Acknowledgment of the Legacy of Racism and Discrimination

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Introduction

European colonization of the Americas more than 500 years ago led to a dramatic shift in populations and the establishment of new forms of societal governance. Economic development was dependent on the genocide and oppression of the Indigenous populations of the Americas with resulting economic marginalization. The enslavement of people of African descent with subsequent forced migration of more than six million persons created wealth for a privileged class in the American colonies and laid the foundation of the modern United States. Although legal slavery ended with the United States Civil War and the passage of the 13th Amendment to the Constitution, our country continues to struggle with this history. Inequality, lack of economic opportunity and poor health persist today broadly in American society defined both by social class as well as by race and ethnicity. As scientists, it is our responsibility to address how structural racism and discrimination affect the causal pathways to health outcomes in these groups and to execute interventions to mitigate and eliminate disparities where possible.

Discrimination of individuals based on demographic characteristics is common and has been a pervasive component of human society. Discrimination is almost always part of a power structure of how one group sustains dominance over other social groups. Racism refers to discriminatory practices toward members of socially defined racial groups most often characterized by differences related to skin color and other phenotypical features, but also ancestry, such as the "one-drop rule." White or lighter color has been associated with being "su-

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perior" and having privilege and power. Darker skin was relegated to being an inferior servant class, and in the extreme American example, to slavery. Skin color is not the only factor driving racism and discrimination as evidenced by the genocidal approach to American Indigenous populations by European colonial powers and the discrimination based on documentation status within wealthy countries.

Early Research on Racism and Discrimination

During the past 50 years, health researchers have developed many efforts to quantify and describe how societal racism affects health outcomes. The evidence from population health data is compelling for African Americans, American Indians, and Pacific Islanders and the lack of any complete explanation for these disparities based on known behavioral and biological mechanisms has led to more in-depth evaluation of societal factors.

The initial efforts at studying racism and discrimination in health began with asking respondents about their personal experiences. Research based on the National Survey of Black Americans launched a series of studies that systematically addressed the role of everyday racist experiences with both mental health and physical function outcomes in longitudinal studies.[1] Experimental data showed that exposure to blatant racist activities altered cardiovascular reactivity among African Americans.[1] Awareness of being treated unfairly in the past 30 days because of racial or ethnic background in stores, at work, entertainment venues, during police encounters or while seeking health care was reported by 53% of African Americans and 36% of Latinos in a survey conducted by the Kaiser Family Foundation in 2015.[2] Measures of interpersonal racism have been developed, widely used and accepted as reliable and valid in conducting population health research. Experiences with racism and discrimination are best conceptualized as a form of chronic stress that is cumulative and contributes in the pathways to chronic diseases as well as behavioral and mental health conditions. The National Institutes of Health (NIH) endorse the Major Experiences and Everyday Discrimination Scales to be used by scientists as standardized measures (available in the PhenX Toolkit version February 23, 2021, Ver 37.0., www.phenxtoolkit.org), which assess perceived unfair experiences based on race, ancestry or national origin, religion, gender, sexual orientation, and physical appearance and their frequency. There is extensive evidence to support the role of racism and discrimination on health. However, there is a growing societal recognition that racism and discrimination extend beyond the behavior of individuals.

Structural Racism and Discrimination

Racism and discrimination are embedded in societal structures and linked inherently to power differentials. Structural racism and discrimination form part of social, institutional, organizational, and governmental structures, processes, procedures, and practices that limit opportunities and resources to segments of the population on the basis of phenotypical characteristics. This construct is supported by history, culture and institutions as well as codified in policies that perpetuate inequity by promoting an ideology of inferiority. Although slavery was made illegal almost 160 years ago, American society organized a system that categorized and assigned value to groups of people on the basis of race. The Jim Crow laws in the South and the mass incarceration initiated in the 1980s are the most blatant examples post-slavery, but the more elusive and effective practice of redlining led to systematic residential segregation in most urban centers in the United States.[3] Marginalization of African Americans and subsequently of Latinos in America's cities and rural areas led to the substantial wealth gap due to less buildup of family equity in property, poor access to quality education, limited economic opportunities, and increased challenges to public safety. Residential segregation has been the foundation of structural racism that has contributed to health disparities by race and socioeconomic status that has not been addressed.

In this issue of *Ethnicity and Disease*, the National Institute on Minority Health and Health Disparities (NIMHD) made a call for scientists to address the topic of structural racism and its effects on health. Leveraging the guidance provided in the NIMHD Research Framework,[4] health researchers need to routinely incorporate constructs and measurement of structural racism and discrimination across multiple domains and levels of influence. After limited progress over the past 30 years since

the Office of Minority Health Research was established, this will be needed for reducing health disparities and achieving health equity for all. This special issue provides the field with some important contributions. Dennis et al[5] presents a framework in historical terms dating to the 15th century highlighting how Indigenous populations have been affected. This perspective has implications for the Americas and provides a lens by which to unify the research approach to structural racism in the Western hemisphere. In the article by Gee et al,[6] the interconnections among institutions and racialized rules that establish a hierarchy built on inequality and devaluing specific groups is made evident. It is an important step to accept that structural racism is not only about rules created by others, but also includes all persons who are benefitting from these rules and work within these institutions and organizations irrespective of their individual perspectives. Volpe et al point to the intensely racist components of the online world where anonymous and random language can be extensively found that perpetuate anti-Black messages.[7] They propose a system by which online racism can be measured and how it may translate into health disparities.

Empirical work on wage theft and work-related injuries among Latino day laborers[8] highlights the systematic disadvantage that marginalized population groups experience. Positive association of wage theft with risk of physical injuries was found in construction workers, but there was no association with mental health indicators. Although Latinas, in general, have no disparities in birth outcomes, concerns have been raised that fears of immigration enforcement creates a structural barrier to health care for unauthorized immigrants and may lead to worse outcomes.[9] Place-based inequities driven by regulation of mortgage markets is one of the core drivers of residential segregation and structural racism, and evaluating associations with clinical syndromes in populations with health disparities represents a novel approach to the study of structural racism and discrimination.[10]

There is a need to move the field of research on structural racism and discrimination from observational and analytic studies to interventions. Understanding mechanisms is an important first step, and development of intervention components must be followed by careful testing. Qualitative analyses of researcher field notes and semi-structured interviews with students and teachers across 10 urban schools illustrated the value of considering structural racism in an implementation research model.[11] Interventions to address organizational-level climate such as tolerance of abuse, harassment and microaggressions, were evaluated with a multipronged initiative grounded in Public Health Critical Race praxis within the Bureau of Communicable Disease at the New York City Department of Health and Mental Hygiene. Seven interventions were designed and implemented ranging from multimedia training to surveillance and data equity.[12] The absence of measures of social determinants of health, and the lack of an operational construct of structural racism within implementation science models are deficiencies that need to be addressed to advance health equity.[13]

NIH-funded researchers have examined the effects of interpersonal racism and discrimination and found significant associations on mental health symptoms, substance use behavior, cardiovascular events and overall physical function.[14] However, the consequences reflected in the coronavirus 2019 (COVID-19) pandemic are derived from the ingrained practices, laws, policies, and social norms that define structural racism and discrimination and limits individual and community potential on a daily basis without overt personal events. Structural racism and discrimination exist to perpetuate the status quo, to create a culture of inferiority among "some" and elevate barriers to protect "others" in power. Most people who have not experienced the cruel effects of structural racism have acclimated to it, tolerated it, and even benefited from it.

Research Needed: Domains within Structural Racism and Discrimination

As a nation, we need to reverse practices and norms that have blocked people and entire communities from accessing what many of us take for granted: affordable housing, quality public education, access to health care, living wages, job and career opportunities, equal police protection, and the ability to live without fear of discrimination, harassment, and violence. Examples of domains in which

research on structural racism and discrimination may occur include, but are not limited to, three settings.

First, organizational-level climate or lack of cultural humility in the workplace such that hiring, promotion, or disciplinary practices are affected by stigmatization and tolerance of harassment among other factors. This is of special relevance to academic research institutions funded in part by NIH and to the institutions along the educational pathways.

Second, environmental and place-based research on policies and practices that affect housing or lending practices, zoning laws, distribution of public transportation, maintenance of green spaces, full-service grocery stores, health clinics, major thoroughfares, industrial or waste sites and targeted social marketing of harmful products is needed.

Finally, research examining societal policies and laws affecting criminal justice sentencing practices, land or water use rights, self-governance or political representation for tribal communities and US territories, immigration and asylum policies and procedures, voter suppression, religious and cultural discrimination, and depiction or representation in national media have the potential to advance the study of minority health and health disparities through multisector partnerships.

Conclusion

As a major funder of research and as an entity that influences policy and public health practices through scientific discovery, NIH has a unique and important responsibility to identify and address structural racism and end racial inequities in health care and in the biomedical research enterprise. NIMHD is committed to lead the scientific efforts to develop, implement, and evaluate interventions to manage, reduce, and eliminate structural racism and discrimination.

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