Confronting Institutionalized Racism
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Confronting Institutionalized Racism

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When I was invited to submit a paper for this issue of *Phylon,* I immediately knew that my topic would be "Confronting Institutionalized Racism." That is because I have become convinced that it is only by naming racism, asking the question "How is racism operating here?" and then mobilizing with others to actually confront the system and dismantle it that we can have any significant or lasting impacts on the pervasive "racial" health disparities that have plagued this country for centuries. However, it has taken me a long time to actually write this piece because each time I started, I had so much to say that I didn't know where to start or end, or what my tack should be. Should it be a presentation of a scientific roadmap for addressing the impacts of racism on the health and well-being of the nation's children? Or a review of the domains of racism that should be covered in any measures that we develop or use? Or an outline of strategies we might employ in launching local efforts to combat institutionalized racism in our cities?

In the end, I decided on this format, a conversation centered on/in what I consider to be some of the emergent questions facing us today as we seek to understand *and intervene on* the impacts of racism on the health and well-being of this nation. Some of these questions are: Why discuss racism at all when talking about health? What is racism? What is "race"? Is there something about the environment that we have previously not named that we can usefully describe as the racial climate, and if so, how do we measure it and what is it doing? If we want to confront institutionalized racism, what does that really mean and how do we get started?

So sit back in your office chair or your airplane seat or your bed, and wander with me as I raise and seek to answer some of these questions. After all, it is only in the raising of important questions and the naming of the un-nameable that we will be able to focus our tremendous personal and intellectual resources on a system so powerful and pervasive that the majority of Americans are still in denial about its very existence.

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**The author would like to acknowledge discussions of these issues with members of the Measures of Racism Working Group at the Centers for Disease Control and Prevention.

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Why discuss racism when talking about health?

The public health community in the United States has made a commitment to ridding the nation of "racial" and ethnic health disparities. This commitment was first articulated in February 1998 as the Initiative to Eliminate Racial and Ethnic Health Disparities by the Year 2010,[1] and has since been formalized in the second of the two over-arching goals of Healthy People 2010.[2] In order to approach such an encompassing goal with any hope of success, we must seek to understand and address the fundamental causes of these disparities.[3]

"Racial" health disparities are produced on at least three levels: Differential care within the health care system, differential access to health care, and differences in exposures and life opportunities that create different levels of health and disease. "Racial" health disparities must therefore be addressed on each of these levels (see Figure 1). That is, it is not enough to provide equal levels

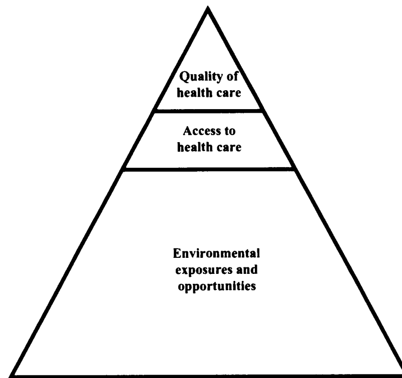

Figure 1. Ideas for addressing the different levels at which "racial" health disparities are produced.

Differential care within the health care system:
- Monitoring of physician practice
- Implementation of provider reminder systems
- Adherence to treatment protocols
- Training of a more racially, economically, and linguistically diverse health workforce at all levels
- Provision of "cultural competency" or antiracism training to health providers
- Community oversight of health care institutions
- Adequate numbers and training for translators

Differential access to health care:
- Universal health care coverage
- National health system
- Training of a more racially, economically, and linguistically diverse health workforce at all levels
- Mechanism for assuring the appropriate geographic distribution of physicians

Differences in exposures and life opportunities by "race":
- National conversation on racism
- National campaign against racism
- Confronting institutionalized racism through examining structures, policies, practices, and norms
- Reparations to African-Americans

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of care within the system if there are many who cannot access the system, and it is not enough to provide universal access to the system without addressing the unequal distribution of goods, services, and opportunities by "race" that structure the greater burden of illness in certain individuals and communities.

Racism is an important aspect of our social environment that is increasingly being discussed at both national and international levels. Recent documents that cite the importance of paying attention to racism and its impacts on health include the *Declaration and Programme of Action* from the third World Conference Against Racism, Racial Discrimination, Xenophobia, and Related Intolerance convened by the United Nations in 2001 (WCAR, 2001), the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* published by the Institute of Medicine in 2002,[4,5] and the resolution "Research and Intervention on Racism as a Fundamental Cause of Ethnic Disparities in Health" adopted as public policy by the American Public Health Association in 2001.[6]

A growing number of scientists hypothesize that racism is a fundamental cause of "racial" and ethnic disparities in health outcomes.[7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25] Yet the scientific investigation of the role of racism in contributing to health disparities is not simply an academic exercise of establishing a causal relationship or decreasing the amount of unexplained variance in our statistical models. This work will be of value when it identifies the pathways and structural mechanisms by which racism has its impacts. Once that has been accomplished, it will be a matter of political will to target these pathways and mechanisms for intervention.

Public health scientists clearly have a stake and a role in confronting racism. That role evolves from commitment to eliminating "racial" disparities in health outcomes. In addition, all citizens of this nation have a stake and a role in confronting institutionalized racism. That role evolves from commitment to social justice and to maximizing the functioning of the society as a whole.

What is racism?

First of all, racism is a system. It is not an individual character flaw, nor a personal moral failing, nor a psychiatric illness. It is a system (consisting of structures, policies, practices, and norms) that structures opportunity and assigns value based on phenotype, or the way people look. And what are the impacts of this system? It unfairly disadvantages some individuals and communities. When we talk about racism at all in this country, it is usually discussed in this context. But at the same time that the system is unfairly disadvantaging some individuals and communities, it is also unfairly advantaging other individuals and communities. This issue of white privilege is much less frequently discussed in this country.[26] Yet even more profoundly, the system of racism undermines realization of the full potential of our whole society because of the waste of human resources. Because we do not value the potential contributions of the children living in our ghettos, barrios, or reservations, because we feel that we can

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get along "very well thank you" without them, we do not invest in developing their genius and it is lost. Just imagine where our nation would be if we truly valued all of our people as precious resources, and allowed each the opportunity to know and develop to their full potential.

So I offer the following **global definition of racism:**

Racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that:

- unfairly disadvantages some individuals and communities
- unfairly advantages other individuals and communities
- undermines realization of the full potential of the whole society through the waste of human resources.

When trying to understand how this system impacts on health, I find it useful to think about racism as operating on three levels: Institutionalized, personally-mediated, and internalized.[27]

Institutionalized racism is defined as the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by "race." Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need.[28]

Institutionalized racism manifests itself both in material conditions and in access to power. With regard to material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment. With regard to access to power, examples include differential access to information (including one's own history), resources (including wealth and organizational infrastructure), and voice (including voting rights, representation in government, and control of the media). It is important to note that the association between SES and "race" in the United States has its origins in discrete historical events, but persists because of contemporary structural factors that perpetuate those historical injustices. In other words, it is because of institutionalized racism that there is an association between SES and "race" in this country.[29]

Personally-mediated racism is defined as prejudice and discrimination, where prejudice is differential assumptions about the abilities, motives, and intents of others by "race," and discrimination is differential actions towards others by "race." These can be either intentional or unintentional. Like institutionalized racism, personally-mediated racism includes acts of omission as well as acts of commission. It manifests as lack of respect (poor or no service, failure to communicate options), suspicion (shopkeeper vigilance, everyday

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avoidance including street crossing, purse clutching, and empty seats on public transportation), devaluation (surprise at competence, stifling of aspirations), scapegoating (Rosewood incident, Charles Stuart case, Susan Smith case), and dehumanization (police brutality, sterilization abuse, hate crimes).[30]

Internalized racism is defined as acceptance by members of the stigmatized "races" of negative messages about our own abilities and intrinsic worth. It is characterized by our not believing in others who look like us, and not believing in ourselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-expression. It manifests as embracing "whiteness" (hair straighteners and bleaching creams, skin-tone stratification within communities of color, and "the white man's ice is colder" syndrome), self-devaluation (racial slurs as nicknames, rejection of ancestral culture, and fratricide), and resignation, helplessness, and hopelessness (school drop-out, voter nonparticipation, and risky health practices).[31]

Although all three of these levels of racism can have distinct impacts on health, it is clear that addressing only personally-mediated racism or internalized racism will not change the structural conditions in which stigmatized groups find themselves. It is only through intervening at the institutionalized level that profound and permanent change can occur.

The role of public health scientists in confronting racism. Public health scientists can use their expertise to confront racism in the following ways:

- Clarifying what "race" is and what it is not.
- Vigorously investigating the basis of observed "race"-associated differences.
- Conceptualizing and measuring racial climate as an important aspect of the social environment.
- Developing individual and aggregate measures of racism on three levels (institutionalized, personally-mediated, and internalized).
- Articulating a scientific roadmap for understanding and addressing the impacts of racism on health.
- Monitoring outcomes for evidence of institutionalized racism.
- Examining structures, policies, practices, and norms to identify the mechanisms of institutionalized racism.

I will elaborate on only a subset of these points in this paper. The issue of vigorously investigating the basis of observed "race"-associated differences was addressed in detail in an earlier work.[32] The goals of developing individual and aggregate measures of racism on three levels and of articulating a scientific roadmap for understanding and addressing the impacts of racism on health will be the focus of later works.

"Race" is the social classification of people based on phenotype. That is, "race" is the societal box into which others put you based on your physical features.

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As such, it is distinct from genetic endowment or cultural heritage. Public health scientists have too long used the variable "race" as a proxy for socioeconomic status (SES), culture, and genes. While historical injustices and the contemporary structural factors that perpetuate those injustices (institutionalized racism) have created a relationship between phenotype ("race") and SES in this country, even that proxy relationship is rough. With regard to culture, each phenotypic ("racial") group is diverse in cultures, and there are cultural similarities across groups. With regard to genes, the few genes that determine skin color, hair texture, and facial features (the principle aspects of phenotype used to classify people into "races" in the United States) are not informative about other aspects of the genotype at the individual level.[33]

Yet the "race" noted by a hospital admissions clerk on a medical record is the same "race" noted by a sales clerk in a store, a taxi driver or a police officer on the street, a judge in a courtroom, or a teacher in a classroom, and this "racial" classification has a profound impact on life opportunities and daily life experiences in this country.[34] I hypothesize that it is this classification by others based on phenotype (and not self-identity) that impacts health. I therefore propose that researchers measure "race" with the following question:

> **How do *other people* usually classify you in this country?**
>
> Would you say White, Black or African-American, Hispanic or Latino, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, or some other group?

This question has already been included on the "Reactions to Race" module that was piloted on the 2002 Behavioral Risk Factor Surveillance System[35] by six states: California, Delaware, Florida, New Hampshire, New Mexico, and North Carolina. Note that the response options for this question include all of the "race" categories as specified by the Office of Management and Budget (OMB), as well as the category "Hispanic or Latino" which is classified by OMB as "ethnicity" (OMB, 1997).

Ethnicity is cultural heritage. It reflects historical, cultural, contextual, and geographic experiences of a defined population.[37] While I include "Hispanic or Latino" as a "racial" option, it can be broken down to include ethnicities such as Cuban, Dominican, Mexican, Mexican-American, and Puerto Rican. Similarly, the "racial" option "Black or African-American" can be broken down to include ethnicities such as African-American, Ethiopian, Haitian, Jamaican, and Nigerian. It is important for researchers to acknowledge ethnic diversity within so-called "racial" groups, and to collect detailed ethnic data to allow analysis of cultural influences on health. Even simple questions such as the place of birth of the respondents, their parents, and their grandparents will enable better understanding of this ethnic diversity within "race."

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Conceptualizing racial climate. There is an aspect of the social environment that reflects the existence of a system of "racial" classification and the pertinence of that classification to the different groups in the society. I propose racial climate as a contextual measure for a given place and time, having three components: 1) The pertinence of "race" as a basis of classification in that place and time, 2) the specific rules for "racial" classification, including the number and names of "racial" categories and the sorting algorithm, and 3) the opportunities and value accorded the different "racial" groups.[38] Fish swimming in water may be unaware of the water, but the water in which they swim can be clean or polluted. Similarly, there are aspects of our environment that are so pervasive that we are not consciously aware of them, but these aspects can be health-enhancing or damaging. I propose that we try to see the water in which we swim, that we articulate a notion of racial climate that characterizes a given place and time. We can then examine how this racial climate varies over place and time, including in response to intervention efforts.

Before proposing an approach to operationalizing racial climate, I ask the reader to answer the following question: How often do you think about your caste? Many of you are now staring at the page quizzically, wondering what in the world I am talking about. But if I were to ask the same question in India, it would be immediately understood and everyone would have an answer. Certainly the answers would vary, with Dhalits (the "untouchables") more likely than Brahmins to respond that they constantly think about their caste. India is a caste-conscious society. Caste is pertinent as a basis for social classification, and there are specific rules for assignment as well as differential opportunities and value accorded the different groups. There is a "caste-al" climate in India that is very different from the "caste-al" climate in the United States, even for Indians living in the United States.

Although not caste-conscious, the United States is a "race"-conscious society with a highly charged racial climate. I propose that researchers operationalize racial climate by first assessing the pertinence of individual racial assignment using the following "race"-consciousness question:

How often do you think about your race?

> Would you say never, once a year, once a month, once a week, once a day, once an hour, or constantly?

This question has already been included on the "Reactions to Race" module that was piloted on the 2002 BRFSS.[39] It has also been included on two large postal surveys, the 1995 Nurses' Health Study II (NHS II with 93,681 respondents, Walter Willett, Principal Investigator) and the 1997 Black Women's Health Study (BWHS with 53,269 respondents, Lynn Rosenberg and Lucile Adams-Campbell, Principal Investigators).

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The distribution of responses to this question on both the BWHS and the NHS II are shown in Figures 2a and 2b, stratified by "race." Note that the distribution of frequency of thinking about one's "race" is almost identical between the black women responding to the 1997 BWHS and the black women responding to the 1995 NHS II, even though these are entirely different groups of women who were queried two years apart. Further note that the distribution of "race"-consciousness for the white women responding to the NHS II differed markedly from the distribution for the black women in NHS II, even though both groups were nurses and they were surveyed at the same time. More than 50% of the white women in NHS II reported that they never think about their "race", and only 0.3% reported thinking about their "race" constantly. On the other hand, 21% of the black women in NHS II and 22% of the black women responding to BWHS reported thinking about their "race" constantly, and roughly 50% of the black women in both groups reported thinking about their "race" once a day or

Figures 2a, 2b and 2c. Responses to the question "How often do you think about your race?" among a) Black respondents to the Black Women's Health Study (1997) and Black and White respondents to the Nurses' Health Study II (1995), b) Asian and Hispanic respondents to the Nurses' Health Study II (1995), and c) Pakeha (White) and two groups of Maori respondents from convenience samples in New Zealand (1999).

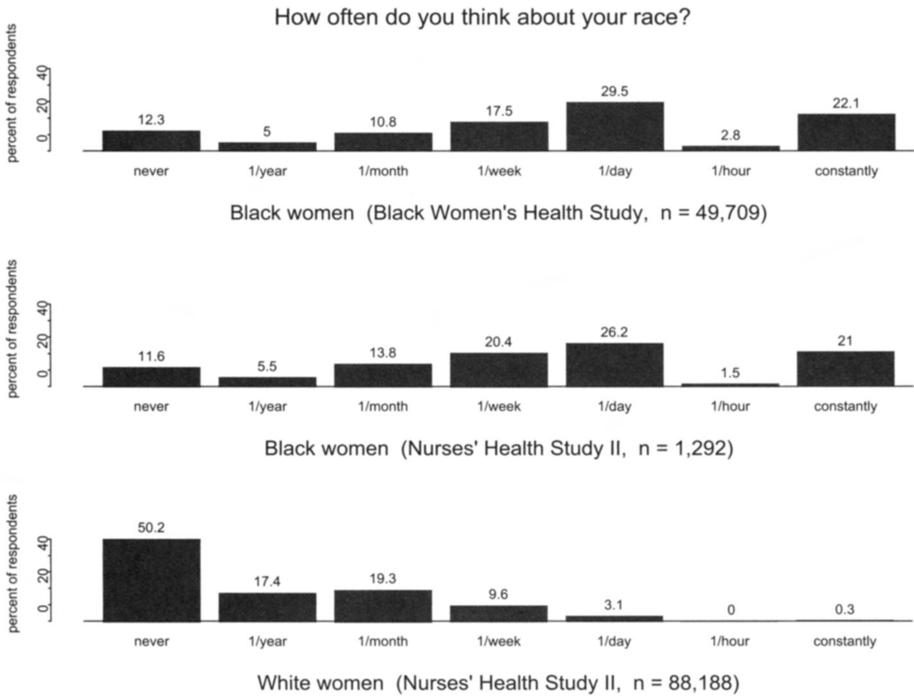

Figure 2a.

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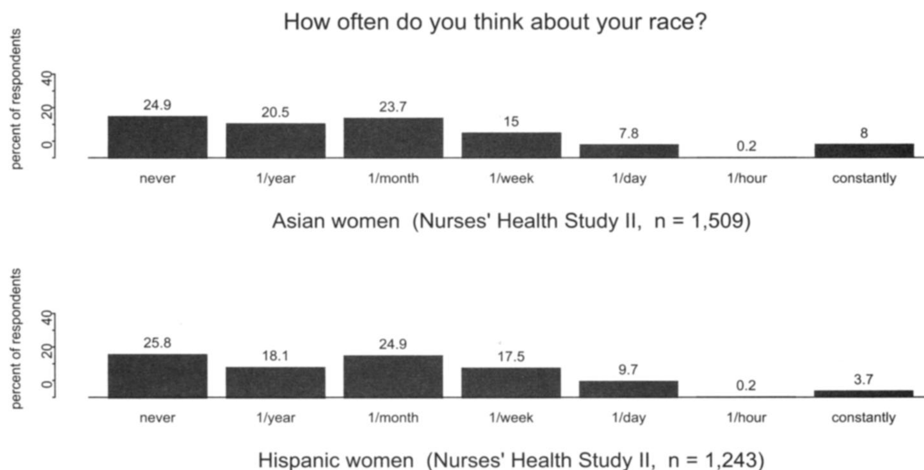

Figure 2b.

more frequently. The distribution of frequency of thinking about one's "race" for Asian and Hispanic respondents to NHS II was intermediate between the black and white distributions.

The same question was asked in the New Zealand context, where the frequency of thinking about one's "race" was compared between Pakeha (white descendants of the British colonizers), Maori (descendants of the Polynesians indigenous to Aotearoa (New Zealand)), and those who were sometimes identified as Pakeha although they self-identified as Maori ("mixed Maori").[40] The distribution of responses from these three groups is displayed in Figure 2c. It is clear that there are differences in the distribution of "race"-consciousness in New Zealand, just as there are in the United States. However the relationship between the "race"-stratified distributions differs between the two countries, reflecting a difference in racial climate in the two locations.

I propose that a summary measure of racial climate be derived from stratifying responses to the "race"-consciousness question by "race," examining pairwise differences between the "race"-stratified distributions, and collapsing each pairwise difference into a weighted sum (see the algorithm in Table 1). This measure represents a joint assessment of the differences between the frequency distributions (discordance) and the placement of the frequency distributions on the "never" to "constantly" contimuum (location). Using this approach, the more similar the "race"-stratified distributions being compared, the lower the racial climate score. This would reflect a place and time in which "race" would be equally pertinent to the groups being compared. There would not be a disconnect between groups, with one group highly conscious of its "racial" position while the other group was relatively unconscious of "race" as a personal delimiter. In addition, the more both "race"-stratified distributions are shifted toward lower frequencies of thinking about one's "race," the lower the racial climate score. This

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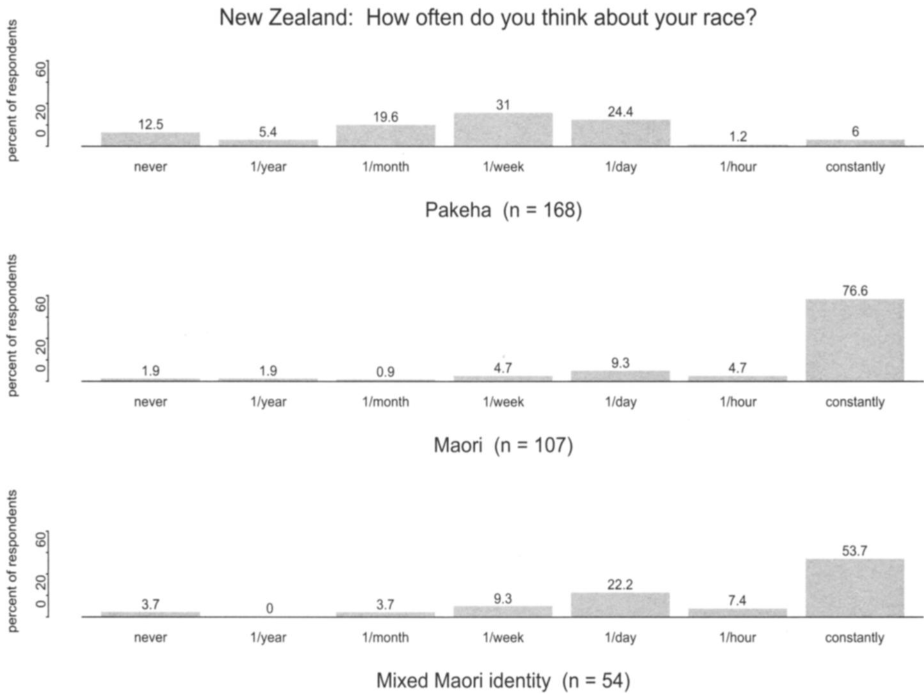

Figure 2c.

would reflect a place and time in which "race" was not a highly pertinent factor in determining life opportunities and daily life experiences for either group. Instead of thinking about their "race," members of both groups would be thinking about their talents or their beauty and feeling their full humanity. (This racial climate measures still needs some refinement. In a place like Nazi Germany where all groups were highly conscious of their "race," the racial climate score would still be low because of low discordance. Although this is not a desirable situation, the proposed algorithm would not penalize such a racial climate.)

Measuring institutionalized racism. The measurement of institutionalized racism has two facets, documentation of differential access to the goods, services, and opportunities of society by "race", and identification of the contemporary structural factors that perpetuate the differentials. Public health scientists therefore have a dual role in confronting institutionalized racism, both monitoring outcomes for evidence of institutionalized racism, and examining structures, policies, practices, and norms to identify the mechanisms of institutionalized racism. It is not enough to simply document the existence of systematic disparities. After all, a Martian could look at the distribution of housing or education or income in the United States and quickly conclude that there is something systematic going on by "race" in this country. It is important to know whether or not there are "racial" disparities in the receipt of cardiac procedures,

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or in the treatment of breast cancer, or in infant birthweight. We need to routinely survey all types of outcomes in all types of settings by "race" until we no longer have evidence of "racial" differentials in our society. That level of measurement will provide us with the scope of the problem and help target our intervention efforts.

Table 1. Algorithm for calculating summary measure of racial climate

Step	Description
Stratify respondents by "race".	Stratify respondents by response to the question, "How do other people usually classify you in this country?"
Examine the distribution of "race"-consciousness for each "racial" group.	For each "race" stratum, make a histogram of percent frequency of responses to the question "How often do you think about your race?" (see Figures 2a, 2b, and 2c).
Examine discordance in "race"-consciousness between pairs of "racial" groups.	Make pairwise plots of histogram differences. For each pair of "racial" groups being compared, use the group with the higher percent frequency of "never" responses as the reference.
Calculate a racial climate score that reflects both discordance and location of "race"-consciousness.	For each histogram difference plot, calculate a weighted sum of the positive differences using weights from 0 (never) to 6 (constantly).

The following algorithm operationalizes racial climate as the weighted difference between "race"-stratified distributions of responses to the question, "How often do you think about your race? Would you say never, once a year, once a month, once a week, once a day, once an hour, or constantly?"

- Stratify respondents by "race," operationalized as response to the question, "How do other people usually classify you in this country?"
- For each "race" stratum, make a histogram of percent frequency of responses to the question "How often do you think about your race?" with responses arranged from "never" on the left to "constantly" on the right.
- Make pairwise plots of histogram differences. For each pair of "racial" groups being compared, subtract the histogram from the group with the higher percent frequency of "never" responses from the other histogram.
- For each histogram difference plot, calculate a weighted sum of the positive differences using weights from 0 to 6, as follows:
    - Weight a positive difference in "never" responses by multiplying by 0.
    - Weight a positive difference in "once a year" responses by multiplying by 1.
    - Weight a positive difference in "once a month" responses by multiplying by 2.
    - Weight a positive difference in "once a week" responses by multiplying by 3.
    - Weight a positive difference in "once a day" responses by multiplying by 4.
    - Weight a positive difference in "once an hour" responses by multiplying by 5.
    - Weight a positive difference in "constantly" responses by multiplying by 6.

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However, that level of measurement will not provide us with the blueprint for our intervention efforts. In order to address the disparities, we must also have insight into the mechanisms by which the disparities arise and are perpetuated. Armed with the confidence that these mechanisms are knowable, identifiable, and addressable, we need to engage in qualitative research examining the structural fabric of our society. This should include an examination of the structures, policies, practices, and norms that are in place, as well as identification of those that are absent, and include those that promote equity as well as those that erode it.

For example, here are four classes of policies that serve as contemporary structural factors that perpetuate historical injustices:[41]

- Policies that allow segregation of resources and risks. These include redlining, zoning, and toxic dump siting policies that allow segregation of residential resources and risks; policies mandating the use of local property taxes to fund public education that perpetuate segregation of educational resources; and institutional policies allowing discretion in hiring or lending or medical treatment that permit and condone the expression of personally-mediated racism in these arenas.

- Policies that create inherited group disadvantage (or advantage). These include the lack of social security for children, the intergenerational transfer of wealth through estate inheritance, and the lack of reparations for historical injustices.

- Policies that favor the differential valuation of human life by "race." These include curriculum policies that teach certain histories and not others. They also include societal blindness to racism that denies the continued existence of an unfair system, and the myth of meritocracy that devalues those who are not successful in it.

- Policies that limit self-determination. These include policies that affect representation on school boards, policies that result in disproportionate incarceration and subsequent disenfranchisement, and "majority rules" as the only mode of decision-making when there is a fixed minority.

Confronting institutionalized racism. In order to confront institutionalized racism, public health scientists must join with all citizens in naming racism, asking the question "How is racism operating here?", and mobilizing for action. There is a need for a national conversation on racism to be followed by a national campaign against racism. Following is an outline for an intervention pilot at a local level that could provide insight into how to successfully launch a larger national effort. This pilot has three foci, which would probably need to be

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sequentially staged:

1) Naming racism (leadership consensus). Leaders from various sectors in the local community would be approached and asked about the need, timing, and process for naming racism in order to address racial disparities in health and in other aspects of life which impact on health (including education, employment, and economic segregation). An effort would be made to have local leaders put and keep racism on the political agenda.

2) Understanding the local mechanisms and impacts of racism (community conversations). Members of the general public as well as public servants (police, educators, elected officials, appointed officials) would be engaged in a conversation that names racism, identifies its impacts, and then asks the question, "How is racism operating here?" This process would involve:

    - Use and dissemination of the "Levels of Racism: A Gardener's Tale" allegory[42] (delivered personally, published as a children's book, turned into a popular song), as well as other allegories on "race" and racism that have been developed by Camara Jones (unpublished manuscripts).
    - Training of a cadre of interested persons to hold conversations on "race" and racism for teachers, for police officers, at community meetings, in schools and workplaces, and in other settings. Would also enlist current antiracism trainers[43,44] and professional storytellers[45] in this effort.
    - Development of a billboard campaign with slogans to start people thinking and talking about racism and its detrimental impacts on the health and well-being of the city.

3) Acting to dismantle racism (focus on the structures and processes of institutionalized racism). The selection of an initial focus would be the result of the leadership consensus and community conversations. For example, if the initial focus were primary and secondary education in the city, areas for study and intervention might include school board decision-making, racial and economic segregation of neighborhoods, mechanisms for funding public schools, content of school curricula, expectations of school performance, and the history and role of independent schools in the area.

Our charge. Racism is a fundamental cause of "racial" disparities in health. We must confront institutionalized racism if we seek to eliminate those

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disparities. Although the task of confronting institutionalized racism may seem overwhelming, it is not. The first step is to name racism in a society where many are in denial about its continued existence and impacts. As public health scientists we can be clear about the meaning of "race" and about the importance of measuring racism. The second step is to identify the mechanisms by which institutionalized racism operates. As public health scientists we can join with others to raise the question, "How is racism operating here?" The detailed understanding of these mechanisms will engender a sense of collective efficacy that can move people to action. The final step is to mobilize the political will for action. As public health scientists we can study the impacts of racism on the health and well-being of the nation. We can then join with our fellow citizens, armed with the knowledge, motivation, and determination to intervene. If we do not confront institutionalized racism, we abandon all hopes for success in our struggle for social justice and health equity.

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