EDITORIAL

Research on Race/Ethnicity and Health Care Discrimination: Where We Are and Where We Need to Go

This photograph by Lori Waselchuk from the "Grace Before Dying" exhibition humanizes a nameless population, and bears witness to a community of men who provide love and support in an institution that was constructed to provide neither. Printed with permission.

Racial/ethnic disparities in access to care, receipt of treatment, health status, and health outcomes are well documented. A number of factors are posited to underlie these disparities including socioeconomic status, lack of health care knowledge, cultural beliefs and preferences, and racial/ethnicity-based discrimination—the focus of this theme issue of the *American Journal of Public Health*® (*AJPH*). Both overt and more subtle and indirect[1] expressions of personal prejudice and racial/ethnic discrimination remain prevalent in the general US community. Because the current social and legal environment is no longer openly supportive of discrimination against racial/ethnic minorities, contemporary discriminatory behavior is often attributed to other factors that can be more easily justified.[2] This makes it difficult to accurately assess the overall prevalence of racial/ethnic discrimination and to track trends over time which may contribute to the belief among some that discrimination is no longer a problem in the United States. Nevertheless, in a 2008 nationwide Gallup Poll conducted June 5–6, 2008, 56% of those surveyed agreed that racism against African Americans was widespread.[3] Data from the National Latino and Asian American Study show that 30% of Latinos perceived that they had been discriminated against.[4a] Unfortunately, biases, stereotypes and prejudices prevalent in the general community are unlikely to be held at bay at the doors of our medical or other institutions. In 2008 the United Nations Committee on the Elimination of Racial Discrimination (CERD) urged then President George W. Bush's administration to "take effective actions to end racist practices against minorities in the United States in areas of criminal justice, housing, healthcare and education."[4b]

The specific objective of this theme issue of the *AJPH* is to highlight the need for and state of empirical research on racial/ethnic discrimination and its association with the health and health care received by racial/ethnic minority populations. Discrimination is experienced by many minority and population subgroups. However, the majority of previous research on discrimination and health has focused on African Americans which is likely a result of the predominant role that race has played in African American social history. From the more than 100 abstracts we received in response to our open call for papers, it is clear that a vast amount of current research focuses on African Americans.

HOW DISCRIMINATION CONTRIBUTES TO HEALTH DISPARITIES

In the first article, Smedley[5] proposes a comprehensive model of the lived experience of race, one that will facilitate a better understanding of the interaction of race with gender, socioeconomic status, geography and that also considers the negative consequences of racism for Whites. Krieger[6] proposes an integrated approach for assessing how discrimination ultimately produces health disparities. The approach is guided

by ecosocial theory, which conceptualizes discrimination at multiple levels with multiple pathways that span the life course and generations. Dovidio and Fiske[7] use a social psychological framework to explain how unexamined racial/ethnic biases contribute to health disparities and discuss implications for understanding health care bias and developing appropriate interventions.

STATE OF RESEARCH

Shavers et al.[8] focus on the prevalence and state of empirical research regarding racial/ethnic discrimination by health care providers or occurring within health care settings. Currently used measures, research approaches, data resources, and results of research on race/ethnicity-based health care discrimination are reviewed. This article sets the stage for the other theme articles, which cover issues of measurement, implicit bias, and perception of discrimination.

MEASUREMENT

The accurate measurement and tracking of exposure to discrimination although essential to establishing discrimination as a health risk remains a challenge for researchers interested in this topic area. Gee et al.[9] expand on the discussion of the life course perspective with a detailed examination of how sensitivity to discrimination and the context in which discrimination occurs changes over time. The authors also provide an interesting discussion of the relevance of discrimination experienced by others, latency, and stress proliferation. Williams et al.[10] examine question framing, racial categorization, type of discrimination, and variation in the assessment of discriminatory experiences by race and socioeconomic status.

IMPLICIT BIAS

Our unconscious biases reflect our attitudes, beliefs, stereotypes and prejudicial associations we have for particular groups. These biases or implicit attitudes have the potential to influence the way we perceive and behave toward others. Four studies in the theme section focus on implicit attitudes and biases. Cooper et al.[11] describe the results of a cross-sectional study of the association between clinician implicit attitudes about race and clinician communication and patient ratings of care. Sabin and Greenwald[12] use clinical vignettes and Implicit Association Tests to examine the relationship between pediatricians' implicit and explicit racial attitudes and racial variation in treatment recommendations. In an intriguing study of stereotypes, Moskowitz et al.[13] use subliminal exposures of the faces of Black and White men to explore stereotype activation among White physicians. The study by Mazzocco and Brunner[14] provides insight into factors that underlie opposition for race-focused health care policies by examining its association with cognitive- and belief-based mechanisms regarding the salience of racial health disparities.

PERCEIVED DISCRIMINATION

The extent to which discrimination influences important outcomes depends not only on the attitudes and actions of the perceiver (typically a health care provider) but also how individuals perceive and respond to discrimination. Three studies in the theme section of *AJPH* focus on perceived discrimination processes and outcomes. In a prospective study among adolescents Brody et al.,[15] examine the association of perceived racial discrimination and subsequent increase in substance use. Harris et al.[16] examine the association between experiences with health care and general discrimination and the perception of negative health care experiences and receipt of cancer screening among Maori women. Sawyer et al.[17] show that anticipating a racially incongruent interaction with a person perceived to be prejudiced is sufficient to trigger hemodynamic and vascular effects and has psychological consequences. These studies demonstrate that perceiving discrimination in health care settings can have palpable physiological, attitudinal, and behavioral downstream effects with substantial consequences.

It was our goal to highlight the importance and need for research that examines racial/ethnic discrimination as a putative risk for racial/ethnic health disparities. Noticeably absent from this themed section are articles that focus on institutional racism. Perhaps the most insidious form of racism is the structural or systemic factors that influence differential availability, access, appropriateness and utilization of and access to health care. This form of racism is less easily recognized than personal discrimination because the perception of what is racist in the United States is largely shaped by our system of legal remedy for discriminatory behavior, which focuses on the presence of conscious intent. Whether regulations, policies, rules and customary procedures within health systems, organizations, or governments have a discriminatory intent is an important question. Equally important, however, is whether these regulations, policies, rules, and procedures have a discriminatory impact.

Together, the articles in this theme issue provide a good overview and informed discussion of the limitations of current measures and approaches for examining racial/ethnic health care discrimination. The articles also identify strategies for improving measurement and suggest areas for future research. As these articles clearly indicate, there is much that we don't know about the overall prevalence and impact of racial/ethnic discrimination on health, particularly within US health care settings.

On February 2–4, 2011, the National Cancer Institute (NCI) of the National Institutes of Health (NIH) sponsored a three-day conference in collaboration with the Agency for Health Care Research and Quality (AHRQ), National Institute on Drug Abuse (NIDA), Office of Behavioral and Social Science Research (OBSSR) and National Heart Lung and Blood Institute (NHLBI) to examine the research and research methods used for investigating the role of racial/ethnic discrimination in health. The specific purposes of the conference were to (1) promote the science and research on racial/ethnic discrimination and its contribution to racial/ethnic disparities in health, (2) identify gaps in the research literature and areas for future research or NCI/NIH funding initiatives, and (3) increase awareness of the NCI's interest in funding research in this topic area through the Program Announcement, The Effect of Racial and Ethnic Discrimination/Bias on Health Care Delivery (PA-11–162, PA-11–163, PA-11-165).

Several of the articles are from presenters from this conference, many of whom are leaders in this field of research. It is our belief

that the articles in this theme section of *AJPH* both illustrate the state of the field and will also help position researchers, policymakers, and professionals at all levels of health care to address the effects of discrimination in the evolving health care environment. ■

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Human Participant Protection

Because no human subjects were involved, institutional review board approval was not required.

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