenspace and recreational opportunities, as well as high concentration of poverty, pollution, and violence—all of which threaten health directly and indirectly.¹⁶

While social networks may be strong and promote health and well-being in communities of color, policies and practices in our criminal justice system disproportionately incarcerate Black men, women and children, with direct health impacts on those who are incarcerated and potentially dismantling what would have otherwise been strong social support and community networks.^{17,18} In addition, the stress of racial discrimination is associated with coping behaviors that are detrimental to health, such as smoking, and alcohol and drug use.¹⁶ Ongoing stress associated with racism can also have direct physiological impacts on the body (i.e. allostatic load) and is associated with mental health problems such as anxiety and depression.¹⁶

All of these negative influences and exposures can accumulate over time and across generations.¹⁴ An understanding of how structural racism shapes the determinants of health for Black communities leads us to conclude that structural racism is a fundamental cause of health inequities.^{19,20}

A Focus on Residential Segregation

“Residential segregation is a foundation of structural racism”.^{14, p1457} **Residential segregation** is the physical or spatial separation of two or more social groups within a geographic area. It is a fact of history in the US and has long been identified as the root of many social and racial inequities in American cities. While different racial and ethnic groups and immigrants have experienced segregation in the US, African Americans have been victims of an unparalleled level of deliberate segregation that is perpetuated today through individual actions, institutional practices and public policy²¹ and patterns of segregation among Blacks in the US remain the highest across all racial/ethnic groups²². According to Dr. David Williams, a leading scholar on racism and health, “the single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans is residential segregation”.^{23, p177} Further, residents of segregated neighborhoods continue to be politically alienated and lack power such that conditions often remain entrenched.²⁴

Importantly, segregation is a contemporary problem that persists in the US, despite the myth of integration.²⁵ While the latter half of the 20th century saw an end to explicit policies aimed at keeping Blacks from White neighborhoods (e.g. the Fair Housing Act of 1968), “such practices continue to be realized by purportedly color-blind policies that do not explicitly mention ‘race’ but bear racist intent”.^{14, p1454} For a detailed historical analysis of segregation, including its roots in law, public policy, and public and private institutions, and its contemporary manifestations and enduring impacts see *A Century of Segregation: Race, Class and Disadvantage* by Leland Ware¹³.

An estimated 176,000 deaths were attributable to racial segregation in 2000²⁶, and there is a growing evidence base linking segregation to a range of indicators of poor health status of Blacks living in segregated communities. Health inequities are “largely a function of the separate and unequal neighborhoods in which most Blacks and Whites reside”.^{22, p179} Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities, and that health inequities remain even after income and education levels are accounted for. Rather, the places themselves and the nature of the social, political, built and physical environments affect health directly and indirectly in myriad ways.^{14,16,17,27} For an overview of the pathways through which residential segregation impacts health outcomes with strong supporting evidence see figure 4.

Figure 4: Pathways and Outcomes through which Residential Segregation Harms Health

Pathways through which segregation is believed to contribute to health inequities

- Poor quality housing, including dampness, inadequate heat, noise, overcrowding, and presence of environmental hazards and allergens^{e.g.,14,19,27}
- Negative social environments, including exposure to violence, crime, and systematic differences in policing and incarceration^{e.g.,22,27,28}
- Substandard built environment, including higher exposure to fast food outlets and alcohol retailers, reduced access to supermarkets with fresh fruits and vegetables, and lower access to recreational facilities^{e.g.,19,29,22,30,31}
- Exposure to pollutants, toxins, and other environmental hazards^{e.g.,22,32,33,34}
- Limited educational and employment opportunities and earning potential^{e.g., 17,19,27}
- Limited access to quality health care^{e.g.,19,22,35,36}

Health Outcomes with Evidence linked to Segregation

- Adverse birth outcomes, including low birthweight, pre-term birth and infant mortality^{e.g.,17,37,38,39}
- Decreased life expectancy and increased mortality^{e.g., 19,40,41}
- Increased risk of chronic diseases including CVD, heart disease, cancer, hypertension, asthma, and mental health problems such as anxiety and depression^{e.g.,16,22,33,42,43,44}
- Increased risk of homicide and other forms of violence^{e.g.,45,46}
- Increased risk of infectious diseases, including tuberculosis and HIV^{e.g.,47,48}

Policy Recommendations

According to the Centers for Disease Control and Prevention, “**health equity** is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances”.⁴⁹ Given the discussion presented above, it is evident that achieving health equity requires action on multiple fronts to dismantle structural racism.

Improving neighborhood conditions – Addressing social conditions through policy change has long been recognized by experts as the best way to improve health and advance health equity. Place-based and cross-sector policy strategies are recommended to address the multitude of ways in which the housing market, education system, job market, and the built and physical environments interact to produce health. Investments in communities can have direct benefits that reduce health threats (such as crime and pollution) and indirect benefits that promote healthy behaviors (such as sidewalks, green space, and healthy food establishments). High quality, equitable education and safe, affordable housing are fundamental to health improvement, as are promoting living wage jobs and access to quality health and social services.

Shifting power and decision-making – Improving neighborhood conditions is insufficient, however, if the underlying structures and processes that determine the distribution of resources are not fundamentally changed. The evidence cited above suggests that conditions in Black communities have roots in historical and contemporary racism. Therefore, we must confront structural racism if we are to have a meaningful impact on health inequities.²⁰ This means, among other things, a fundamental shift in power and decision-making with respect to public policy and distribution of resources from the local level to the federal level.

Further, while improving conditions in Black neighborhoods is critical for health improvement, “the issue of separation that remains so pervasive and endemic to the American way of life that we rarely even question it.”²⁵ We must debunk the myth that integration has been achieved and continue the unfinished work of the civil rights agenda.

Training and professional development – It has been argued that training for health professionals should more systematically include content related to SDH and specifically racism and health.^{14,50} However, the need to work across sectors to address underlying neighborhood conditions to improve health calls for broadening the scope of such training to other sectors and disciplines. Just as there can be an accumulation of burdens

and risks when racist policies and practices are perpetuated, dismantling such policies and practices in one sector can have a positive ripple effect in other areas.

Research – There is much we can still learn about the ways in which racism impacts health, including for instance, the ways in which racism can be mediated, how racism interacts with other forms of oppression, or for understanding generational health impacts of racism. There is also a need for improving the ways in which both racism and health are measured, and for using multilevel analyses to capture the complexity of factors in the racism and health equation. These and other research activities can improve our understanding of this complex issue and may be particularly important for addressing criticisms and skeptics. However, it seems evident that **we know enough about racism as a determinant of health inequities to act**. Further, where research may be most useful is in evaluating policy and practice changes meant to address racism and its consequences. Similarly, research is needed on the most effective strategies for building public and political will for change, such as research on framing and social movements. Findings from these kinds of applied studies can help to further our collective efforts to advance equity in health.

Conclusion

For those with a social justice orientation, addressing structural racism is a moral imperative. Those with a more practical world view may approach this work from the understanding that “racism undermines the realization of the full potential of the whole society through the waste of human resources”.^{20,p9} Both perspectives are relevant to efforts to advance health equity given that health is both a human right, as well as a resource for living and working. Addressing structural racism requires efforts on multiple fronts and on many levels. The evidence suggests there is good reason to be optimistic that changing underlying structural conditions will lead to improved health and well-being.

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Our Vision: Healthy, Thriving Communities for All

The Partnership for Healthy Communities is inspired by the possibility of this reality for all Delaware communities; as well as being inspired by a vision of equity in health. This prompts our work so that all of our residents can live in communities with the resources that are necessary to promote optimal health, and the burdens or threats to good health are minimized. We focus especially on communities currently experiencing social inequities.

The mission of the UD Partnership for Healthy Communities is to align and strengthen University of Delaware research, educational, and service capabilities to improve the health and well-being of Delaware communities and beyond through effective community partnerships.

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