I'M COMING UP ON THE ROUGH SIDE OF THE MOUNTAIN:

RACISM, RACIAL IDENTITY, SOCIAL JUSTICE

AND THE HYPOTHESIS OF DIMINISHING RETURNS IN HEALTH DISPARITY

BY

EDWARD C. SUAREZ

A Thesis Submitted to the Graduate Faculty of
WAKE FOREST UNIVERSITY GRADUATE SCHOOL OF ARTS AND SCIENCES
in Partial Fulfillment of the Requirements
for the Degree of
MASTER OF ARTS
Bioethics
December, 2015
Winston-Salem, North Carolina

Approved By:
Ana Iltis, Ph.D., Advisor
Nancy M. King, J.D., Chair
Ronny A. Bell, Ph.D.
ACKNOWLEDGMENTS

Firstly, I would like to express my sincere gratitude to my advisor, Professor Ana Iltis, for her continuous support, encouragement, and motivation. Her guidance helped me in the writing and completion of this thesis. Besides my advisor, I would like to thank the rest of the members of my thesis committee, Professors Nancy King and Ronny Bell, whose insightful comments and proving questions provided the incentive to expand my thinking on this topic.

I like to also thank my colleagues and friends who encouraged and supported me throughout: Jody Power, Sarah H. Lisanby, Jason Faulkner, David Bronat, Trey Sartin, and Greg Westby. Thank you to each and every one of you.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES AND ILLUSTRATIONS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>iv</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2. APPROACHES TO HEALTH DISPARITIES AND THE ROLE OF RACISM</td>
<td>15</td>
</tr>
<tr>
<td>3. ARE ALL DIFFERENCES IN HEALTH OUTCOME MEASURES DISPARITIES?</td>
<td>26</td>
</tr>
<tr>
<td>THE MOST COMMONLY USED DEFINITIONS OF HEALTH DISPARITIES AND RECENT</td>
<td></td>
</tr>
<tr>
<td>UPDATES</td>
<td></td>
</tr>
<tr>
<td>4. MORTALITY RATES FOR CARDIOVASCULAR DISEASES, CANCER AND DIABETES:</td>
<td>39</td>
</tr>
<tr>
<td>COMPARISONS BETWEEN BLACKS AND WHITES IN THE UNITED STATES</td>
<td></td>
</tr>
<tr>
<td>5. SOCIAL DETERMINANTS OF HEALTH AND RACIAL DISPARITIES: RACE</td>
<td>47</td>
</tr>
<tr>
<td>DIFFERENCES IN THE RELATION OF SES TO HEALTH OUTCOMES</td>
<td></td>
</tr>
<tr>
<td>6. WHAT IS RACE? HISTORICAL PERSPECTIVES AND CONCEPTUALIZING RACE</td>
<td>54</td>
</tr>
<tr>
<td>AS A SOCIAL CONSTRUCT: THE INFLUENCE OF RACISM ON RACIAL IDENTITY</td>
<td></td>
</tr>
<tr>
<td>7. RACISM AND ITS INFLUENCE ON WELL-BEING AND ITS ESSENTIAL DIMENSIONS:</td>
<td>61</td>
</tr>
<tr>
<td>APPLYING THE SOCIAL JUSTICE THEORY OF POWERS AND FADE</td>
<td></td>
</tr>
<tr>
<td>8. CONCLUSION</td>
<td>79</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>83</td>
</tr>
<tr>
<td>SCHOLASTIC VITA</td>
<td>103</td>
</tr>
</tbody>
</table>
LIST OF TABLES AND ILLUSTRATIONS

LIST OF TABLES

TABLE I  AGE-ADJUSTED DEATH RATES (PER 100,000) FOR WHITES AND MINORITIES FOR LEADING CAUSES OF DEATH IN THE UNITED STATES 1996………………………………………………………………………………… 41

TABLE II  AGE-ADJUSTED DEATH RATES FOR BLACKS AND WHITES FOR THREE CAUSES OF DEATH, AND RACIAL DISPARITIES, 1950 – 2000………………………………… 44

LIST OF ILLUSTRATIONS

FIGURE 1  MORTALITY RATES ACCORDING TO RACE, SEX, INCOME AMONG MEDICARE BENEFICIARIES 65 YEARS OF AGE AND OLDER…………………………………… 3

FIGURE 2  THE WORLD HEALTH ORGANIZATION SOCIAL DETERMINANTS OF HEALTH………………………………………………………… 22

FIGURE 3  LIFE EXPECTANCIES FOR ALL RACES, AND FOR WHITES AND BLACKS, 1970 – 2010………………………………… 26

FIGURE 4  THE RELATION OF LIFE EXPECTANCY BY EDUCATIONAL ATTAINMENT IN MEN AND WOMEN……………………………………………………………………… 69
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>AmI</td>
</tr>
<tr>
<td>American Pacific Islander</td>
<td>API</td>
</tr>
<tr>
<td>Center for Disease Control</td>
<td>CDC</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>CHD</td>
</tr>
<tr>
<td>High density lipoprotein</td>
<td>HDL</td>
</tr>
<tr>
<td>Museum of Modern Art</td>
<td>MoMa</td>
</tr>
<tr>
<td>National Cancer Institute</td>
<td>DCI</td>
</tr>
<tr>
<td>Office of Management and Budget</td>
<td>OMB</td>
</tr>
<tr>
<td>Socioeconomic Status</td>
<td>SES</td>
</tr>
<tr>
<td>Social Determinants of Health</td>
<td>SDOH</td>
</tr>
<tr>
<td>Total cholesterol</td>
<td>TC</td>
</tr>
<tr>
<td>White</td>
<td>W</td>
</tr>
<tr>
<td>World Health Organization</td>
<td>WHO</td>
</tr>
</tbody>
</table>
ABSTRACT

Applying the social justice theory of Powers and Faden, I consider the negative consequences of racism on levels of well-being and its essential elements and deliberate whether racism-induced insufficiencies contribute to cumulative disadvantage that, for Blacks, undermines the magnitude of health gains associated with increasing educational attainment. Referred to as the diminishing return hypothesis, evidence has suggested that increasing levels of educational attainment for minorities do not incur similar health returns as those noted in Whites. Using Powers and Faden’s concept of well-being, I speculate how racism may diminish not only levels of health but also personal security, reasoning, respect, attachment, and self-determination that form the bases for cumulative disadvantage. Although there is evidence linking racism to poor health outcomes, to date, the effects of racism on the remaining five essential dimensions of well-being have not been discussed. If racism mitigates the ‘capability and the freedom’ of Blacks to attain sufficient levels of well-being and its essential elements, the result is a pattern of insufficiencies that provide a foundation of disadvantages that undermines the potential health gains of increasing educational attainment.
CHAPTER 1

INTRODUCTION

Americans are living longer than ever before. In the last few decades we have witnessed a steady increase in life expectancy in the United States (US) with actuarial data suggesting that, in 2010, life expectancy reached 78.7 years, an increase of 11% from life expectancy in 1970 (1). Despite the increase, the data also has revealed differences in life expectancies that fall along racial lines with Blacks living five to eight years less than Whites (2). That life expectancy for Blacks is lower than for Whites has led to efforts being directed at (a) identifying factors that contribute to differences in life expectancy and (b) developing and implementing strategies that eliminate the underlying causes. To date, it is still not well understood what factors contribute to differences between Blacks and Whites with the strongest evidence suggesting that the lower life expectancy in Blacks is tied to higher rates of mortality for some of the major causes of death such as heart disease, diabetes, and cancer (e.g., 3). Besides the role of higher mortality rates, other explanations for Blacks having shorter life expectancy have been proposed. One such explanation that has garnished considerable attention is race differences in social determinants of health (SDOH), and specifically socioeconomic status (SES), which appear to contribute to differences in life expectancy and mortality rates between Blacks and Whites (4). There is an a considerable body of evidence to suggest that SES, measured by either occupation, educational attainment, or income, is significantly associated with a wide range of health outcomes such that decreasing levels of SES are
associated with worsening health outcomes including higher rates of mortality (5-7). The robust nature of this relationship, referred to as the ‘SES gradient’, has influenced a range of scientific inquiries, including those in public health (8), health psychology (9), mental health (10), and medicine, and health care (11).

Despite the overwhelming evidence in support of the SES gradient, emerging evidence suggests that racial differences in health outcomes persist despite increases in SES (12). Although negative findings have been reported (13), the majority of studies have reported racial heterogeneity in the relation of SES to various measures of health outcomes such that increasing levels of income and education, two commonly used measures of SES, are associated with improving health status more strongly in Whites than in Blacks (12, 14-20). For example, in one study that used educational attainment as the indicator of SES, comparisons of all-cause mortality rates for Black and White women with less than 12 years of education did not differ (14). However, among women with at least 16 years of education, age-adjusted death rates for all-causes for Black women (318.7 deaths per 100,000) was over two-times greater than that of White women (147.4 deaths per 100,000) (14). Other studies have reported a similar pattern such that, relative to Whites, Blacks have higher all-cause mortality rates across all levels of educational attainment, including comparison among Blacks and Whites with 16 years of more of education (14, 16, 17, 21). Similar differences have also been reported when income is used as the indicator of SES. While higher family income is associated with lower mortality rates from cardiovascular diseases, cancer and other causes, Blacks had higher death rates
even after adjusting for income (22). Lastly, a study comparing death rates among 26+ million Medicare beneficiaries, Gornick et al. (19) observed that as income increased the death rate decreased significantly more for Whites than for Blacks, with the widest difference in death rate noted in comparison between Whites and Blacks at the highest levels of income (see Figure 1).

![Figure 1. Mortality rates according to race, sex, and income among Medicare Beneficiaries 65 year of age and older. Rates adjusted for age to the total Medicare population](image)

In addition to the abovementioned studies, a small number of studies have evaluated if race differences in health outcomes can be detected among high SES adults. For example, in a study of Black and White male physicians, a profession considered to be an indicator of high SES, the incidence of cardiovascular disease and diabetes was significantly higher for Black doctors relative to their White colleagues, differences that remained even when statistically controlling for potential confounders (15). Similarly, among college-
educated mothers, the infant mortality rate was higher for Black mothers compared to White mothers (23). Although preliminary, the combined evidence from these two studies suggests that racial differences in measures of health can be observed even among adults who are at the highest levels of SES. These findings, that race differences continue to be noted even among high SES persons, has led some to speculate that being Black in America not only imposes an added health burden that high SES fails to eliminate but also mitigates the potential health gains observed with rising educational attainment and income (18, 20, 24).

Ferraro and Farmer have proposed the hypothesis of ‘diminishing returns’ to explain why increasing levels of educational attainment do not incur similar health returns for Blacks as they do for Whites, (25). They have posited that racial minorities receive declining health returns with increasing SES, and that such race differences are most notable among higher SES groups, such as those with a college education (25). What is not known at this time is what factors undermine the relation of increasing SES to health returns in Blacks. To address this point, Ferraro and Farmer speculated that ‘social awareness of racial oppression and discrimination’ may be one important factor that influences the relationship between educational attainment and health gains in Blacks (25). Such a possibility falls in line with existing evidence suggesting that racial discrimination is associated not only with poor health outcomes (26) but also race differences in SES. For example, Williams has suggested that racial discrimination explains why, relative to Whites, college educated Blacks receive
lower income, have less wealth, and reduced purchasing power (18). Moreover, racial discrimination may also explain why, compared to equally educated Whites, college educated Blacks are more than twice as likely to be unemployed and those who are employed are ‘under employed’, meaning they are employed in positions that do not require a college degree (27). Thus, diminishing health returns with increases levels of SES among Blacks relative to White may reflect the influences of racial discrimination (and racism) on many fronts including the relation of educational attainment to level of income and employment rate. That race differences in employment rate and economic gains are noted even among those with a college education raise the possibility that health disparities are not just a problem of race differences in SES but one of racism and racial discrimination. In this case, it is reasonable to speculate that racism and racial discrimination that influences social determinants of health, including non-economic factors that could potentially influence the strength of the relation of increasing SES to improving health status in Blacks.

A recent meta-analysis of approximately 300 studies has suggested that racism is associated with poorer mental, physical, and general health and that these associations are not moderated by age, sex, and education suggesting that other mechanisms may be at play (28). One possibility is that racism and racial discrimination may negatively influence health via other mechanisms such as: (a) adverse cognitive/emotional processes and associated psychopathology (29, 30); (b) pathophysiological processes (31); (c) diminished health promoting behaviors and increased unhealthy behaviors (32); and (d) greater risk of
physical injury as a result of racially motivated violence. For the most part, the above pathways have greater relevance at the level of the individual, with racism affecting individual functions. What is less well understood is how racism influences health from a public health perspective. As defined by the Institute of Medicine, public health ‘is what we, as a society, do collectively to assure the conditions of ‘which people can be healthy’ (33). From a public health perspective, how racism may negatively influence conditions that are essential to improving the health of minority groups is a critical step toward eliminating health disparities. This step requires that we consider how racism undermines the many facets of the social conditions needed so that ‘people can be healthy’. In order to address this critical problem I first address the questions: What is racism? Is racism different from racial discrimination?

To begin with, racism is the belief that members of a group are inferior based on the false assumptions linked to race supremacy. Racism is not just an individual attitude. It is also part of the social structure rooted in the historical foundations and legacy which the US was built upon. Racism is diametrically in contrast to statements in the Declaration of Independence that proclaim that ‘all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness’. Yet, when those words were written, 18% of the US populace was enslaved and Thomas Jefferson, the principal author of the Declaration of Independence, ‘owned’ as many as 223 slaves at some point in his life. Racism alludes to the persistent racial inequalities in the areas of social policy (34).
Bonilla-Silva has suggested that racism refers to an organized system, based on an ideology of inferiority that categorizes, ranks, and allocates desirable societal resources to socially defined race (35). The consequences of racism are far reaching and it is believed that it serves as the foundation that promotes negative attitude and beliefs toward racial subgroups (e.g., prejudice) and differential treatment of members of these groups by both individuals and social institutions (e.g., discrimination) (36). Racism is a salient and common occurrence in the lives of Blacks in the US and it is thought to be imbedded in a system of policies and practices that contributes to racial inequalities. It has been suggested that racism reflects a network of social relations that shapes the life chances of minority groups (37). Such a network includes 'specific mechanisms, practices, and social relationships that produce and reproduce racial inequality at all levels', reducing the likelihood that minorities live decent lives (35).

I believe that racism, regardless of where it emanates from, imposes restrictions that prevent individuals from attaining sufficient levels of well-being and its essential dimensions. From a public health perspective, I opinion that racism is the failure of our institutions and communities to identify and rectify it as a potent source that undermines the possibility of living a 'decent life' (38). The nature of racism, therefore, is not only to weaken the 'moral foundations of public health and health policy' (39) but also to create a long-term and cumulative process of disadvantages that, for Blacks, lessens the potential health gains associated with increasing educational attainment.
Aim of Thesis. As proposed by Farmer and Ferraro, the diminishing return hypothesis posits that increasing levels of educational attainment do not incur similar levels of health returns in Blacks as in Whites (25). The aim of this thesis is to apply the social justice theory of Powers and Faden (39) and (a) consider the effects of racism on levels of well-being and its essential elements, and (b) whether racism mitigates levels of the essential dimensions of well-being resulting in insufficiencies that lessen the health gains associated with increasing educational attainment for Blacks. As described by Powers and Faden, well-being encapsulates complex dimensions that, individually, they view as something of independent moral significance: health, personal security, reasoning, respect, attachment, and self-determination (39). While there is body of evidence to suggest that racism negatively influences health, to date, the detrimental effects of racism on the remaining five essential dimensions of well-being have not been adequately addressed. If racism imposes limitations on levels of well-being and its essential elements, then for Blacks such insufficiencies potentially form the basis for unfavorable social conditions that hinder the health gains associated with higher education. For Blacks, attaining higher levels of education (or income) may not be sufficient to diminish or eliminate the negative influences of racism on well-being. What I propose is that, for Blacks, the experiences of racism and racial discrimination undermine the social conditions necessary for increasing SES to yield positive health returns comparable to those noted in Whites. Using the lyrics of the American gospel song ‘Rough Side of the Mountain’, attaining the health benefits of increasing
SES is like ‘coming up on the rough side of the mountain’ and ‘doin my best to make it in’ (40).

Outline of Thesis. In developing this thesis, I was guided by the steps recommended by the Rockefeller Foundation when discussing health disparities (41). The Foundation’s recommendations, as described in Healthy People 2010, include the following: (a) define which aspect(s) of health to measure. In this thesis I will use mortality rates; (b) identify the relevant population groups across which to compare health status, in this thesis, the comparison is between Blacks and non-Hispanic Whites living in the United States (US); (c) choose a reference group against which to compare the health of different groups. In this thesis the reference group will be Non-Hispanic Whites; and lastly (d) decide whether to examine absolute or relative differences in health status between population groups. In this thesis I will describe both absolute and relative differences in mortality rates given evidence that proposition that the diminishing return hypothesis reflects the impact of racism on absolute rates of mortality that contribute to relative differences between Blacks and Whites.

To begin, Chapter 2 provides a review of the most commonly used definitions of health disparity and highlights the central concept shared by all definitions. In a 2002 article, Carter-Pokras and Baquet (42) identified 11 different definitions of health disparity, with some definitions referencing differences between minorities and non-minorities, while others comparing specific groups to the overall population, and others reflecting specific group comparisons. In Chapter 2, I briefly review the origin of the term ‘health disparity’
and describe some of the contemporary definitions proposed by prominent health and government organizations. The purpose of this short review is not to argue that one definition is better than another. On the contrary, the purpose is to underscore the basic assumption incorporated in all definitions that health disparity refers to group differences in measures of health that systematically affect one group relative to another with group differences viewed as inequitable and unjust (43).

In calling attention to health differences between Blacks and Whites, I have focused on race-specific mortality rates for three major causes of death; cardiovascular disease, cancer, and diabetes, with Type 2 diabetes, relative to Type 1 diabetes, being the more prevalent condition. A number of health indicators have been used to illustrate the magnitude of differences between Blacks and Whites. Mortality rates, however, have garnished considerable attention from the perspective of public health agendas and researchers in health disparity (44). This is likely due to the fact that mortality rates for all causes are 30% to 50% higher in Blacks than in Whites across most age groups (45-48). In Chapter 4, I review race-specific mortality rates for cardiovascular diseases (49), cancer (50), and diabetes (51) and arrive at the conclusion that mortality rates for all three causes are much higher in Blacks than in Whites. In illustrating the magnitude of the problem, Woolf et al. calculated that, if the overall mortality rate for Blacks approximated that of Whites in the 1990s, 886,202 fewer Blacks would have died during that 10-year period (48).
In Chapter 5, I review the World Health Organization (WHO) Social Determinants of Health (SDOH) and specifically focus on the role of SES as a major determinant of various health outcomes. While individual determinants are believed to reflect social disadvantages and marginalization, what promotes health differences associated attributed to individual determinants is not the same as what contributes to distribution of individual determinants (52). Furthermore, factors that lead to improvements in general health, such as improvements in the environment, good sanitation and clean water, better nutrition, high levels of immunization, good housing, may not reduce health disparities. This is because the determinants of good health are not necessarily the same as the determinants of health disparities (53). It is necessary, therefore, to distinguish between the causes of health improvements and the causes of health inequities. As previously noted, health disparities are linked to social disadvantage. If generalized health improvements are not linked to questions of social disadvantage, while everybody’s health overall may be improving (although at different rates across the social spectrum) health disparities remain, as it appears to be the case. The reason for this is that the factors which improve overall health have differential effects on the population with the better off always benefiting disproportionately. Sometimes there is a ‘catching up’ effect with the less well-off making up ground later, but differences remain (54). It may be that widening differences in health do not matter if everyone is benefiting to some degree, so differences appear to be less important.
In evaluating the role of SES as a social determinant of health, I focused on evidence that Black men and women have the highest death rates from almost all causes and the shortest life expectancy at all levels of education. Even among those at the highest levels of educational attainment (e.g., 16 or more years of education) racial health disparities are noted. That increasing levels of education does not diminish health differences between races provided the impetus for the formulation of the hypothesis of diminishing returns that draws attention to the diminished health returns associated with higher educational attainment in Blacks. In Chapter 5, I discuss the hypothesis of diminishing returns and review supporting evidence. Although few studies have been published, the data are relatively consistent and supportive such that, relative to health gains documented in Whites, Blacks receive declining health returns with increasing SES. Given that the relation of SES to health outcomes has been firmly established and critical importance of SES as a social determinant of health, it is critical to now examine what factor(s) may play a role in explaining race differences in the education/health gradient. I propose that one such factor is racism. There is an abundance of evidence to suggest that racism and racial discrimination are significant determinants of health for Black Americans (28). Another possibility, and one that has not been adequately addressed, is that racism and racial discrimination propagate a network of social disadvantages that acts in a manner that minimizes the effect of increasing SES on health gains in Blacks, a possibility that I address in this thesis.
In addressing the objective of this thesis - that racism attenuates health returns in Blacks by creating a network of social disadvantages that mitigate the influence of increasing educational attainment – I discuss the concept of race within the framework of Critical Race Theory (CRT) and speculate on the degree to which racism is reflected in the concept of racial identity (55). Racial identity is a multidimensional construct that incorporates and influences individual’s situational appraisal and behaviors which are also influenced by a history of oppression and experiences of racism. In chapter 6, I discuss the relation of racism to racial identity and specifically address the overlap between these two concepts.

In Chapter 7, I discuss the possibility that racism propagates a pattern of social disadvantages that hinder Blacks from attaining better health. By applying Powers and Faden’s social justice theory, I describe how racism potentially influences levels of well-being and its essential dimensions that include personal security, reasoning, respect, attachment, and self-determination as well as health. If racism contributes to insufficient levels of well-being, such insufficiencies may serve to mitigate the relation of increasing SES to health gains. If, as proposed, racism lessens the health returns of increasing SES, it may do so creating a pattern of social, economic, and political disadvantages (56).

Lastly, in chapter 8, I provide a final synopsis on how racism mitigates the relation of SES to health and specifically how it alters the relation of education to health gains in Blacks. I suggest that racism is part of the racial identity of Blacks
with its influence noted from birth to the end of life. Thus, racism is the bases for social disadvantages that promote insufficient levels of well-being that mitigate the positive health returns associated with increasing SES and most prominently educational attainment. By taking a broader approach to the effects of racisms, one that goes beyond its effects of health, I propose that racism serves as the basis for a spectrum of cumulative disadvantages that diminishes the salutary health returns of increasing SES for Blacks.
CHAPTER 1

APPROACHES IN HEALTH DISPARITIES AND THE ROLE OF RACISM

Sources of health disparities between Blacks and Whites are multivariate and complex. A wide range of determinants have been proposed as contributing factors to health disparities. Some of these factors include: (a) lack of access and barriers to health care (57); (b) increased risk of disability and disease resulting from occupational exposure and living environments (58); (c) family factors (32); (d) cultural values and education; (e) social relationships between majority and minority population groups; (f) autonomous institutions within ethnic minority group populations; and (g) culturally insensitive health care systems. A number of theoretical frameworks have been proposed with each emphasizing different putative pathways. For health disparity models that incorporate racism, it is suggested that the impact of racism on health is via mechanisms that include excessive psychophysiological reactivity (59), risky health behaviors (32), and poor health care (29, 57).

Another possibility that has not been discussed is the possibility that racism, a form of social injustice, works to create a ‘a vicious kind of racially based disregard for the welfare of certain people’ (60-62). Thus, health disparities may reflect the extent to which racism influences social conditions, including civil liberties, necessary to good health. From a public health perspective, Blacks exposure to racism may impose social conditions that contribute to a systematic pattern of disadvantages that undermine the prospects
for good health. Such disadvantages, which I equate to insufficiencies in levels of well-being and its essential dimensions, also act in a manner that imposes a ‘ceiling effect’ with respect to health returns associated with increasing SES.

If racism attenuates health gains associated with increasing SES, then it is imperative to consider the impact of racism on social conditions necessary for achieving sufficient levels of well-being. If, as many have suggested, educational attainment is ‘the great equalizer’ capable of eliminating health differences between Blacks and Whites (63), it is import to why increasing educational attainment is not associated with similar health gains in Blacks and Whites. It is not sufficient to conclude that racism affects health status since this may only be one aspect of how racism contributes to health disparities. It is also important to consider if, for Blacks, racism mitigates social conditions necessary to attain the health gains associated with increasing SES. I propose that racism, beyond its direct effects on health, also contributes to health disparities by reinforcing and maintaining a structure of social disadvantages that diminish the potential health gains with increasing SES. As a form of social injustice, racism serves to promote less than optimal social conditions that not only decrease the likelihood of attaining good health but also undermine the social conditions necessary for health gains to occur with increasing SES.

A considerable body of evidence suggests that racism has deleterious health consequences (64). It is also likely that racism influences other aspects of life necessary to achieve good health. In this thesis, I speculate on the possible consequences of racism on attenuating the levels of well-being and its essential
dimensions (39). I describe how racism influences levels of personal security, the development of reasoning capacities and of capacities for attachment to others, and the ability to determine for oneself some important aspects of one’s own destiny. I then speculate that the disadvantaged social conditions propagated by racism diminish the health-related benefits of increasing SES including education (25). It is important to note that sufficient levels of well-being are not securable by attaining greater wealth and income or higher education. Similarly, greater wealth, income, and education do not guarantee that individuals will not experience racism. As a matter of fact, evidence suggests that the experience of racism is independent of level of income and education (65). Experiences of racism transcend any social or economic boundaries such that, for Blacks, the social disadvantages stemming from the experience of racism occur at all levels of SES.

**The Relation of Racism to Health Outcomes.** The notion that racism affects health status was a central theme in the writings of W. E. B. Du Bois and Kelly Miller who, in the late 1800s and early 1900s, suggested that racism contributed to poor health and premature death in Blacks living in the US (66, 67). The writings of Du Bois and Kelly still resonate in today’s society as study after study suggests the relation of poor health outcomes to the experience of racism. The argument outlined in this thesis attempts to elucidate the negative effects of racism on dimensions of well-being and how such deleterious effects may influences the relation of health to SES for Black Americans. In outlining my argument, I suggest that the negative health consequences of racism are not due
solely on an individual’s personal exposure to racism but also on the cumulative effects of aversive historical events and current racial tensions.

The lives and experiences of Blacks in America are distinctively different from those of other immigrants or refugees. Over the past four centuries, Blacks have struggled through turbulent and prolonged periods of slavery, segregation, and discrimination. These periods cast a long shadow and the recent string of racially motivated violence such as the killing of Black parishioners in Charleston, South Carolina, the burning of Black churches across the South, and the situation on the campus of the University of Missouri appear to continue and connected to the struggles for American Blacks. In response to these events, the activist movement ‘Black Lives Matter’ came to being with its campaign against violence toward Blacks. And it is not just Blacks who are less fortunate who experience racism and violence, but also high SES Blacks. In the words of a journalism professor on the campus of the University of Missouri, ‘I have been called the N-word too many times to count.’

In outlining my thesis, I suggest that recent experiences of Blacks add to the long and tortuous history of slavery, segregation, disenfranchisement, and discrimination that contribute to the added health burden of Blacks (68). Though government actions, such as the Civil Rights Act of 1964, have outlawed discrimination based on race, color, religion, sex, or national origin, racism, racial violence, and racial discrimination are part of the everyday lives of today’s Black Americans. Reports of the event that occurred in Charleston, South Carolina in June of 2015 have suggested that the perpetrator targeted the church not only
because it was a place of worship but also because it was a site historically used by Blacks to meet. And it is not just acts by private citizens that fuel the fires of racism but those acts perpetrated by police that fuel the distrust and pessimism of Blacks. The case of Justin Griffin is but one example that adds to Blacks’ mistrust of law enforcement. Mr. Griffin was a young basketball coach who had an on-court argument with a referee who happened to be an off-duty sheriff’s deputy. After the game, a fight ensued between Mr. Griffin, the referee, and another deputy sheriff with Mr. Griffin being beaten to death.

In the past, such racially motivated violence as the ones described above were reported by traditional news outlets. Today, however, these events, some as they occur, are described on non-stop television programs, Internet sites, Twitter, Facebook, and other casting sites. The explosion of coverage by professional and non-professional across various methods has led some to speculate that the increased exposure to depictions of racial events influences racial identity and specifically what it means to be Black in America, not only for Blacks but also for Whites (69). That many of the depictions of these situations are characterized as the result of actions instigated by Blacks, with the actions of Whites portrayed as ‘just and reasonable’ reactions, adds to the burden of social injustices and racism experienced by Blacks. It is not just skin color that is at the core of the racial tensions in this country, but prevailing and systematic social injustices that are driven by racism. I speculate that it is not just an individual’s personal experiences of racism that impact health. I propose that acts of racism and racial violence that are not personally experienced but depicted in the media
influence the thought processes, perceptions, and racial identity of Black Americans. Particularly influential may be those overt acts of racism that transcend the actions and behaviors of individual citizens and reflect actions propagated by law enforcement and social institutions (70). Given that race is a social construct that incorporates communities and group actions as well as institutional policies (71), the depictions of racial violence likely influence the racial identity of Blacks.

It is not surprising that racial differences in mortality rates align with the racial tension in the US. It has been even been suggested that racially motivated social turmoil and the experiences of racial discrimination and racism contribute to higher rates of smoking, drug use, and overeating, behaviors thought to be important mediators of the relationship between racism and racial health disparities (29). The Biopsychosocial Model of Racism as a Stressor posits that the persistent stress of racism takes a biological and mental toll on the health of Black Americans (59). In extending this model, recent evidence has suggested that the health consequences of racism may also be passed from one generation to the next through epigenetic inheritance (72). This latter evidence falls in line with my speculations that it is not just an individual’s own experience of racism that impacts health but also the experiences of their ancestors as well as the events that are experienced by others and depicted in media outlets.

Health Disparities: The Intersection among Race, Racism, and Social Justice Theory. In my thesis, I have focused on mortality rates for major chronic diseases, heart disease, Type 2 diabetes and cancer for Blacks and Whites (3,
Unarguably, the evidence overwhelmingly suggests that mortality rates for these three major chronic conditions are higher for Blacks than for Whites (48). Even with recent medical advances in prevention and treatment, racial discrepancies in health outcomes reported in the 1980s/1990s continue to be noted in the first decade of this century. Sadly, for some medical conditions such as breast cancer, racial differences in the survival rate over the past decades appear to be decreasing for Blacks (73). The decrease survival rate for breast cancer in Blacks is in stark contrast to one of the major goals mandated by the U. S. Congress and outlined in Healthy People 2010, that of eliminating health disparities and improving health (74), a goal reiterated in Healthy People 2020 (75). While we have made progress, closer inspections of the mortality data suggest that we not fallen short of eliminating health disparities with certain medical conditions, such as breast cancer, showing growing race differences (73).

Many factors may contribute to the slow progress in reducing and eliminating health disparities. One possibility is that current models of health disparity and health do not take into consideration the possibility that factors that predict health outcomes for one group may not influence health in a similar manner for another group. As illustrated in Figure 2, the most prominent model of health is the (WHO model of Social Determinants of Health (SDOH) (see Figure 2).
Figure 2. The World Health Organization (WHO) Social Determinants of Health (SDOH).

Guided by the WHO model, researchers have generated a wealth of information suggesting that race differences in social determinants of health, and specifically levels of education, economic stability, access to health care, neighborhood environments, and social and community context, are the primary causes of health disparities (76, 77). To date, however, few studies have examined what factors contribute to racial differences in these social determinants (78). For example, as illustrated in Figure 2, economic stability is considered a social determinant of health. What have not been fully considered is what factors underlie economic stability and whether these factors differ between races. Thus, it is necessary to identify factors that contribute to race
differences in social determinants and whether one of these factors is racism as it relates to racial identity.

The aim of my thesis is to consider how racism-related social disadvantages potentially alter the relation of increasing SES to health gains in Blacks. While this thesis is not data driven, the conceptual approach I have adopted parallels that taken by statistician when 'decomposing differences in mean outcomes across two groups into a part that is due to group differences in levels of explanatory variables and a part that is due to differential magnitude of regression coefficients (79). That analytic strategy, referred to as the Blinder-Oaxaca decomposition, was introduced into the labor economic literature by studies that analyzed the effects of discrimination on the labor markers (80). The Blinder-Oaxaca technique decomposes group differences in mean outcomes (e.g., all-cause mortality) into a portion that is due to differences in characteristics (e.g. educational attainment) and a portion that cannot be explained by such differences (79, 81). In this thesis, I propose that racism accounts for racial differences in mortality that cannot be explained by racial differences in educational attainment. Moreover, I propose that racism, in addition to its direct effects on health, influences other factors, and specifically levels of well-being and its essential dimensions, that hinder the health returns associated with increasing in educational attainment. That racism limits the levels of well-being and its essential dimensions creates a pattern of social disadvantages that undermine the effect of increasing educational attainment on health returns. Given that race is a risk factor for exposure to racism (82) suggest that the
effects of racism on well-being are more discernable for Blacks and less so for Whites.

In explaining the role of racism and its influence on health outcomes, it is was necessary to consider race as a social construct and not a scientific category based on immutable biological differences (71, 83). It has been suggested that the conceptualization of race as a biological construct places greater emphasis on differences in biology that (a) diverts attention from the social origins of diseases, (b) reinforces social norms of racial inferiority, and (c) promotes the maintenance of the existing perceptions of race as a biological construct (84). Race is a significant and important factor across many fields of research, yet, it is rarely defined or operationalized (83). To avoid such pitfalls, I apply Critical Race Theory (CRT) (85) and its key elements with ‘race’ referring to race consciousness (85). Moreover, and in line with one of the primary propositions of CRT, I consider racism as an ‘ordinary, not aberrational—normal science, the usual way society does business, the common, everyday experience of most people of color in this country’ (55).

In addition to CRT, I also consider how racism potentially influences well-being and its essential dimensions. Powers and Faden have suggested that social and cultural factors that have ‘historical roots’ and are pervasive in today’s society facilitate the current state of disparities (39). In extending their view, I propose that individuals who are members of a racial group that has been historically disadvantaged and continue to experience disadvantages are likely to bear greater health burdens that may be tied to less than optimal levels of well-
being. Important to this thesis, and as noted above, racism is independent of SES. Thus, even among Blacks who attain high levels of SES, racism and discrimination create a pattern of social disadvantages that undermines the positive health consequences of increasing educational attainment.
CHAPTER 3

ARE ALL DIFFERENCES IN HEALTH OUTCOME MEASURES DISPARITIES?
THE MOST COMMONLY USED DEFINITIONS OF HEALTH DISPARITY
AND RECENT UPDATES

The overall health of the population of the US has been gradually improving with 2010 data suggesting that Americans are now living healthier and longer lives than at any time since measures of health began to be collected. In 2010, life expectancy for the average American reached 78.7 years, an 11% increase from mean life expectancies in the 1970s. Closer inspection of this positive trend, however, reveals some discouraging patterns: life expectancies for almost all racial and ethnic minorities (e.g., an exception is the life expectancy for Asians which is higher than Whites and minorities) remain significantly lower than Whites. As illustrated in Figure 3, life expectancy increased for all Americans (grey line) between 1970 and 2010. Yet, inspection by race shows that for Blacks (green line), although increasing over time, life expectancy was significantly lower throughout the 40 year period (2, 86).

Lowering mortality rates has been one of the driving factors for increasing life expectancies over the past decades. As described by Woolf et al. (48), medical advance have contributed to age-adjusted mortality rates declining at an average rate of 0.7% per year translating to 176,633 fewer deaths between 1991 and 2000. Yet, during this same period of time, age-adjusted mortality rates for White men and women were on average 29% and 24% lower than Black men and women, respectively. As of 2000, the mortality rate for Blacks aged 25 to 54
years was more than double that of similarly aged Whites. If age-specific mortality rates for Whites and Blacks were comparable, Woolf et al. calculated that 886,202 fewer Blacks would have died between 1991 and 2000.

![Figure 3](image)

**Figure 3.** Life expectancies for all races, and for Whites and Blacks, 1970-2010.

Closer inspection of mean life expectancies for Blacks and Whites also reveals that the mean life expectancy for Blacks in 2010 is comparable to the life expectancy for Whites in the early 1980s (see Figure 3). While I do not propose that life expectancy for Blacks has not increased over this 40-year period, the improvements have not been sufficient to approximate life expectancy for Whites. Not surprisingly, race differences in life expectancies reflect race differences in mortality rates for chronic diseases such as those for cardiovascular diseases, cancer and diabetes, with Blacks having higher mortality rates than Whites.

While the race difference in life expectancy is striking, there is no established criterion to conclude what magnitude of difference constitutes a disparity. To address this issue, what magnitude of differences between races
are considered disparities, it has been suggested that we consider the perceived degree of control individuals have over factors thought to contribute to group differences (87). Therefore, whether health differences are considered disparities requires interpreting the observed differences within the context of specific causal factors or determinants and whether individual behaviors influence these factors. For example, the life expectancy for 65 year old adults is less than that of 25 year old men and women, yet this difference is not considered a disparity given that the difference reflects the effect of an immutable factor, age. However, if a difference in life expectancy for similarly aged Black and White adults is observed, then it is necessary to consider what factors contribute to group difference and whether individual behaviors contribute to the contributing factors. Thus, to determine if a difference between racial groups constitutes a disparity requires conceptual guidance from proposed definitions of disparity in evaluating whether factors that contribute to observed differences are avoidable. If evidence suggests that a factor is avoidable, then the next question to address is whether the factor is unfair, or from the perspective of social justice theorists, unjust (42). In the following section I describe the most commonly used definitions of health disparity. But first, I provide a short description of early studies in the area and how researchers at the time interpreted group differences in health outcomes.

Early studies and the Emergence of Evidence for Health Differences among Social Groups. One of the earliest studies to report differences among population subgroups was conducted in the early 1700s by Bernardino
Ramazzini, who today is considered the father of occupational medicine. Ramazzini reported that relative to married women, he observed a higher rate of breast cancer in Catholic nuns (88). In light of his findings, Ramazzini suggested that the observed difference was due to sexual practices. Sixty years after Ramazzini published his study, the British surgeon Sir Percival Pott reported a cluster of scrotal cancer cases among British chimney sweeps (88). In 1840, Edwin Chadwick observed mortality differences between social classes living in Liverpool, England. Chadwick suggested that the observed differences were likely due to poverty and lifestyle factors common to poor working classes (89). The conclusions by Chadwick led others, such as Virchow and Villerme, to propose that differences in disease rates were due to societal differences that included limited or no education and poor working conditions (90). By the beginning of the 20th century, most studies had suggested that variations in morbidity and mortality rates were linked to class differences (90). In taking the next step European scientists, and especially those in England where census data tracked trends in national mortality, started evaluating differences in health status as a function of social class. One outcome of this approach was the observation that infant mortality rates differed between upper- and lower-class infants with infants from lower class mothers having higher rates of mortality (89).

The wealth of information that emerged from those studies conducted in the early to mid-20th century led the British government to issue a report in 1980 known as the *Black Report* (91). The *Black Report* was the first attempt by a national government to systematically examine and explain health inequalities with the
general conclusions suggesting that differences in health were linked to income, education, housing, diet, employment, and conditions of work (92, 93).

During the same period, studies in the US reported that differences in health were linked to geographic location. For example, one US study reported variability in health outcomes were associated with clinical practices that differ across geographic locales; differences that remained even when comparisons were conducted among clinics treating similar patient populations (94). In light of the research conducted in the US, the Department of Health and Human Services released a report in 1983 entitled, *Health United States and Prevention Profile* (95). Highlighted in the report was the observation that the mortality rate for Black infants was ‘twice as high as for White infants’ (96, pg. 7). Despite that the reported noted an overall improvements in the health of the nation, it also stated that major disparities existed such that the ‘burden of death and illness experienced by Blacks and other minority Americans was greater compared to the nation’s population as a whole’ (96). The conclusions of the 1983 report led US Secretary of Health and Human Services to convene groups of experts to evaluate the data specifically from studies of minority health. The outcome was the *Report of the Secretary’s Task Force on Black and Minority Health*. While the Report included a number of recommendations it was notable for the absence of the term ‘health disparity’. Instead the Reported opted to describe differences in health status or health outcomes by race as ‘differences’ or, in some instances, ‘inequalities’ in health. It was not until the early-to-mid 1990s that the term ‘health disparities’ began to appear in the literature. Appearing in
writings of Margaret Whitehead in 1992, the term ‘health disparities’ was used to refer to group differences in health that were considered unnecessary, preventable, and unjust (97).

**Current Definitions of the Term Health Disparity.** In the current health literature, a number of terms have been used to describe health differences and similarities between subgroups of the population. In addition to the term ‘health disparities’, terms such as ‘health inequalities’ and ‘health inequity’ appear in the literature. While the definitions among these three terms differed to some degree, all terms attempted to capture the basic idea that differences between population subgroups on health status and/or health outcomes stemmed from group differences in medical and nonmedical factors (42). In addition, all definitions incorporated the ideas of Whitehead who emphasized that the terms health disparity or health inequality denoted differences due to situations that were avoidable, unjust, and unfair (97). Interestingly, none of the current definitions include a statement about the magnitude of differences which goes in line with the premise that any magnitude of differences in health outcomes that is the result of unjust and unfair treatments and avoidable circumstances is considered a health disparity.

**The World Health Organization (WHO) Definition.** Guided by the initial writings of Whitehead, the World Health Organization (WHO) proposed that ‘equity meant the people’s needs, rather than their social privileges, guides the distribution of opportunities for well-being’ (98). The proposed definition by the WHO aimed to underscore the need to ‘reduce the gap in health status and health between
groups with different levels of social privileges’ (98). The WHO definition clarified that differences in social privileges were ‘not limited to those of health care’ but included ‘differences in social advantages that reflect socioeconomic, geographic, gender, ethnic, and age differences’ (99). The revised definition of health inequity by the WHO, however, represented a critical shift by defining health inequity as ‘any avoidable differences in health among individuals, who should not be grouped a priori according to social characteristics with the exception of geographic location’ (100). In revising their definition, the WHO stressed that health disparities implied differences in health that were not associated to specific groupings established a priori with the exception being geographic groupings. By emphasizing health differences among geographic locations, the WHO introduced a ranking system that compared the performance of nations’ health care systems. Publication of this ranking system, however, drew strong criticisms, including the suggestion that the calculated index had a strong ideological component that was arguably unrelated to actual health performance. Interestingly, it was also suggested that the WHO definition of health inequity was consistent with groupings based on indicators of SES (101). For example, Braveman and Gruskin (102) suggested that comparisons between geographic regions were similar to comparisons between social groups in that both involved a priori selections based on categorizing grouping variables selected because of their demonstrated associations with health differences.

The Center for Disease Control (CDC) Definition. For US based authors, the term most frequently used has been health disparities with definitions generated
by various US agencies, including the Center for Disease Control (CDC) Office of Minority Health. The CDC Office of Minority Health defined health disparities as encompassing ‘differences by gender, race or ethnicity, education or income, disability, geographic location or sexual orientation’ (41). With the publication of Healthy People 2010 in 2000 (74), the CDC modified their definition by substituting the word ‘cause’ with ‘closely linked’ to reflect the difficulties in establishing causality. A second word change saw ‘rural’ replaced with ‘geographic’ since the CDC suggested that rural did not capture urban-rural differences. In further refining their definition, the CDC clarified that health disparity was a ‘particular type of health difference that is closely linked to social or economic disadvantage’, thus implying that health disparities adversely affected groups of people. The most recent revision acknowledged the existence of targeted groups to include persons with ‘cognitive, sensory or physical limitations, and geography’, characteristics that are historically linked to discrimination or exclusion (103).

The National Institutes of Health Definition. Other US agencies have also released their own definition for health disparities. In 1999, the National Institutes of Health (NIH) defined health disparities as ‘differences in the incidence, prevalence, mortality, and burden of diseases…that exist among specific groups in the United States’. The initial 1999 NIH definition was later modified to incorporate the passage of the United States Law 106-525, also known as ‘Minority Health and Health Disparities Research and Education Act’ (104). Within the act, the legal definition of health disparities was introduced and
it included which populations were considered a health disparity population. Accordingly, a ‘population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity and mortality or survival rates in the population as compared to the health status of the general population’ (104). While public agencies in the US refer to their own definition when setting agendas, each agency’s definition appears to have elements in common; that health disparity implies significant differences between subgroups on disease incidence, prevalence, morbidity and mortality, and survival rates.

**National Cancer Institute Definition of Health Disparity.** The National Cancer Institute (NCI) revised the NIH definition by specifying differences in cancer rates, related adverse health conditions, and survival rates for specific racial and ethnic groups such as African Americans, Hispanics, Asian Americans, and Native Americans. NCI, however, recognized that health disparities could reflect group differences beyond race/ethnicity. This led NCI to add that the definition of health disparity included differences in access to healthcare, SES, gender, biological and behavioral factors.

**Healthy People 2020 Definition of Health Disparity.** The *Healthy People Initiative* outlines the United States’ strategic approach to improving the health of the population. For each decade, a new version of the *Healthy People Initiative* is issued with new and refined goals that include quantifiable objectives for health improvements during the succeeding ten years. Although there has been some success, concerns have been expressed with the effectiveness of *Healthy*
In reaching the goals set out for each decade. With greater understanding, Healthy People 2020 has placed greater emphasis on the development of health promotion and disease preventive strategies that fundamentally focus on addressing social determinants of health (105). In the past two decades the overarching goals have been on reducing health disparities with Healthy People 2010 setting the goal of eliminating, not just reducing, health disparities. In Healthy People 2020, the goals were extended to include achieving health equity, eliminating health disparities, and improving the health of all groups. As part of the Healthy People 2020, the plan defined health disparity as ‘a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantages’. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, and mental health, cognitive, sensory, or physical disability. sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.’(75).

Health Disparity Definitions and Concluding Observations. As reviewed above, definitions of health disparities generated by various health agencies as well as Healthy People 2020 have emphasized health differences between groups defined across various grouping factors. Examples of grouping factors include gender, race, income, and healthcare to name a few. The unifying element across all definitions, however, is the shared view that only those differences between groups that systematically and negatively influence one group over
another meet the definition of health disparities (43). For this thesis, the aim is not to argue the merits of one definition over another. The use of the term ‘health disparity’ refers to differences that systematically and negatively affect the health of Blacks over Whites. I will, however, rely more heavily on the CDC Office of Minority Health of health disparity that stresses determinants as ‘closely linked’ to health outcomes rather than ‘causes’ of health outcomes.

Recognizing that the US is a melting pot of cultures, races, and ethnicities, US-based definitions have placed greater emphasis on race and ethnic groups with Non-Hispanic Whites often serving as the referent group. This has led to the majority of studies in the US placing greater emphasis on examining race and racial and ethnic group differences on a spectrum of health outcomes (103). The result of these efforts is a rich body of evidence suggesting that relative to non-Hispanic Whites, Black Americans are disproportionately affected by most chronic medical conditions with higher mortality rates in Blacks relative to Whites (3, 73, 106). In this thesis, I refrain from arguing which agency specific definition best captures the meaning of health disparity. The reason is that such arguments detract from the aim of this thesis, which rests upon the basic premise shared by all US agency definitions of health disparities, that health disparity refers to differences in health outcomes that ‘systematically impacts one group relative to another’ (87, 107). With this as a starting point, I posit that putative factors that influence health status are not invariant across racial groups and that some factors may significantly affect health outcomes more strongly in Blacks and to a lesser extent in Whites. Moreover, it may also be the case that the
effect of some factors is not only on health but also on aspects of life that mitigate actions and behaviors that promote better health, such as increasing education attainment and income, the underlying premise of the diminishing return hypothesis (25). In light of this possibility, it is important to understand not only how factors contribute ‘directly’ to health differences but also whether these same factors mediate the effects of behaviors known to influence health in a race specific manner. This two-prong approach allows for the evaluation of race differences in health outcomes that are due to distributional differences (e.g., SES) and exposure differences (e.g., racism) and whether exposure variables mitigate the health returns of increasing SES.

The above scenario is not without precedence. For example, there is evidence that the relation of established risk factors to chronic diseases may differ in a race dependent manner. To illustrate race specific differences in the relation of risk factors to health outcomes, I reviewed studies that suggest that some, but not all, established risk factors of CVD similarly affect cardiovascular disease risk in both Blacks and Whites, whereas the relation for factors appear to be race dependent (108). Cardiovascular disease is a multi-causal condition with many factors known to contribute to risk and there is evidence to suggest that factors may have differential effects on risk in a race specific manner. As many before have suggested, health status is the result of a complex set of inter-related factors and interactions whose cumulative affects manifest in differences in health across a spectrum of outcomes. A number of factors have been shown to influence cardiovascular health in a similar manner for Blacks and Whites. For
example, high lipid levels are associated with increased risk of coronary heart
disease (CHD) with high total cholesterol (TC), low high-density lipoprotein-
cholesterol (HDL-C) and a higher TG/HDL-C ratio associated with incident
myocardial infarction (109). For these lipid constituents, comparisons between
Blacks and Whites revealed no race differences in hazard ratios (110). In
contrast, other CHD risk factors show associations with CHD that differ in a race
specific manner. One of those CHD risk factors is hypertension. Hypertension
incurs a greater risk of CHD in Blacks than in Whites and more strongly in Black
women than in White women (111). Thus, it is possible that like biological risk
factors, the relation of non-biological risk factors to poor health outcomes may
also differ as a function of race (108).

If the evidence that the risk of cardiovascular disease attributed to
biological factors differs between Whites and Blacks, it may also be that non-
biological determinants of health, such as SES, are differentially associated with
health outcomes in a race dependent manner. While this has not been
systematically examined, there is some evidence to suggest that this is a
possibility, with emerging evidence suggesting that the relation of indicators of
SES, such as educational attainment and income, is associated with mortality
rates but that the strength and form of the associations may differ between
Blacks and Whites.
CHAPTER 4

MORTALITY RATES FOR CARDIOVASCULAR DISEASES, CANCER, AND DIABETES: COMPARISONS BETWEEN WHITES AND BLACKS IN THE UNITED STATES

In 2012, Blacks represented the second largest minority (Hispanics are the largest minority group) living in the United States. Establishing racial and ethnic categories, however, has posed some challenges that have included discussions as to who is “Black or African American” (112). In attempts to address this issue, the US Census Bureau implemented the US Office of Management and Budget’s (OMB) classification on race and ethnicity. Though the terms ‘race’ and ‘ethnicity’ are often used interchangeably, federal standards mandate that race and ethnicity be considered separate and distinct concepts (112). In furthering clarifying the distinctions between race and ethnicity, the OMB considered African Americans or Blacks as a racial group composed of those who self-identified as having origins in any of the Black racial groups of Africa. While the OMB policies underscored self-identification as the preferred mode for establishing race group membership, it has been recognized that observer identification may be more practical in some situations, such as the completion of a death certificate. Yet, completing a death certificate is not a trivial matter given that mortality rates, often the focus of health disparity research, are derived from government documents. It has been speculated that for a certain percentage of death certificates, race is ‘misclassified’ due to its
determination by observers, with such misclassification potentially contributing to miscalculations of the estimations of death rates in Blacks.

As described in Chapter 1, the definition of health disparity generated by WHO emphasized geographic location as the primary *a priori* grouping factor used for comparisons of health differences (43). Geographic location, however, is not the emphasis of definitions developed by US agencies, yet it was recognized that the distribution of Blacks differed significantly by geographic locations. For example, approximately 55% of Blacks living in the US reside in the South. In 2011, the states with the largest number of Black residents were New York, Florida, Texas, Georgia, California and North Carolina, with a combined total population of approximately 17.6 million (113). In 20 states, however, Blacks represent less than 5% of the state’s population. Data from the 2012 US Census suggest that the majority of Blacks, 51.5%, live in metropolitan areas inside the central city, with fewer Blacks living in areas outside the central city (36%) and nonmetropolitan areas (12.5%). Although beyond the scope of this thesis, it is important to note that geographic location has been identified as an important factor when probing the relation of race to health disparities (2) and that the majority of Blacks who live in the South raises the possibility that race differences reflect geographical factors. However, it is also important to note that the majority of Blacks live in areas of the US with a prolonged history of racism and racial discrimination, with evidence suggesting that racism most closely tracks historical racial conflict and other conditions that have a greater influence relative to social and economic factors (114-116).
Health Disparities and Causes of Death. Mortality is a crude indicator of health status, but it is one that is useful in demonstrating the significance of health disparities between Whites and Blacks.

**Table I.** Age-adjusted death rates (per 100,000) for Whites and minorities for leading causes of death in the United States 1996\(^1\).

| Causes                      | White (W) (Rate) | Black/W Ratio | Am|b/W Ratio | API|b/W Ratio | Hispanic/W Ratio |
|-----------------------------|------------------|---------------|-------|---------|-----------|------------------|
| All causes                  | 466.8            | 1.58          | 0.98  | 0.59    | 0.78      |
| 1. Heart disease            | 129.8            | 1.47          | 0.78  | 0.55    | 0.68      |
| 2. Cancer                   | 125.2            | 1.34          | 0.68  | 0.61    | 0.62      |
| 3. Stroke                   | 24.5             | 1.80          | 0.86  | 0.98    | 0.80      |
| 4. Pulmonary disease        | 21.5             | 0.83          | 0.59  | 0.40    | 0.41      |
| 5. Unintentional injuries   | 29.9             | 1.23          | 1.93  | 0.54    | 0.97      |
| 6. Flu and pneumonia        | 12.2             | 1.45          | 1.15  | 0.81    | 0.80      |
| 7. Diabetes                 | 12.0             | 2.40          | 2.32  | 0.73    | 1.57      |
| 8. HIV/AIDS                 | 7.2              | 5.75          | 0.58  | 0.31    | 2.26      |
| 9. Suicide                  | 11.6             | 0.57          | 1.12  | 0.52    | 0.58      |
| 10. Liver cirrhosis         | 7.3              | 1.27          | 2.84  | 0.36    | 1.73      |

As presented in Table I, the ratio of Black to White (W) mortality rates suggests that for almost all causes of death, mortality rates for Blacks are higher than those of Whites. This conclusion is certainly true for the three causes of death that are the focus of this thesis, cardiovascular disease, cancer, and diabetes.

For several decades, dramatic differences in US death rates between Whites and Blacks have been documented. Reviews of recent data suggest that today’s death rates for Black are comparable to Whites’ death rates observed thirty years ago. Framed differently, if the death rates for Whites and Blacks were similar, 100,000 fewer Blacks would die each year (117) and the cost of health care reduced considerably. Comparisons of death rates between 1980 and 1998 have revealed that approximately 4.3 to 4.5 million more premature
deaths occurred in Blacks relative to Whites (117). Between 2000 and 2009, medical advances in detection and treatment contributed to an increase life expectancy of 1.9 years for men and 1.6 years for women. Yet, such improvements were race dependent. Whites outlived Blacks by 5.5 years in 2000 and 4.3 years in 2009. In 2009, the life expectancy for Blacks and Whites was 74.5 years and 78.8 years respectively, a difference of over four years. Attempts to explain the greater mortality rates in minorities in comparison to non-minorities have revealed that when access-related factors, such as insurance status and income, are taken into account, race differences in mortality rates still emerge (118, 119). In light of the observed racial disparities for all-cause mortality, some researchers have examined whether race differences are due to differences in rates for major causes of death. What follows is a discussion of death rates and health disparities as they relate to cardiovascular disease, diabetes and cancer, three chronic diseases that account for the largest proportion of deaths in Blacks.

**Cardiovascular Diseases.** Similar to Whites, the leading causes of death for African Americans are cardiovascular diseases, cancer, stroke and diabetes. In 1950, death rates for coronary heart disease (CHD) were comparable for Blacks and Whites. By 2000, however, the CHD death rate for Blacks was 30% higher than for Whites (120). Although both Whites and Blacks showed declines in deaths from heart disease between 1950 and 2000, the decline was greater for Whites (57% reduction) than for Blacks (45% reduction), with the relative and absolute racial differences larger in 2000 than in 1950 (120). Additional
comparisons of CHD death rates by race and gender reveal more profound differences. Twice as many Black women (37.8%) as White women (19.4%) and one and a half times more Black men (61.5%) as White men (41.5%) died of CHD before the age of 75 (121). The same pattern emerged for deaths from stroke where the death rates for Black women (39%) and Black men (60.7%) clearly outpaced the death rates in White women (17.3%) and White men (31.1%)(121). Thus, race differences in cardiovascular mortality rates not only were higher in Blacks but also were gender-specific, with profound differences between Black and White women and men.

Cancer. Similar to the reported race differences in mortality rates for cardiovascular diseases, racial differences have also been observed for cancer mortality rates for all cancers but more so for death rates for colorectal, prostate, breast, and ovarian cancers, where the race differences are alarming (122). For example, the prevalence of colorectal cancer is not only greater in Blacks but also the death rate is greater with 38% to 43% of Blacks more likely to die from colon cancer than Whites (123). These differences were even more profound given the fact that in 1950, Blacks had lower cancer death rates than Whites (122). Between 1950 and 2000, Whites and Blacks showed similar death rates for lung and ovarian cancer but death rates from colorectal, breast and prostate cancers increased for Blacks but remained stable or declined for Whites (122). Inspection of Figure 2 revealed that, beginning in 1950 and every decade thereafter, adjusted death rates for Blacks and Whites for cancer differed significantly with Blacks showing increasing death rates with each ensuing
decade whereas the death rates in Whites remained relatively stable.

**Table II.** Age-adjusted death rates for Blacks and Whites for three causes of

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homicide</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>2.6</td>
<td>2.7</td>
<td>4.7</td>
<td>6.7</td>
<td>5.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Black</td>
<td>28.3</td>
<td>26.0</td>
<td>44.0</td>
<td>39.0</td>
<td>36.3</td>
<td>20.5</td>
</tr>
<tr>
<td>Difference</td>
<td>25.7</td>
<td>23.3</td>
<td>39.3</td>
<td>32.3</td>
<td>30.8</td>
<td>16.9</td>
</tr>
<tr>
<td>Ratio</td>
<td>1.09</td>
<td>0.96</td>
<td>0.94</td>
<td>0.88</td>
<td>0.98</td>
<td>0.77</td>
</tr>
<tr>
<td><strong>Heart disease</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>584.8</td>
<td>559.0</td>
<td>492.2</td>
<td>409.4</td>
<td>317.0</td>
<td>253.4</td>
</tr>
<tr>
<td>Black</td>
<td>586.7</td>
<td>548.3</td>
<td>512.0</td>
<td>455.3</td>
<td>391.5</td>
<td>324.8</td>
</tr>
<tr>
<td>Difference</td>
<td>1.9</td>
<td>-10.7</td>
<td>19.8</td>
<td>45.9</td>
<td>74.5</td>
<td>71.4</td>
</tr>
<tr>
<td>Ratio</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.1</td>
<td>1.2</td>
<td>1.3</td>
</tr>
</tbody>
</table>

**Cancer**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>194.6</td>
<td>193.1</td>
<td>196.7</td>
<td>204.2</td>
<td>211.6</td>
<td>197.2</td>
</tr>
<tr>
<td>Black</td>
<td>178.4</td>
<td>199.1</td>
<td>225.3</td>
<td>256.4</td>
<td>279.5</td>
<td>248.5</td>
</tr>
<tr>
<td>Difference</td>
<td>-18.2</td>
<td>6.0</td>
<td>28.6</td>
<td>52.2</td>
<td>67.9</td>
<td>51.3</td>
</tr>
<tr>
<td>Ratio</td>
<td>0.9</td>
<td>1.0</td>
<td>1.2</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
</tbody>
</table>


**NOTES:** Deaths per 100,000 population. “Difference” is calculated as black death rates minus white death rates for each cause of death. “Ratio” refers to the ratio of black deaths to white deaths.

Recent studies continue to report not only the lack of a reduction in racial disparities in cancer related mortalities between 1988 and 2007, but also that racial differences survive adjustments for various confounding factors, such as education, income, age, marital status, stage of disease at presentation and therapy (73). Relative to Whites, Blacks were found to have higher estimates of cancer-specific mortality for all cancers combined (Hazard ratio = 1.28, 95% confidence interval: 1.26-1.30) and within each individual cancer type. That Black women, relative to Whites, have higher mortality rates for breast cancer
(124) may reflect the fact that Black women benefit less than White women from advances in early detection and treatment (125).

**Diabetes.** Prior to 1986, death rates for diabetes as a primary cause were underreported. For example, in a national sample of the 1986 death registry, only 36.2% of Blacks and 38.6% of Whites with diabetes had diabetes listed anywhere on the death certificate (126). The underreporting of diabetes as a cause of death was attributed to US death certificates not being standardized with respect to cause. Not until 1989, when a new standardized death certificate was implemented in the US, was diabetes specifically included as a cause of death. As of result, age-adjusted diabetes death rate increased 15% and continued to increase throughout the 1990s. It is not unexpected that the age-adjusted diabetes rate in 1994 was 27% higher than in 1980. In 1997, further changes in diabetes death rates reflected changes in diagnostic criteria (127). From 1994 to 2001, mortality rates for persons with diabetes decreased by approximately 5% but this decrease was due primarily to a 6% decrease among Whites. Closer inspection of race differences in diabetes death rates reveals that the trends were radically different when comparing same gender across racial groups. In a sample of Medicare beneficiaries aged 65 or older, comparisons among race-sex groups revealed that the only group to show a significant decrease in mortality was White women (128).

**Race-differences in Mortality Rates from Major Chronic Diseases – Conclusions and Possible Contributing Factors.** Overall, for Blacks, mortality rates for three of the major causes of death have been increasing over the period 1950 to 2000.
This is in stark contrast to Whites, whose mortality rates have either remained relatively stable or decreased across the time. Even in the case where Blacks show decreasing mortality rates, the rate of decline has not been similar to decreases observed for Whites (129). It is also important to note that differences between Blacks and Whites in mortality rates not only occur in adults but also infants (130). There is evidence to suggest that the mortality rate for Black babies is more than twice as large than that for White babies (130). Such race differences in infant mortality rates led Bird (130) to suggest the need for separate mortality models and specifically race-specific models of infant mortality.

The lack of improvements in mortality rates in Blacks has led to a number of mitigating factors being proposed (107). One of the most prominent is SES. Recent studies have attempted to control for SES and access to health care to better estimate the true effect of race on mortality rates (131). In the next chapter, I review the literature on social determinants of health and specifically focus on indicators of SES, such as educational attainment and income. Although a significant overlap between race and SES has been consistently reported, a difference in the distribution of Blacks and Whites across the SES gradient does not fully explain race-differences in death rates for chronic diseases.
CHAPTER 5

SOCIAL DETERMINANTS OF HEALTH, RACIAL DIFFERENCES IN HEALTH OUTCOMES AND RACE DIFFERENCES IN THE RELATION OF SES TO HEALTH OUTCOMES

Social determinants of health encompass various areas of life and are indexed by aspects of the social and physical environments, health services, and structural and societal factors. Simply stated, social determinants are conditions in which people are born, live, learn, work, play, worship and age, as well as access to health care, factors that affect a wide range of health outcomes, functioning, quality-of-life, and risks.

The vast majority of research on social determinants has focused on measures of SES (76). Commonly used measures of SES have included income and educational attainment. More complex assessments have included measures of wealth, employment, and occupational status. Aside which aspect of SES is used in studies, it is widely accepted that SES is a multifactorial construct reflective of varying resources that include not only income, wealth, and educational attainment but also access to goods, services, and knowledge that these resources afford. In some studies, SES has been operationalized as the distribution of money, power, and resources throughout communities. That health disparities track SES and that this association is highly reproducible has led many to suggest the underlying cause of racial health disparities is race-related SES differences. Some have even suggested that racial health
disparities are due to a confounding of SES and race due to an over-representation of Blacks among lower SES strata (132). The degree to which racial categories, health endpoints, and SES overlap has led investigators to question the interpretation of studies that adjust for SES (132). To illustrate the issue of potential confounding when adjusting for SES, Kaufman et al. (132) conducted a series of computerized simulation studies so as to illustrate the potential for incorrect conclusions to be made regarding the independent effect of race when adjusting for SES measures (132). Results of the simulation studies suggested a potential bias for concluding an independent effect of race when adjusting for SES indicators (132). In light of those findings, Kaufman et al (132) suggested that adjusting for SES may contribute to false conclusions regarding the importance of race on health and that race differences in health outcomes essentially reflect racial differences in SES.

Toward addressing the same question posed by Kaufman et al (132), whether race differences in health outcomes were due to a confounding of race and SES, Braveman et al. (133) conducted a stratified analysis using national data from five large studies and examined whether race differences in health outcomes, including life expectancy, emerged across all levels of SES. Results showed that increasing life expectancy was associated with increasing income and education and that these associations were observed not only above and below specific incomes and education levels but also across the SES spectrum. Confirming previous findings, Braveman et al. (133) also observed that increasing life expectancies were associated with increasing income levels, and
those with intermediate levels of income and education had life expectancies that were lower than the wealthiest and most educated (133). Specific to the race stratified analysis, Braveman et al. (133) observed racial differences in life expectancy at all levels of income and education, such that, within the same level of income and education, life expectancies for Blacks were significantly lower than for Whites. Moreover, the relation of life expectancy to income and education appeared to differ as a function of race such that, for Blacks, increasing levels of education and income were not significantly associated with increasing life expectancies, an association that was significant for Whites. The findings by Braveman et al. suggest not only that race differences in life expectancy were independent of education and income level but also that for Blacks increasing levels of education and income are not associated with the same magnitude of increases in life expectancies as that observed for Whites.

Another study examined racial differences in measures of cardiometabolic health (e.g., cardiovascular disease, age of onset) among high SES Blacks and Whites (15). The study compared physicians from John Hopkins University with a cohort of Black physicians from Meharry Medical College. Analysis revealed large racial differences in health outcomes, even though the sample included highly educated professional males working in similar social context. Thomas et al. observed not only a higher rate of cardiovascular disease but also earlier age of onset in Black relative to White physicians. Moreover, incident diabetes and hypertension was twice as high in the Black compared to the White physicians. Thus, even in high SES groups were the effects of race would be diminished if
race and SES overlapped significantly, racial health disparities still emerged with Blacks physicians exhibiting poorer health outcomes.

Others studies have also examined whether the relation of SES to health outcomes differed as a function of race. Using the US National Health and Nutrition Examination Survey, Farmer and Ferraro (25) examined self-rated health differences between Blacks and Whites and whether the SES health gradient differed between racial groups. Analyzing data from a 20-year period, Farmer and Ferraro observed significant interactions between race and education and race and employment status. Relative to Whites, Blacks at all employment groups, including those who were unemployed, tended to report more serious illness and poorer self-rated health. Interesting, and consistent with the study of Black and White physicians, racial differences were largest at the highest levels of income and occupational status. In light of those findings, Farmer and Ferraro concluded that racial-differences in the relation of education/income to self-rated health supported the hypothesis of ‘diminishing returns’ which posits that increasing education and income do not have the same health gains in Blacks and in Whites (25). Such conclusions are in stark contrast to one well-recognized hypothesis that posits that health differences between Black and White adults would substantially diminish and potentially disappear if SES differences are eradicated (134, 135).

While few in number, the above described studies suggest that being Black in America carries additional social disadvantages that stem from racism and racial discrimination, situations not likely to be experience by most Whites
and racism-related social disadvantages diminish the expected health benefits associated with increasing SES (e.g., diminishing hypothesis). While not part of this thesis, it is interesting to note that the unemployment rate for Black college graduates is almost three times higher than for White college graduates, a situation that may contribute to the attenuated health returns associated with a college education. Thus, the hypothesis of diminishing returns appears to extend beyond measures of health to include higher rates of unemployment for college educated Blacks relative to equally educated Whites. It is important, therefore, to examine more closely what social factors may contribute to social disadvantages that potentially add to the health burden in Blacks. As outlined in this thesis, one possibility is the effects of racism and discrimination (29). It is not enough to compare Blacks to Whites on measures of health and conclude that Blacks exhibit less favorable health outcomes than Whites. What is now needed is to explore what it means to be Black in America and whether racial identity carries additional burdens not experienced by Whites. Purportedly said to a reported who asked how he felt to be a ‘Black painter’, the American artist Jean-Michel Basquait supposedly responded, ‘I am here with you, but history walked in with me too’. While Basquait did not elaborate, his statement suggests to me that being Black in America is much more than having dark skin color or specific physical characteristics. It is about being a member of a group that has experienced a history of oppression and discrimination. Interestingly, at the time the interview took place, the Museum of Modern Art (MoMA) in New York did not own a Basquiat painting, one of the most heralded painters of the late 20th
century. It was not until 2015 did MoMA acquire and show works of Black American artists. While the art world may be far removed from the world of health research, it mirrors the everyday struggles faced by Black Americans and the added burden of being Black.

Braveman et al. (43) have suggested that current theoretical models of racial health disparities may benefit from greater operational specificity of race so as to reduce the overlap with SES. The suggestion by Braveman et al. does not imply that distributional differences in SES are too closely aligned with race as to make racial comparisons often difficult. What these investigators suggest is that race and SES, although correlated, are distinct concepts that independently and jointly contribute to health status (136, 137). Another possibility to understand issues of racial health disparities is to disentangle the effects of race from those associated with racism (26, 29, 82). However, it may be the case disentangling the effects of race and racism on health may pose a greater challenges than the decomposition of the contribution of SES and race, given that the prevalence of racism is associated with being Black (133, 138). Yet, race and racism are not transposable constructs. Race is a social construction with no biological basis, whereas racism refers to a social system that reinforces racial group inequality (35, 139). Thus, it may be possible to disentangle the independent effects of race and racism on health outcomes, an approach that would add to our understanding of health disparities and the lack of progress we have made in the past decades.
In outlining my argument, it was first necessary to review approaches to the study of race so as to provide a better framework for understanding current conceptualizations of race as a social construct. The following chapter provides a short historical review of the meaning of race and how early conceptualizations of race were grounded within historically specific events and concerns.
Chapter 6

WHAT IS RACE? HISTORICAL PERSPECTIVES AND
CONCEPTUALIZING RACE AS A SOCIAL CONSTRUCT: THE
INFLUENCE OF RACISM ON RACIAL IDENTITY

The use of race as a category has a long history that can be traced to medical models that use race as a variable that reflect shared physical characteristics (140). Current perspectives, however, argue that race is not a static categorical designation but a fluid and dynamic social construct that goes beyond mere physical characteristics (85). This re-conceptualization of race represents a clear departure from the use of race as a grouping factor based on shared physical characteristics. It has been suggested that racial identity incorporates and is reflective of an individual’s own assessment of his/her relation to a social-historical framework, a process that is unstable and decentered due to the influences of change in the political, social, and economic landscape (55). The view that race is a complex socio-political structure incorporates the perspective that racial identity is also the sum total of thoughts and actions experienced by each race. Racial identity, however, should not be equated with a static set of factors that are differentially aligned for Whites and Blacks. On the contrary, racial identity is the result of dynamic influences that include historical and sociopolitical events that are common everyday occurrences and influence individual's thoughts and processes and their racial identity.
**Historical Perspectives of the Concept of Race.** In the US, race has played a central role in a series of events that go back to the early settlers. The first Africans in the US arrived almost a century before the arrival of settlers on the Mayflower. Yet, the arrival of Africans in the US is conspicuously absent from many historical records. According to the cultural historian and literary critic, Henry Louise Gates Jr., the first Black person to arrive in the US, Juan Garrido, came as a free man. Garrido arrived in 1513 with the conquistadors that were led by Diego Valezquez de Cuellar and Juan Ponce de Leon. By many accounts, Garrido was also the first documented Black conquistador who is thought to have been ‘the first to plant and harvest wheat’ in the New World. It was not until 1619 that the Dutch introduced the first captured Africans to America, the event many point to as the beginning of slavery. It was not long thereafter, in 1641, that the English legalized slavery. The reliance of the early White Europeans settlers on Black indentured slaves to cultivate the land began a cycle of oppression that, even when revoked by England, was maintained as a necessary condition for the economic foundation of the new nation.

With these events serving as a background, the idea that shared physical characteristics defined race emerged. It was not that long ago that *A Dictionary of Epidemiology* defined ‘race’ only as ‘persons who are relatively homogenous with respect to biological inheritance’ (141). And it was not simply just shared characteristics that defined race, and specifically the Black race, but the idea that the White race was superior. This and other historical events is thought to have contributed to race becoming ubiquitous when discussing Blacks and even to this
day, racial incidents evoke the need for a conversation about race when implying a discussion about Blacks. Despite the lack of a scientific rationale for race being biologically based and the recognition of race as a social construct, the majority of today’s published medical research and epidemiological studies, and to some extent bioethical treatise, continue to use race taxons (83).

More current views conceptualized race as ‘pre-eminently a social-historical concept’ (142). As described by Omi and Winant (142), race is an ‘unstable and decentered complex of social meaning that is constantly being transformed by political struggle’ (142). From the perspective of Omi and Winant, the concept of race takes into account the influence of factors across the social, political, and economic spectrum. The racial formation approach of Omi and Winant (142) allows race to be framed within the context of comparative and historical sociological events that create ‘micro-macro linkages’ that influence race and racial issues including racism. In extending the work of Omi and Winant, I speculate how racism may negatively influence levels of the six dimensions of well-being, dimensions that are deeply reflective of social inequalities and racial experiences that are part of the everyday lives of Black Americans.

If phenomenological differences underlie racial identity, then comparisons between racial groups do not equate to comparisons between apples and apples but rather between apples and oranges. If we consider race as a significant determinant of health, it seems reasonable that identifying and understanding race-related factors that contribute to health status necessitates a shift from a
‘one-size-fits all’ universal model of health to an approach that considers race-related or race-specific factors. From this perspective, racism is such a factor (130). By placing race and racial identity at the center of models of health, it may be possible better understand determinants of health for Blacks that potentially have little or no relevance to the health of Whites.

It is my argument that racism plays a greater role for Blacks than Whites. By acknowledging that racial identity and the intersection between racial identity and racism are critical factors that influence health is an important step away from the antiquated idea that race is biological categorization. The proposed argument aligns itself with many racial scholars who have suggested that ‘racism produced rates of morbidity, mortality, and overall well-being that varies depending on socially assigned race’ (85). Yet the question that must then be addressed is to what extent is racism part of racial identity? It may be that unlike SES and race, which are correlated yet distinct concepts, racism and race are interwoven to such an extent that racism becomes a critical aspect of racial identity that cannot be parceled into a distinct concept separate from race. In other words, partialing the health effects of racial identity and racism may pose a more difficult task than decomposing the effects of SES and race on health.

This above is not an problem that is unique to this thesis and it is one that has led to three approaches to race and racism (56). The first perspective frames racial identity and racism within a social-psychological framework with racism being replaced by a new and different brand of racism referred to as symbolic reclaims or racial resentment. Proponents of this approach argue that
the negative stereotypes of Blacks underlie the opposition of Whites to Affirmative Action or to voting for Black candidates. In contrast to the ‘old racism’ based on the biological inferiority of Blacks, the ‘new racism’ or ‘racial resentment’ is defined as a conjunction of anti-Black feelings and American moral traditionalism (143). While some have questioned the concept of ‘new racism’, most agree that racial attitudes are transmitted from one generation to the next through early childhood socialization.

A second approach is referred to as social structural theories (35). Supporters of these theories argue that individuals identify with their own racial group, that group conflicts emerge from competing interests, and that dominant groups maintain and even legitimize their higher social status (56). Within this framework, racism emerges from competition and struggle over real symbolic resources and privileges. While it can be argued that Whites show support for racial equality, Whites remain reluctant to support federal policies that would bring about these goals.

Lastly, the third perspective is sometimes referred to as principled politics. It is thought that Whites’ racial attitudes reflect their opposition to racial policies including Affirmative Action and federal aid to the poor. It has been suggested that Whites’ negative perceptions of Blacks are reinforced by the over-representation of Blacks at the lower end of the SES spectrum, circumstances that are often the focus of governmental policies.

Independent of which of previously described perspective is adopted, most writers believe that the lives of Black Americas reflect a history of negative
racial events that are interwoven with racial identity (144). Recognizing that the construct of race incorporates both historical and political influences allows for racial identity to be continuously recalibrated reflecting the ebbs and flows of racial relations. For Blacks, the history of slavery remains a constant aspect when defining what it means to be Black in America. In the words of William Faulkner wrote, ‘The past isn’t dead and buried. In fact, it isn’t even the past’ (145). Thus, regardless of how race is conceptualized, identifying as Black brings into play a history of racial violence, oppression, discrimination that spams through all of society. Some have even suggested that the term racism should be used to describe the racial ideology of a racialized social system whose roots are traceable to prior generations’ experiences with slavery, White supremacy, and past historical racial situations that still influence and transform today’s perspectives of race.

Examining the impact of internalized racism may help to elucidate the overlap between racial identity and racism (26, 146). The internalized racism perspective posits that negative consequences are more likely to occur if individuals internalize negative racial stereotypes about their own group (147). As an example, a young Black person who has been bullied early in life because of his/her race becomes more vulnerable to negative messages about race, messages that contribute to systemic oppression. Internalized racism, however, should not be confused with low self-esteem that can be suffered by anyone regardless of race. Thus, beyond the discrimination and harassment that racism
brings into play, racism also contributes to psychological injury likely to diminish an individual achieving good health.
CHAPTER 7

RACISM AND ITS INFLUENCE ON WELL-BEING AND ITS ESSENTIAL DIMENSIONS: APPLYING THE SOCIAL JUSTICE THEORY OF POWERS AND FADEN

If racism contributes to poor health outcomes including higher mortality rates in Blacks, it raises an important question: Can a model of health outcomes be a one-size fits all? To better understand the root causes of health disparities, it is important to identify factors that contribute to health status within the social, political, and economic environments experienced by individual groups. Identifying and examining determinants of health within individual groups, however, does not fall in line with the majority of studies whose general approach for examining health disparities is to identify factors that account for differences between groups. For example, there is a wealth of evidence to suggest that SES significantly predicts differences in mortality rates between Blacks and Whites (3, 50). Yet there is emerging evidence to suggest that the relation of SES to mortality may differ in Whites and Blacks (148). While increasing levels of SES are associated with decreasing rates of mortality in Whites, this association appears to be weaker for Blacks (6, 25). In studies that have examined race differences in health outcomes among high SES individuals, Blacks show higher rates of mortality (149), greater risk of chronic diseases (15), and greater risk factor burden (20), suggesting that the relationship between SES and health outcome measures in Blacks is moderated by factors that may not influence the
relationship in Whites. Such a pattern of findings raises the possibility that health disparities are the result of the joint effect of race and SES. What is now necessary is for investigators to consider what factor(s) may mitigate the relationship between SES and health outcomes in Blacks.

**Racism and its Influence on the SES Gradient.** Racism is part of the lives of Black American yet its influence cuts across all aspects of life. A noticeable effect of racism is on the association between economic returns and educational attainment with Blacks earning less income than Whites with the same level of education. Given that income is a recognized determinant of health, Blacks’ attenuate health gains with increasing educational attainment may reflect race differences in the relation of income to education. Another possibility is that racism influences the conditions and environments in which Black Americans are born, live, learn, work, play, worship, and age. Thus, the influence of racism extends beyond financial aspects of life to include the social conditions necessary to achieve a sufficient level of health as well as other aspects of well-being.

Social justice theories may be helpful in understanding the pervasive nature of racism and its influences on the lives of Black Americans. Most individuals would agree that racism is a form of social injustice that impacts elements of life that are important to live a decent life (39). Racism contributes to the creation of a pattern of disadvantages that produce and maintain social barriers difficult to overcome. One such barrier is economic attainment and employment possibilities; yet, this is one consequence of racism.
creates additional barriers that cannot be described as an unequal distribution of valuable human goods. The focus of Powers and Faden’s Theory of Social Justice is on aspects of the social structure that are likely influenced by racism (38, 39). In their various publications, Powers and Faden have suggested that social justice is the ‘moral foundation for public health and health policies’ due to is primary concern with ‘achievement of well-being, not the freedom or capability of achieving well-being’ (39). As stated by Power and Faden, social justice is one that goes ‘beyond issues of distributive justice, micro-allocational questions of priority setting in medical care, or any number of questions centered on how one individual fares relative to some other individual. It is perhaps not surprising that our focus in social justice is largely directed at the well-being of people in social communities or groups’ (39). That Powers and Faden’s framework extends to the well-being of groups provides an entryway to apply their theory to understanding the deleterious effects of racism on the lives of Black Americans.

Thus, I propose that racism influences levels of well-being and its essential dimensions that serve as the basis for social disadvantages that contribute to the health status of Blacks comparing unfavorably to that of Whites and why educational attainment does not have similar health gains in Blacks as it does in Whites.

As suggested by Powers and Faden, there is no single theory of justice that is the right account of justice. Powers and Faden have proposed is that aim of social justice is the recognition of ‘social and economic conditions that determine whether certain inequalities that may themselves result from the
promotion of other indispensable moral aims, should be evaluated' (39). As they have suggested, their perspective is applicable to answering questions such as ‘Which inequalities matter most?’ Their theory calls for special attention to be paid to inequalities between groups, and specifically, inequalities that affect ‘not only the suffering but also the insufficiencies or depravations of the dimensions of well-being in the subordinate group’ (39). For Powers and Faden, it is not sufficient to determine whether individuals have the capabilities to achieve well-being. On the contrary, for them it is more important that individuals achieve sufficient levels of the dimensions of well-being with public policies guaranteeing ‘the actual functioning of the dimensions of well-being’ (39).

The theory of social justice proposed by Powers and Faden has been most closely linked to the social theories proposed by Sen (150) and Nussbaum (151), who emphasized capabilities or ‘what people are able to do and be’. However, for Powers and Faden, the concerns of social justice are less about functioning and more about actual well-being. It is not enough to have the capabilities for attaining higher education, a position in line with the perspectives of Sen and Nussbaum, but rather for Powers and Faden it is having higher education. Moreover, Powers and Faden suggest that having sufficient levels of well-being demands ‘being in some state or condition, such as being healthy, being respected, or leading a self-determining life.’ (39). Independent of an individual’s goals and interests, individuals desire to possess aspects of well-being and it is not enough to just have the capabilities of attaining well-being. While owning much to Sen’s and Nussbaum’s theories of social justice that
emphasize what persons ‘can do and be’ (150), the framework of Powers’ and Faden’s significantly differs from other well-recognized theories of justice that are grounded within the principle of distributive justice (e.g., 152, 153). For Powers and Faden, their theory of social justice starts with the conception of human good and specifically the concept of human well-being. As noted in the introduction to their seminal work:

*Social justice is concerned with human well-being. In our view, well-being is best understood as involving plural, irreducible dimensions, each of which represents something of independent moral significance. Although an exhaustive, mutually exclusive list of the discrete elements of well-being is not our aim (and may not be possible), we build our account around six distinct dimensions of well-being, each of which merits separate attention within a theory of justice. These different dimensions offer different lenses through which the justice of political structures, social practices, and institutions can be assessed. Without attention to each dimension, something of salience goes unnoticed (39, p 15).*

As suggested by Powers and Faden, understanding and addressing health disparities demands that we acknowledge that ‘people continue to be systematically disadvantaged by virtue of their membership in minority groups (39). Taking this stance, it may be that the source of systematic disadvantages for Blacks reflects: (a) racism tie to racial identity and (b) implicit and explicit racial biases inherent within the social, political and economic systems. For example, while negative economic and social events are likely to disadvantage
both Whites and Blacks equally, Whites may perceive such downturns as the consequences of poor governmental actions or policies whereas for Blacks, they represent examples of the racial discrimination and racism that is widespread in this country. In the preface to their book, “Living with Racism: ‘The Black Middle Class Experience’ Joe Feagin and Melvin Sikes write (154):

“What is it like to be a Black person in White America today? One step from suicide! What I'm saying is – the psychological warfare fames that we have to play every day to survive. We have to be one way in our communities and one way in the workplace or in the business sector. We can never be ourselves all around. I think that maybe a given for all people, but us particularly; it’s really a mental health problem. It's a wonder we haven't all gone out and killed somebody or killed ourselves.” (pg vii).

The above statement captures the feelings and thoughts of many Black Americans. For Blacks, a constant state of unrest, or in the language of Powers and Faden insufficient well-being, reflects the pervasiveness of racism and social injustices that are part of the everyday lives of Blacks in America; a conclusion that brings into focus the intersection of racial identity, racism, and social justice. It is at this juncture where the argument for this thesis resides; that American Blacks are faced with ‘everyday’ racism and racial discrimination that significantly influences their well-being, circumstances not likely experienced by most Whites in American. Such experiential differences may explain why, in studies that assess health outcomes, comparisons between Blacks and Whites tend to focus
on aspects of life that are experienced by both races, such as access to health care, insurance status, education, and income.

To gain greater insight as to what factors mitigate the positive health effects of higher SES, it is important to consider social circumstances that reside at the intersection between racial identity, racism, and social justice. The fact that Blacks fail to attain similar health returns associated with higher SES, as do Whites, is not due to the fact that they are Black. On the contrary, diminished health returns for Blacks may be due to the cumulative experiences of racism, discrimination, and social exclusion that result in a pattern of social disadvantages that is independent of SES (154). The focus of this thesis is not to argue that the least-advantaged Blacks face greater obstacles that contribute to poor health.

There is a wealth of evidence to suggest that social, cultural, and environmental factors vary between the races. Yet, there seems to be little differences among different SES levels within a race. For Blacks, increasing SES does not provide a buffer for the experiences of racial discrimination and racism. On the contrary, the experience of racism appears to be independent of income and education suggesting that health consequences of racism not restricted to individuals at the lower levels of SES. The position taken in this thesis is that any potentially negative exposure that is distributed differentially between racial groups warrants particular attention. The major position of this thesis is that Blacks, across the SES spectrum, are exposed to racism that adversely affects health. Moreover, racism propagates a network of social
disadvantages that mitigate the potential health returns of increasing education attainment. As others before me have point out, race is not the risk factor for poor health. On the contrary, race is a risk marker that serves as a proxy for the increased exposure to racism. Thus, I argue, it is racism that is the primary driving force in promoting differences in health between Blacks and Whites. As noted by Anderson, ‘racial identity is not just an individualized process but it involves the formation of social groups organized around material interests with their roots in social structure’.

Across the lifespan, the health status of Black Americans is influenced by the cumulative effects of what has been referred to as ‘racialized moments’ (155). Moreover, it is not just an individual’s own experiences with racialized moments that affect health status. I propose that it is also historical racialized moments and current racial tensions that negatively influence the health of Black Americans. That we have made less than optimal progress in eliminating health disparities demands that we reconsider our approaches to the study of health differences and address issues of health within the sphere of racialization and race, what proponents of CRT refer to as race consciousness. Within the framework of CRT, the concept of race consciousness acknowledges the importance of racial dynamics not only in society but also within an individual’s life (55). Thus, racism is a powerful aspect of race consciousness.

In examining the role of racial identity in health disparities, it is important to consider racism and its effects not only health outcomes but also well-being. The intersection of CRT and the social justice theory of Powers and Faden provides a
perspective that places race and racism at the center of individual’s experiences with the world around them and how such experiences negatively influence health status. While current models of health determinants and health disparities appear to be ‘color-blind’ and could be characterized as ‘one size fits all’, acknowledging the influence of racial identity and racism on health outcomes is crucial in unraveling the determinants of health status and all its complexities. Applying such an approach allows for the possibility that some factors associated with race, such as racism, are more have greater health consequences for Blacks and less so for Whites.

There is evidence to suggest that a link between non-biological factors and life expectancy. As shown in Figure 4, one such factor is education with increasing education associated with greater life expectancy for both men and women (156).

![Educational Attainment](image)


† This chart describes the number of years that adults in different education groups can expect to live beyond age 25. For example, a 25-year-old man with only a high-school diploma can expect to live 50.6 more years and reach an age of 75.6 years.
Figure 4. The relation of life expectancy by educational attainment in men and women.

If increasing educational attainments is a pathway to better health, then is important to examine why increasing educational attainment for Blacks does not garnish the same magnitude of health returns as observed in Whites. For example, using National Health Interview data from approximately 500,000 adults ages 30 to 65, Holms and Zajacova (63) showed that educational attainment had a positive health effect that was more pronounced for Whites than for Blacks. As important, Holms and Zajacova noted that statistically adjusting for potential sociodemographic, behavioral, and economic mediators did not alter their findings. Such evidence led Zajacova and colleagues to suggest the possibility that there is a 'glitch in the gradient' (21).

Although evidence suggests race differences in the relation of education to health outcome measures (e.g.,157), to date it is not understood what factors underlie the observed race differences. Dannefur (158) and O’Rand (159) have suggested that individuals from advantaged backgrounds receive more health-related benefits from educational attainment than people from a disadvantaged backgrounds. This may be due to higher educational attainment not being able to overcome that social, economic and health circumstances for people with disadvantaged backgrounds. As suggested by O’Rand (159), ‘institutional mechanisms incorporated in opportunity structures stratify the availability of resources and rewards, and these interactions with life-course processes related
to history and mobility produce a complex pattern of cumulative advantage and cumulative disadvantage’. Thus, individuals from disadvantaged backgrounds are more likely to be exposed to health damaging environments and to adopt less healthy behaviors, circumstances that persist though the lifespan with increasing educational attainment having little influence on changing environments and behaviors (157). Thus, it may be that for Blacks a history of oppression combined with racial discrimination and exposure to racism diminishes the availability of resources and rewards that result in cumulative disadvantage. The same process of cumulative disadvantage applies to well-being and its essential dimensions with continued and prolonged exposure to racism and racial discrimination resulting in cumulative insufficiencies in levels of well-being.

I speculate that, for Blacks, cumulative exposure to racism and racial discrimination across the life span results in insufficiencies in well-being and its essential dimensions. Thus, a consequence of cumulative insufficiencies in well-being and its dimensions is the diminished health gains associated with increasing educational attainment. Besides racism’s direct effect on health outcomes (160), racism suppresses the prospects for well-being by ‘locking in systematic constraints’ that also contribute to poor health (39). If constraints are locked in at the beginning of life, they form the basis for cumulative disadvantage that serve to undermine the positive health returns of increasing educational attainment. This would explain why age-adjusted mortality rates for CVD,
cancer, and diabetes are significantly and consistently greater for Blacks than Whites across all levels of SES and in all age groups.

In advancing my argument, the next sections outline the potential negative consequences of racism on levels of the essential dimensions of well-being: (a) personal security; (b) reasoning; (c) respect; (d) attachment; and (e) self-determination. Although health is also an essential dimension of well-being, its relation to racism has been well-described in the literature. What has been missing is a discourse on the possible effects of racism on the remaining five dimensions of well-being. As Powers and Faden have suggested, the role of social justice in public health calls for the state to secure a sufficiency not only of the dimension of health but also a sufficient amount of each of the essential dimensions of well-being (39). I propose that racism imposes a barrier for achieving not only sufficient level of health but also for the remaining essential dimensions of well-being. There is evidence to suggest that racism is associated with greater mortality rates for heart disease, cancer and stroke in Blacks (161). These relationships are such that increasing levels of racism are associated with an 8.2% increase in the rate of all-cause mortality for Blacks, an increase that translates to approximately 30,000 deaths annually (161).

I propose that the negative consequence of racism extends beyond health and includes insufficiencies in the remaining five essential dimensions of well-being. Given that the experience of racism is not associated either with income or educational attainment (65, 162), the cumulative disadvantage of exposure to racism and its effects on well-being is likely to occur at all levels of SES.
spectrum. In the following sections, I describe the potential effects of racism on the dimensions of well-being of Powers and Faden.

Racism and Personal Security. It is not difficult to link racism to personal security given that racism is a salient dimension of many of today’s current headlines of racial injustices and the failure of the state to provide for the safety of the Black populace. The recent shootings in Charleston, South Carolina are only one recent event where racism was the motivating factor in the shooting of innocent Blacks. In light of this and other racial events in the news, it is reasonable to suggest that racism can take the form of violence based on irrational hate targeted at Black Americans. The events in Charleston highlight the potential of racism to trigger acts of violence that define one extreme of the insufficiencies in personal security. Powers and Faden, however, extend the realm of personal security to include not just physical aggression, such as those in Charleston, but also assault, degradation, and psychological abuse (39). Thus, I suggest that insufficient levels of personal security also incorporate the experience of racial microaggression which is defined as ‘brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group’ (163). Racial microaggression can be explicit or implicit racial snubs, put-downs, or a pattern of disrespect. It has been suggested that the most painful and harmful ones are likely to occur between those who hold power and those who are most disempowered (164). Some have argued that racial microaggression is a reflection of an unconscious worldview of White
supremacy, superiority–inferiority, and inclusion–exclusion that are imposed on racial and ethnic minorities (164, 165). Even among individuals at high SES environments, such as college campuses, studies have shown that stereotyping and marginalizing of Black males lead to greater stress symptoms, such as fear and hopelessness, feelings that reflect the sense of hostility directed to Black males in the college environment (166). Thus it is speculated that for Blacks, racism and racial microaggression across the spectrum of SES contribute to insufficient levels of personal security.

Racism and Reasoning. There is an extensive discourse on what is reasoning that stems back to Aristotle. As used by Powers and Faden, reasoning is defined not only as the organic health of the brain, but also the cognitive capacities that include both critical intellectual faculties and independence of mind. While reasoning may appear to share much with the other dimensions of well-being, Powers and Faden argue that reasoning captures a ‘morally salient aspect of human flourishing that is not reducible to the others’ (39). Above and beyond biological health needed for the brain to function, reasoning also captures educational influences that include literacy and mathematical skills and introduces the individual to the knowledge of the social world that underlie the basic cognitions that influence our participation in the world. But education is not the only contributor to reasoning. Powers and Faden stress the importance of public individuals that are recognized as persons of authority whose opinions are highly valued, whether those opinions are factual or not. For Powers and Faden,
these individuals serve as conduits for transmitting moral and social beliefs, including those that underlie the formation of social bonds.

Given the scope of reasoning, it can be said that the influence of racism on reasoning may be via biological, sociological and educational pathways that include the voices of authority figures. Although beyond the scope of this thesis, the effects of racism can already be noted during fetal development, where racism and related stressors are associated with the disproportionately high rates of adverse birth outcomes among Blacks in the US (167). In addition, an important element of CRT is the notion that because of a history of oppression, minority thinkers may be able to communicate matters that Whites are unlikely to know. Thus, it may be that acknowledging the occurrence of racism, not only by Black leaders but also by individuals in power and leaders in religious and social organizations that influence how Blacks perceive many events as the result of racial discrimination and racism.

**Racism and Respect.** Like the relation of racism to personal security, respect can be said to be the antithesis of racism. In his writings, Williams argues that racism is an added burden that impacts all aspects of life, including income and educational attainment (18). The effects of racism are pervasive and it is easy to argue that racism impacts respect. Various social justice theorists, such as Rawls (168), Sen (150), and Nussbaum (151), have addressed the role of respect and have argued that it is an essential component of life that has an important role in social justice. For Powers and Faden, respect is a dimension of well-being and an insufficient level of respect occurs when individuals, due to
membership of a particular group, are the object of discrimination based on judgments of intrinsic inferior social status (39). In their writings, Powers and Faden refer to the distinctions made by Darwall who refers to two types of respects, ‘appraisal respect’ and ‘recognition respect’ (169). Powers and Faden incorporate Darwall’s definition of recognition respect as something that is owed to each of us as individuals entitled to ‘treatment worthy of members of the moral community on a par with all others’ (39). The definition of recognition respect, therefore, contrasts the definition of racism as prejudice (differential *assumptions* about the abilities, motives, and intentions of others according to their race) and discrimination (differential *actions* toward others according to their race) that can manifest as disrespect (170). It is reasonable to argue that racism *per se* is the manifestation of the lack of respect that contributes to insufficiencies in well-being.

**Racism and Attachment.** For Powers and Faden, attachment refers not only to bonds between friends and loved ones, but also to ‘a sense of solidarity or fellowship with others in one’s community’ (39). Moreover, Powers and Faden suggest that attachment relates to an individual’s access to valuable social opportunities that are offered by social institutions and social conventions, thus promoting bonds of attachment among all members of society. From the perspective of social justice, racism acts as a chasm that limits Blacks from accessing valuable social opportunities. Racism shatters the bonds among individuals, further disconnecting Blacks from achieving a sufficient level of attachment to the whole of society. The effect of racism on attachment is to
further marginalize and disenfranchise individuals who find themselves in less advantageous positions.

Racism and Self-determination. As Powers and Faden noted, self-determination is a concept that is part of many social justice theories. The importance of self-determination as a dimension of well-being is reflective of the widely held opinion that individuals have the right to have control of who they are and who they will become (39). However, Powers and Faden do not employ self-determination as a path to self-discovery or a better understanding of one’s self. For Powers and Faden, the importance of self-determination as a dimension of well-being reflects the nature of determination as it relates to what is important to individuals, to shape their own lives by personal choices that are influenced by their personal values and interests. The impact of racism on self-determination is complex because it incorporates the concerns of many Blacks, that of succeeding in a society that is culturally immovable and whose attitudes are reflective of the majority race (139, 170). It could be argued that residential segregation is an example of the impact of racism on self-determination. Convened by President Lyndon Johnson in 1967, the National Advisory Commission on Civil Disorder concluded in their report that ‘Our nation is moving to two societies, one Black, one White – separate and unequal’. The opinion of the advisory board was that ‘segregation and poverty’ had contributed to the creation of racial ghettos that were viewed as destructive environments totally unknown to most White Americans. Almost 50 years later, we still deal with residential segregation and its relation to racial identity and racism (171, 172), suggesting that the capability
of Blacks to determine where they wish to live continues to be influenced by racial divides.

Racism and Health. In contrast to the other five essential dimensions of well-being, there is overwhelming evidence for the impact of racism on health (28). Moreover, results of a recent meta-analysis suggest that the effects of racism on health outcomes are independent of age, geographic setting, gender, and educational attainment, the latter being consistent with observations that racism is independent of education and income (65). There is emerging evidence to suggest that racism impacts newborn infant mortality with Black mothers’ exposure to interpersonal racial discrimination associated with increased infant mortality rate and low birth weight (173, 174), the latter influential in the risk of infant mortality. Thus, from the beginning of life and throughout the lifespan, racism impacts all aspects of health including mortality rates.

Overall Conclusion – Racism and Well-being. For Powers and Faden, each dimension of well-being represents an essential feature for living a decent life. Their perspective forms a basis for assessment of social institutions and practices relevant to public health. As proposed in this thesis, the framework of Powers and Faden is also useful for outlining the putative effects of racism on health via its effects on the remaining essential dimensions of well-being and how such effects potentially mitigate the positive health returns of educational attainment in Blacks.
CHAPTER 8

CONCLUSION

To better understand the causes of health disparities, it is important to examine social conditions that promote and sustain race differences in a range of health outcomes including mortality rates. In reviewing mortality rates for many of the major causes of death including heart disease (the leading cause of death for Blacks and Whites), cancer (the second leading cause of death) and diabetes (7th leading cause of death) revealed higher mortality rates for Blacks than for Whites. Such race differences in mortality rates are further reflected in race differences in life expectancy with Blacks living 3.8 years less than Whites. While increasing levels of SES, including higher education and greater income, are associated with improving health status, yet, comparisons between Whites and Blacks reveal that education-related health gains for Blacks are not similar to those in Whites (see Figure 1). If, as some has suggested, education is ‘the great equalizer’ (63) then it is important to examine why higher education is not associated with similar health benefits for Blacks as for Whites (25). Empirical evidence and public health statistics suggests that, even among those with 16 years of more of education, Blacks bear the burden of higher mortality rates. The aim of my thesis has been to elucidate how racism, and its effects on various aspects of well-being, results in a pattern of social disadvantages that undermine the relation of educational attainment on health-related returns in Blacks.
To address this aim, it was necessary to integrate a number of different perspectives. In this thesis I adopted the position that an account of social justice would help in elucidating the effects of racism on aspects on the social conditions that not only contribute to health disparity but also mitigate the relation of educational attainment to improvements in health outcomes. Toward supporting the premise of my thesis, it was important to align my proposal with the idea that experiences of racism contribute to multiple disadvantages that extended beyond racism’s effects on health. There is a considerable body of evidence to suggest that racism impacts health status across the lifespan (28). In contrast, there is a paucity of evidence that addresses the putative effects of racism on the remaining aspects of well-being: personal security, reasoning, respect, attachment, and self-determination. Thus, I speculated and described how racism impacts each of these dimensions of well-being. I proposed, racism is the basis for social insufficiencies that promote and maintain a network of disadvantages that mitigate the health benefits of higher education. Such a conclusion is consistent with evidence suggesting that health benefits of higher education appear to be greater for individuals from advantaged backgrounds and less so for those with disadvantaged backgrounds (157).

The nature of racism is such that it is integrally tied to the social construct of race and the effects of racism start at the beginning of life and remains throughout the lifecycle. It has been suggested that racial identity reflects an individual’s own assessment of his/her relation to a social-historical framework, a process that is unstable and decentered due to the influences of changes in the
political, social and economic landscape. Conceptualizing race as a complex socio-political structure requires an understanding of racial identity as the sum total of thoughts and actions relevant to each racial group. While racial groups may share some socio-political factors, thoughts and actions in response to events may differ significantly between racial groups not only in frequency but also in interpretation. Given this possibility, racial identity should not be understood as the result of a static set of factors that are differentially aligned for Whites and Blacks. On the contrary, racial identity is viewed as the result of dynamic influences that encompass historical events and current sociopolitical situations with racism at their epicenter. Thus, in order to disentangle the multiple influences of racism and race on health, one approach is to examine the effects of racism on well-being and its essential dimensions. If, as I propose, the experiences of racism by Blacks create and sustain a pattern of cumulating disadvantages that serve to undermine the magnitude of health gains associated with increasing educational attainment.

The overlap between racial identity and racism is one that has been frequently discussed in the literature. Admittedly, Blacks are exposed to structural and individualized racism across a number of domains including housing, education, employment, medical care, economy, and justice. For the most part, and in my opinion, the impact of racism on aspects of social justice has been too restrictive. Within the framework of Powers and Faden, social justice ‘is concerned with securing and maintaining the social conditions necessary for a sufficient level of well-being and all of its essential dimensions for
everyone’ (39). But, as they have acknowledged, an individual alone cannot achieve well-being without the necessary social conditions of life. Even is an individual does not pursue well-being, for example individuals who choose to smoke and thus limit their level of health, this example of one that relies on the persons’ own volition to participate in this behavior. In contrast, racism imposes and limits members of the disadvantaged group from attaining the necessary social conditions to achieve the same level of health returns associated with increasing educational attainment in Whites.
REFERENCES


15. Thomas J, Thomas DJ, Pearson T, Klag M, Mead L. Cardiovascular disease in African American and white physicians: the Meharry Cohort and


113. U. S. Census Bureau. Black or African American Alone or In Combination with One or More Other Races- 2008 American Community Survey 1 year estimates. In; 2008.


SCHOLASTIC VITA

EDWARD CARLOS SUAREZ

BORN: October 8, 1954, Manzanillo, Cuba

UNDERGRADUATE STUDY:
University of Miami
Coral Gables, Florida
B. A., Mathematics and Psychology, 1979

GRADUATE STUDY:
University of Miami
Coral Gables, Florida
Ph.D., Psychology, 1986

SCHOLASTIC AND PROFESSIONAL EXPERIENCE:

Professor, Department of Psychiatry and Behavioral Sciences, Duke University
School of Medicine, Durham, North Carolina, 2015 - Present

Professor, Department of Psychology and Neuroscience, Duke University,
Durham, North Carolina, 2014 - Present

HONORS AND AWARDS:

Guest Editor, Special Issue of Brain, Behavior, and Immunity, Gender, Race,
Ethnicity and Immunity

Member, Academy of Behavioral Medicine Research (ABMR)

Member, Biobehavioral Mechanisms of Emotion, Stress and Health (MESH),
Center for Scientific Review, National Institutes of Health

Member, Biobehavioral and Behavioral Processes (BBBP)-2, Center for Scientific
Review, National Institutes of Health

Fellow, Society of Behavioral Medicine
General Clinical Research Center Review Committee, National Center for
Member, Research Resources, National Institutes of Health
MBRS Review Panel, National Institute of General Medical Sciences, National
Institutes of Health
New Investigator Award, Society of Behavioral Medicine, 1991
National Institute of Mental Health Fellowship, 1989
National Hispanic Scholarship, 1979
PUBLICATIONS:

Chapters:

relationship between hostility and potentially pathogenic physiological responses
to social stressors. In N. Schneiderman, P. McCabe, A. Baum (Eds). Stress and
Disease Processes: Perspectives in Behavioral Medicine, (175-196), Hillsdale,
NJ: Lawrence Erlbaum

to chronic diseases. In K. Kendall-Tackett (Ed). The Psychoneuroimmunology of
Chronic Disease: Exploring the links between inflammation, stress and illness,
Washington, DC: APA Publishing

and psychological factors associated with an increased risk of atherosclerotic
York NYGB; Oxford University Press

Handbook of Cardiovascular Behavioral Medicine, New York: Springer

Journals Articles:

performance in college men and women. Journal of Counseling Psychology, 32:
283-287


