CULTURAL CONTEXT AND A CRITICAL APPROACH TO ELIMINATING HEALTH DISPARITIES

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The science of eliminating racial health disparities requires a clear understanding of the underlying social processes that drive persistent differences in health outcomes by self-identified race. Understanding these social processes requires analysis of cultural notions of race as these are instantiated in institutional policies and practices that ultimately contribute to health disparities. Racism provides a useful framework for understanding how social, political and economic factors directly and indirectly influence health outcomes. While it is important to capture how individuals are influenced by their psychological experience of prejudice and discrimination, racism is more than an intrapersonal or interpersonal variable. Considerable attention has focused on race-based residential segregation and other forms of institutional racism but less focus has been placed on how cultural values, frameworks and meanings shape institutional policies and practices. In this article, we highlight the intersection of cultural and institutional racism as a critical mechanism through which racial inequities in social determinants of health not only develop but persist. This distinction highlights and helps to explain processes and structures that contribute to racial disparities persisting across time and outcomes. Using two historical examples, the National Negro Health Movement and hospital desegregation during the Civil Rights Era, we identify key questions that an analysis of cultural racism might add to the more common focus on overt policy decisions and practices. (*Ethn Dis.* 2010;20:71–76)

Key Words: Health Disparities, Health Inequities, Blacks, Racism, Social Determinants

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INTRODUCTION

Despite exponential growth in research on health disparities over the last two decades,[1] US racial and ethnic health disparities that have existed for over a century remain significant and pervasive examples of population inequality.[2–5] At no time in the history of the United States has the health status of racial and ethnic minorities equaled or even approximated that of White Americans.[4] While advances in public health and medicine have contributed to dramatic improvements in quality of life and life expectancy overall, they have had minimal impact on persistent disparities in morbidity and mortality between racial and ethnic groups.[4,6–8] The persistence of these inequities has led to calls for increased attention to the science of health disparities.[6,9]

The elimination of racial and ethnic health disparities requires a clear understanding of underlying social processes (ie, social determinants) that drive persistent racial and ethnic differences in health outcomes. While some areas of research may primarily be descriptive, the goal of research on health disparities is to explain differences in health outcomes in such a way that the findings are useful for making predictions, for reducing existing and preventing future health disparities, and for improving human health.[10] As noted by Oppenheimer,[11] in the United States, race and ethnicity are sociopolitical constructs, not anthropologically or scientifically-based categories. In a race-conscious society such as the United States, processes of racialization, involving social, economic, and political processes, transform population groups into races and create meanings associated with races and ethnicity.[12–15] Racialization encompasses three key areas: the definition of racial or ethnic groups as distinct or different; the construction of a (generally inferior or unequal) character associated with specific races and ethnicities; and the imposition of specific images or stereotypes associated with marginalized races and ethnicities.[12–15] In this commentary, we argue that understanding the health implications of these processes of racialization require analysis of the mutual relationships between symbolic or interpretive ideas that reproduce ideas of racial difference or inequality (ie, cultural racism) and the institutional policies and practices that contribute to health inequities (ie, institutional racism). Both terms should be interpreted as applicable to racialized ethnic groups: For simplicity, through the remainder of this paper we refer to cultural and institutional racism.

RACISM AS A FUNDAMENTAL FACTOR IN HEALTH DISPARITIES

Racism is a relational concept that describes how perceived differences in socially defined racial groups become central components of practices, structures, beliefs and representations that yield inequality by self-identified race.[16] Racism is a social determinant of health that, according to Williams and Rucker,[17] can be defined as "an organized system, rooted in an ideology of inferiority that is linked to the political power to categorize, rank, and differentially allocate societal resources to human population groups." Defined

in this way, racism is not a function of individual beliefs or behavior, but a systematic set of ideologies and symbolic frameworks that guide individual and institutional assumptions and practices. Racism, therefore, is a system of beliefs that become imbedded in educational, criminal justice, housing, health and economic institutions and a fundamental aspect of the social structure.[16,18,19]

Racism influences health over the life course by shaping access to environmental resources and stressors critical to health behavior and health outcomes, systematically advantaging some racially defined groups over others.[20] These systematic differences are ultimately expressed as racial health disparities.[18,21] Racism's ability to structure access to the resources necessary to maintain health, and exposures to factors that are inimical to health, is in keeping with definitions of fundamental determinants of health. Specifically, fundamental determinants are defined as those that influence multiple risk factors and multiple disease outcomes and cannot be eliminated simply by addressing the mechanisms that appear to link them to a specific disease.[22] Following the logic of this argument, the science of eliminating racial health disparities must be informed by an understanding of the factors that perpetuate racism, and include an analysis of the potential for dismantling racism.

We take as our central problem in this article the question of how the science of eliminating health disparities may be informed by an examination of the mutually constitutive nature of cultural and institutional forms of racism, and in particular, the potential for change within these processes. We place particular emphasis on examining cultural racism in relation to socially structured health disparities, and offer several illustrative ways that an understanding of cultural racism might contribute to the elimination of racial health disparities, including disparities experienced by ethnic groups encountering (or who have encountered) processes of racism.[23]

CULTURAL RACISM

Culture is the medium through which race is defined and takes on meaning in society; therefore, culture is integral to any discussion of racism and racial disparities. While some have described culture as a blueprint for living in society,[24] micro-macro social theories explicitly recognize that social actors shape, use and recreate culture at the same time that culture shapes and influences individuals.[25–28] Such definitions of culture also move away from the idea of culture as a single internally consistent framework and toward the notion that culture is composed of different bits of information and schematic structures that organize that information.[29] Thus, racism is not a single fixed view of race or racism,[16] but a dynamic story with several subplots that incorporate power relations and historical contexts.[30]

In a race-conscious society, cultural racism reflects attitudes, values, and beliefs about races and the importance of race in society. Processes of racialization involve the emergence of cultural notions of racial and ethnic hierarchy, or cultural racism, that become institutionalized in legislation or in institutional policies.[24,31–32] To the extent that these forms of institutional racism become taken for granted as forms of practice and viewed as rational and correct, they can reinforce and accentuate cultural racism, illustrating the idea of mutual constitution.[32] Cultural schemas offer one way of understanding culture and cultural racism as dynamic processes rather than static entities. Cultural schemas are plots or story lines that emerge within social groups to provide frameworks for individual actors and illustrate ways to respond to imbedded contradictions within a social system or institution.[25] For example, in 1932, the US Public Health Service started the infamous Study of Untreated Syphilis in the Negro Male and yet began supporting the National Negro Health Movement. The former is considered one of the worst examples of ethical misconduct, while the latter is arguably the largest and most successful coordinated minority health intervention in US history.[33–36] Despite their differences, these programs coexisted within the same institution and the larger public health community and were, for several decades, accepted as efforts to improve racial disparities. How could these two programs be viewed very similarly and positively for two decades, yet viewed so differently decades later? One answer may lie within the complex system of cultural schema employed in relation to race in the United States.

As we examine the volumes of data on health disparities, it is critical to explore the tacit values, beliefs and assumptions that underlie the interpretations and the policy recommendations proposed to address racial disparities. When people are presented with new data, theories or information, such as new explanations for why racial disparities in health and social context exist, this information is assessed in relation to existing schema.[37] When information is congruent with existing beliefs and values, it is experienced as accurate, obvious and helpful; however, when information is experienced as contradictory, it can be experienced as inaccurate, flawed, and useless, and be potentially rejected.[37] It is critical to understand how cultural schemas play a role in the structural roots of policies that will either reduce or exacerbate health disparities.

One way to help examine the cultural and institutional roots of policies is through an analysis of power. In a model initially articulated by Lukes,[38] power has been described as having three dimensions: overt decision-making, shaping meaning and value, and agenda and priority setting. The first dimension of power is characterized by the processes and outcomes of observable conflicts or overt decision-making.

The second dimension of power is the process of shaping or framing an issue so that certain ideas are considered, discussed, and esteemed while others are not. The third dimension of power is characterized by the ability to define or determine what is considered to be a relevant issue to be discussed or addressed through setting agendas and determining priorities. While public health efforts typically focus on the first dimension of power, there are considerable limits to only examining overt conflict and decision-making. For example, organizational cultures, institutions and populations may influence health policy and outcomes powerfully through their influence on how issues are framed. Cultural beliefs and norms, the third dimension of power, shape and operationalize what is considered a valuable and important health issue or population of interest. In the next section, we consider how cultural racism may provide key insights into where and how to intervene to eliminate health disparities.

WHAT MIGHT CULTURAL RACISM CONTRIBUTE TO THE SCIENCE OF ELIMINATING HEALTH DISPARITIES?

In this section, we explore potential contributions of a focus on cultural racism to an understanding of the possibility for addressing racial disparities. Building on significant evidence of the role of fundamental inequalities and social determinants on population health (eg, the effects of race-based residential segregation and poverty on health),[21,22,39–44] we argue that fundamental inequalities structured around race and ethnicity influence aspects of the neighborhood or community that shape interpersonal or intrapersonal behaviors and characteristics that affect health outcomes.[43–48] We highlight lessons learned from two historical examples – the National Negro Health Movement and hospital desegregation during the Civil Rights Era – that provide insight into how we might intervene to address cultural and institutional factors that underlie the persistence and pervasiveness of racial health disparities.

NATIONAL NEGRO HEALTH MOVEMENT

The National Negro Health Movement (NNHM) officially began in 1932 and stands as perhaps the largest coordinated intervention to address the poor health of a racial minority group in US history.[36,49–53] The NNHM merged community health promotion, health service provision, and social and political advocacy into a comprehensive campaign to improve the health status of African Americans. It mobilized a broad cross-section of institutions across the African American community, including the African American church, civic and benevolent societies, and professional organizations. One report indicated that during the 1949 fiscal year, approximately 5.5 million individuals attended 10,000 health lectures and 7,500 health sermons that were conducted at churches and houses of worship in 35 states.[54]

According to Bediako and Griffith,[33] there are three key lessons learned from the NNHM: (1) successful interventions can originate from community residents, and create positive health norms and structures with assistance and resources promoting an institutionalized health ethic (a process of coordinating community residents, health professionals, health institutions, and health resources to increase awareness and change norms to make a community healthier); (2) community mobilization efforts to address social inequities and health outcomes can be important health promotion strategies; and (3) in order to sustain health equity, institutional resources must be sustained.

From the lens of cultural racism, a few questions arise. First, what role can initiatives that originate in communities of color play to mitigate the resource inequities associated with race-based residential segregation? Typically there is a strong bias from the scientific community toward the internal validity of interventions that originate from outside of communities over the external validity of those that already exist within communities but may not have demonstrated efficacy.[33] Second, from the perspective of community development and community-based participatory research,[55] building the capacity of communities to address their own health needs from the inside out may be more effective than relying on girding up the community from the outside in. How can we most effectively combine health research and interventions with building stronger, healthier, and more viable communities and community institutions weakened by failed social and economic policies? Some answers, or at least better questions, may come from examining the process of hospital desegregation in the United States.

HEALTHCARE DISPARITIES AND HOSPITAL DESEGREGATION DURING THE CIVIL RIGHTS ERA

Inequitable access to health care is one factor that contributes to racial inequalities in health outcomes. We use the hospital desegregation efforts that occurred in the United States in the 1960s to examine lessons learned regarding the types of changes that may be necessary to eliminate racial disparities in health. Until the 1960s, the American healthcare system was legally segregated by race and class.[4,56–58] It was legal and often customary for hospitals to refuse treatment to Black Americans or to house them separately in inferior, under-funded, and often overcrowded

basement wards and other facilities. There also was considerable discrimination by medical and health professionals who furnished care and ultimately determined the structure, design, and operation of the health system.[56–59]

According to Smith,[57] the three fundamental challenges of hospital desegregation were: (1) ending the formal and legal practice of segregating patients by race; (2) eliminating more subtle forms of segregation shaped by physician referral practices, insurance status, and residential location; and (3) assuring equal treatment once access to care was equal. It is critical to understand the goals of the federal efforts to desegregate hospitals and other public spaces. The legal mandate was desegregation, not integration. The former is removing the overt policies and practices of treating people differently by race, while the latter is a more substantive change that monitors and addresses any inequalities by race.[56] Consequently, in accordance with Title VI of the 1964 Civil Rights Act, while visible symbols of segregation were removed from hospital systems, compliance with federal law was largely superficial in nature, and systems of racial hierarchy remained. It took top-level, hands-on leadership, commitment and effort at reengineering systems to overcome habits and expectations shaped by Jim Crow policies and practices.[56–58]

While the federal government was well within its authority and rights to collect data and monitor the extent of discriminatory medical treatment, as with housing and employment discrimination, no public reporting requirements have ever been developed or imposed for healthcare.[58] As noted by Smith,[58] ''There has never been a lack of regulatory authority to require such collection and reporting; it has always been a lack of political will.'' The lack of political will to use key policy levers (eg, federal funding tied to integration and accountability) is rooted in cultural and institutional values.

From a cultural racism perspective, a few questions arise. (1) How can we develop policies that focus on healthcare quality and health disparities without examining the explicit policies and implicit practices of local, state and federal policy makers and institutional settings? It is critical to consider what is valued by key institutions and defined as success to understand the cultural schemas that underlie the potency of efforts to eliminate racial health disparities. (2) How can medical and public health staff training efforts get to the root causes of racial disparities and shift their orientation more upstream? Relationships between cultural competence[60–61] or cultural sensitivity,[62] key priorities in many healthcare settings, and equal care across racial groups has been weak at best.[63] It is critical to examine institutional contexts[64] and consider how racism operates throughout healthcare systems, rather than focusing solely on individual competencies.[65] Education and diversity efforts must incorporate consideration of racism as a fundamental cause of racial disparities in health outcomes.[66] Finally, how do policy makers within health care institutions, and in public health more broadly, shift research, service, and policy efforts away from failed yet institutionalized strategies, to those focused on elimination of underlying social determinants of racial health disparities?

DISCUSSION

The goal of this paper is to highlight the processes that underlie racial health disparities and argue for an increased focus on the root cultural factors that shape formal policies and practices. We argue that public health professionals must address social determinants of racial and ethnic disparities in health. While research has illustrated the importance of considering underlying social determinants of health, including socioeconomic status and race-based residential segregation,[5,9,21,44,46,67] more attention to the role of cultural racism and processes of racialization in shaping regional, neighborhood, and health policies is warranted. These policies do not occur in isolation, but emerge in the context of race conscious ideologies that, in turn, shape the beliefs and values of decision makers. Race-based residential segregation and hospital segregation, for example, were adjudicated by our federal justice system, congruent with the cultural and social norms of the time, and had the support of major economic, cultural, and scientific institutions.

Structural and institutional factors that are the result of explicit policies and stated practices are critical, yet partial, explanations for racial or ethnic health inequities.[68] More comprehensive frameworks are required that encompass analysis of the interplay of culture and social structure in forming, shaping and perpetuating structural and institutional policies that contribute to persistent racial and ethnic health disparities.[68–69] Racial and ethnic disparities in health arise within contexts of cultural racism and institutionalized racism that are only poorly captured through the use of cross-sectional analyses. Longitudinal studies that capture the effect of accumulated exposures, and qualitative or historical analyses that place these effects within historical contexts, are needed.[70] While more difficult to measure, racialization processes and cultural racism are useful conceptual tools to help health policy and practice institutions examine the persistence, pervasiveness and injustice of racial and ethnic health disparities.

Cultural and institutional racism intersect and identify potential points of intervention that may break the cycles and processes that concentrate disadvantage and exacerbate inequality. The NNHM and hospital desegregation efforts highlight ways that cultural racism may add to conceptualizations

of institutional racism to better understand how and where to intervene to address fundamental determinants of health. These examples highlight the need to place health behavior, health outcomes and health policy in historical contexts that highlight the processes through which they are culturally generated and structurally maintained. An analysis of cultural racism also suggests the importance of attention to organizational and institutional cultures, norms and practices, in addition to the formal policies and activities. These tacit factors shape how people in decision-making roles interpret new data, accept or reject new explanations of data, and decide where and how to intervene. These faces of power[38] are rarely considered, but are necessary factors to consider to understand how we can most effectively eliminate racial and ethnic health disparities.

The institutionalization of racism is historically, culturally, economically and socially located in multiple dynamic pathways that influence health. These pathways are shaped by cultural schemas, including cultural racism. Focusing on cultural racism - and its relationship with institutional racism - highlights the factors that underlie policy decisions, the ideologies, power and politics that shape formal policies, not just the health outcomes of policy decisions. The key challenge facing public health professionals is to examine the processes and assumptions that underlie health policy and health disparities, considering critically why racial and ethnic health disparities exist and persist. These answers are unlikely to come from an analysis that does not grapple with why population health outcomes vary by race and ethnicity. While it will be useful to consider how processes that lead to socioeconomic disparities are similar to that of racial and ethnic disparities, the roots and intersections of these factors are different. Eliminating health disparities is likely to require public health researchers, practitioners, and policy makers to identify, name and systematically address cultural racism as a social determinant of racial and ethnic health disparities.

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