Now Is the Time to Incorporate the Construct of Structural Racism and Discrimination into Health Research

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Introduction

In May 2017, the National Institute on Minority Health and Health Disparities (NIMHD) and the US Department of Health and Human Services Office of Minority Health convened a workshop on incorporating the construct of structural racism and discrimination (SRD) into health research.[1] Drawing on a definition from Healthy People 2020,[2] we defined SRD as macro-level societal conditions that limit opportunities, resources, and well-being of less privileged groups on the basis of race/ethnicity and/or other statuses, including but not limited to, gender identity, sexual orientation, disability status, social class or socioeconomic status (SES), religion, geographic residence, national origin, immigration status, limited English proficiency, physical characteristics, or health conditions.

Although the intent to include SRD in health and health disparities research is evident, a key question remains—how, exactly, should researchers do this?

At the time of the workshop, the topic of SRD, although long studied in some disciplines, had only begun to emerge as a topic of inquiry in health research. Apart from research on residential segregation, SRD was rarely examined as a determinant of health, even in studies focused on health disparities. The workshop was intended not only to showcase examples of current health research on SRD, but to discuss how to conceptualize, operationalize, and measure SRD to facilitate the inclusion of this construct more routinely in health research.

Publication to Address Structural Racism and Discrimination

Sponsoring a journal supplement to discuss and debate these issues in the published literature was one of the key recommendations to emerge

from the workshop. The culmination of this recommendation is this *Ethnicity & Disease* supplement, Structural Racism and Discrimination: Impact on Minority Health and Health Disparities. Little did we know when we first commissioned this supplement in 2019 that subsequent events – the COVID-19 pandemic and protests over the killing of George Floyd and other Black men and women – would catapult SRD into media headlines and become an urgent health research priority.

At the National Institutes of Health (NIH), there is now a widespread recognition of the need to support health research addressing this historically overlooked construct. Although the intent to include SRD in health and health disparities research is evident, a key question remains—how, exactly, should researchers do this? Intent alone is not likely to be sufficient for health researchers for whom the incorporation of SRD represents new conceptual and methodological territory. For example, "considering" SRD when interpreting study findings, in the absence of directly assessing SRD within the study, can lead to unwarranted or inaccurate conclusions. This pattern has been demonstrated with other complex constructs, such as culture and its impact on health.[3] Sole reliance on self-report measures of perceived structural racism and discrimination, often a more familiar strategy for health researchers, emphasizes individual responses to SRD rather than the SRD itself. Labeling certain global socioeconomic determinants of health, such as poverty or educational attainment, as SRD without providing a rationale may also be problematic. Because there is variation of these determinants within populations (eg, SES variation among non-Hispanic Whites, variation in educational attainment among higher income populations), examination of SRD requires researchers to fully explore how embedded structural factors operate over time, place, and across SES gradients to contribute to observed population-level patterns rather than individual differences.

Clearly, for many researchers, including SRD in research will require a shift from research that is solely centered around person-level variables to organizational, community, and societal level variables that reflect current and historical organizational, institutional, and governmental policies or laws, practices, and norms. The intent of this special supplement is to build on existing work in this area[4-6] to provide conceptual models, methodologies, and measures that may further inform, guide, and stimulate future research on SRD and health.

Conclusion

We believe that research to understand minority health and eliminate health disparities is incomplete if the contributions of SRD are not considered. We now have a window of opportunity to add to the existing science of conceptualizing, operationalizing, and measuring SRD, as well as developing and testing interventions to eliminate SRD and its impact on heath. We are confident that this supplement will contribute to achieving this goal.

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