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Christine Stephens

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Racism and Inequalities in Health

Notes towards an Agenda for Critical Health Psychology

CHRISTINE STEPHENS
Massey University, New Zealand

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ADDRESS. Correspondence should be directed to:
CHRISTINE STEPHENS, School of Psychology, Massey University, Palmerston
North, New Zealand. [email: c.v.stephens@massey.ac.nz]



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Abstract

Estacio (this issue) has provided a moving demonstration of the way in which racism impacts on health at interpersonal, societal and global levels and how the discourses that create and sustain unequal treatment may be identified in everyday mediated talk, including the use of humour. In this commentary I develop Estacio's discussion of the importance of racism in regard to health inequalities. Using her structure, I briefly suggest additional ways in which critical health psychologists may approach these issues by drawing on work from psychology and other disciplines to develop just approaches to health research and practice.

Keywords

- *ethics*
- *health psychology*
- *inequalities*
- *justice*
- *racism*

ESTACIO has used an example of horrific injustice within our society to demonstrate the links between global injustices, domestic inequalities and ill-treatment, and the public discourses and attitudes that allow every member of society to be implicated in supporting such cruelties. She has shown how racism impacts on health at all these levels and how the discourses that create and sustain unequal treatment may be identified in everyday mediated talk, including the use of humour. In this commentary I will develop Estacio's discussion of the importance of racism to health inequalities and the approaches health psychologists might take to these issues.

Racism and inequalities¹

Racial and ethnic differences are an important aspect of inequalities in health in many countries but the evidence for the impact of racial differences in health has been largely at the level of population surveys. The effects of racism are often masked by a focus on income inequalities (which are also closely related to ethnic differences). In population studies, a large part of the ethnicity and health relationship may be explained by income or occupation, but there remains an additional effect of race or ethnicity on health. In the USA, Deaton and Lubotsky (2003) have critiqued the assumptions that observed health differences are related primarily to income. Some commentators are willing to consider that the additional underlying factor is structural, institutional or interpersonal racism. To explore such suggestions, Williams, Yu, Jackson, & Anderson (1997) compared self-reports of stress and experiences of unfair discrimination reported by 520 whites and 586 black respondents to show that perceived discrimination and stress explained some of the difference in health status. Such self-report measures of discrimination probably capture a very limited picture of the sorts of daily experiences of discrimination that people are able to recall and do not address the broader, taken for granted and subtle forms of racism in society (e.g. Geiger, 2003; Good, James, Good, & Becker, 2003; McCreanor & Nairn, 2002). However, these findings begin to provide support for the direct role of discrimination on health.

New Zealand is another country in which racial inequalities are an important issue and given some cautious attention. New Zealand's minority indigenous population, the Māori, show marked differences in all areas of health when compared to the European settler majority. Across the whole population the unequal distribution of income, education,

employment and housing is directly related to poorer health for Māori (Sporle, Pearce, & Davis, 2002; Tobias & Yeh, 2006; Woodward, Crampton, Howden-Chapman, & Salmond, 2000). Additional suggested reasons for these inequalities include the effects of colonization and land confiscation, structural and inter-personal racism and unequal access to health services (Blakely, Fawcett, Hunt, & Wilson, 2006; Ministry of Health, 2002; Sporle, 2002). However, investigations into the direct effects of racism are few. Harris et al. (2006) found that Māori were more likely to report discrimination in verbal attacks, physical attacks and unfair treatment by a health professional, at work, or when buying or renting housing. These experiences explained some of the variance in various health outcomes, leading the researchers to conclude that racism contributes to inequalities in health between Māori and Europeans in New Zealand.

A focus on health inequities for people marked by colour or ethnicity, who have histories of racial and ethnic discrimination, injustice, colonization and exclusion, highlights the importance of racism. Racist discrimination may be seen as a blatant expression of the hierarchical structure that has been suggested as the basis of health inequalities (Wilkinson, 2005). The small number of qualitative investigations into the health effects of these social factors suggests that clear markers such as ethnicity define the responses of those in power and act as a marker for social status and differences between dominant and repressed groups in society. For example, in the health care field alone, both Good et al. (2003) in the USA and McCreanor and Nairn (2002) in New Zealand have shown how even well-meaning health care professionals unintentionally reproduce racist categorizations and marginalize ethnic experiences.

In countries in which ethnic divides are disguised for one reason or another, the effects of racism on health are even less likely to be studied. Whereas US and New Zealand public policy on inequities has included racial inequalities, the UK government has focused on disparities in geography and socio-economic status (Exworthy, Bindman, Davies, & Washington, 2006). In some countries racial inequalities may exist with even less attention. For example, Australia is described as an egalitarian country when statistics are considered across the whole population (Wilkinson, 2005). However, Australia includes a small indigenous population with very poor health status. Indigenous life expectation is 17 years lower than other Australians;

infant mortality is three times higher; and death rates for Indigenous Australians are twice as high across all age groups (Human Rights and Equal Opportunity Commission, 2008). The high mortality rate of Aboriginal people does not impact on the generally low mortality rate of the whole Australian population and interest in the plight of Aboriginal peoples is mainly found in the health policy, health promotion or other health professional literature.

Estacio has identified three levels for considering the importance of racism, injustice and health: the everyday discursive effects; the need for care and empowerment of disadvantaged people; and the global inequalities that are behind these injustices. Here, I briefly touch on the ways in which critical health psychologists may approach each of these levels.

Research into everyday racism and health

There is a clear need for ongoing research into the health effects of racism that will reveal and explain the everyday experience of minority group members in different social situations. There are some clear avenues for contributions from critical health psychological research. The first is to use phenomenological enquiry to understand the experiences of and effects on individuals of living with racism. Second, ethnographic enquiry may be more broadly applied to the study of interpersonal interactions in areas such as public health provision, health service provision and practice and the practices of health service personnel including physicians, nurses and community workers. A third approach, as suggested by Estacio, is to study the production of racism in society using discourse and media theory and analysis. These approaches are able to highlight the construction and perpetuation of unequal power relations between groups in society at levels of discourse from government health policy to everyday talk. A critical social view of racism pays attention to the social and structural context in which interpersonal racism may seem to be the norm and jokes about minority group members may be dismissed as only a laugh. It asks questions such as: what are the investments of the dominant culture in maintaining racist discourses and how do these manifest themselves in relation to public health?

In using these approaches there are lessons to be learned from feminist scholarship and activism. Feminist research has provided a successful model for counteracting the discourses of sexism by paying

attention to the constructive power of language and the possibilities for changing dominant views in society (e.g. Gervasio & Crawford, 1989). Feminist scholarship (see Crawford, 2001) has led the way in examining the effects of everyday language on repressed groups in society. For example, Verwoerd and Verwoerd (1994) explored the links between joking, power and injustice. They discuss the ways in which an apparently simple joke is part of the discourses which systematically sustain unequal relations of power and cite Naomi Weisstein who, foreshadowing Estacio's concerns, said: 'So when we hear jokes against women and we are asked why we don't laugh, the answer is easy, simple and short. Of course we are not laughing, you (bleep). Nobody laughs at the sight of their own blood' (Verwoerd & Verwoerd, 1994, p. 69).

Interventions to empower disadvantaged groups

The ill-treatment of low status powerless migrant workers (particularly women) calls for the use of community empowerment work. Critical health psychologists are already involved in community approaches to health promotion and there is a range of resources which may be used to conduct interventions that truly empower and enable underprivileged groups to achieve an equal place in society. One important resource is critical theory. Critical theory draws attention to the power differences in health promoting practice. It provides explanations for inequalities and the ways that privileged groups capture the benefits of interventions aimed at the disadvantaged (Feachem, 2000). A critical approach focuses on the systemic dimensions of health issues and the empowerment of those who are systematically excluded.

Paulo Freire is probably the critical theorist who has had the most direct influence on health promotion practice. Freire's focus on the constitutive nature of language has links with discourse theory. For Freire, knowledge of the world and the words to describe it are the same thing and his dialogic approach highlights the contingent and historically located nature of knowledge. For the student to understand their own relationship to knowledge in this way is a central aspect of Freire's (1972) pedagogy. He called this recognition *conscientização* or critical consciousness. Critical consciousness is the development of critical thinking in the student and may be compared to the feminist notion of 'consciousness raising'.

Through dialogue people are empowered to change the conditions that are affecting their lives and communicate with others so that whole groups may start working for social change. Freire's work has been used by health promotion practitioners such as Campbell and Jovchelovitch (2000), Ramella and de la Cruz (2000) and Williams, Labonte and O'Brien (2003) to contribute to the theoretical basis for participatory health promotion projects that are aimed at empowering communities. This participatory community action approach enables people to understand and act on the inequitable social structures and on the processes that perpetuate exclusion and marginalization (Murray & Poland, 2006).

Global relations and justice

The global relations that lead to the exploitation of powerless migrant workers may be seen in relation to many aspects of health. For example, the dominant individualist approach to disease prevention has been damaging in countries suffering from the HIV/AIDS epidemic when it actively excludes knowledge and recognition of the social and structural causes (e.g. Campbell, 2003; Mabala, 2006). Proponents of social justice claim that it is at this level of macro-political change that health research and promotion efforts will be most fruitful. Beauchamp (2003) suggests that health must be seen as the responsibility of the whole society, and public health ethical activity must challenge the norms of 'market-justice'. In challenging the effects of the ethics of capitalism on public health, Levins (2003) further suggests that health must be seen as a class struggle. Unless the underlying power issues are challenged, the policies developed by government institutions often reflect the interests of the powerful whose focus is on profit.

Social justice approaches suggest that health workers must go beyond ameliorative public health measures to those that focus on the causes of economic and social inequality itself. Mabala (2006) has made a very clear case for such actionable understandings. He shows that HIV/AIDS in urban Africa flourishes in situations of poverty and severe inequity, with young women and girls particularly vulnerable to this situation. He points to the need for health researchers and promoters to address the underlying causes of this inequality including the effects of globalization: debt burdens, trade inequities and the priorities of aid donors.

A values-based approach to health psychology

The issues raised by Estacio's editorial call for a health psychology which recognizes that health is a moral issue and attention must be paid to our own values. As health psychologists we are being asked to take a reflexive stance on our own contributions to societal attitudes and injustices. We must hold up for consideration our personal values, the values involved in the aims of our research and intervention work, the values of all participants and the values underlying the choices to be made in theory, aims and practice. Many commentators have already suggested that values should be a primary focus of evaluating the aims of health practice, rather than an instrumental or strategic basis (e.g. Guttman, 2000; Prilleltensky & Prilleltensky, 2003; Seedhouse, 1997). Recognition of the layers of injustice and their basic importance as a health issue encourages reflexive practice and an evaluation of our own contributions to health-related practice.

Note

1. This section is a version of comments previously published in Stephens (2008).

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Author biography

CHRISTINE STEPHENS is an Associate Professor in the School of Psychology at Massey University, New Zealand. She teaches in the areas of health promotion

and community psychology. Her research interests are presently focused on the social connections, socioeconomic status and well-being of older people.
