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Culture, Race, and Health: Implications for Racial Inequities and Population Health

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Policy Points:

- Racism is a fundamental cause of health inequities and disease, which requires policy solutions that address this cause directly rather than only targeting mechanisms.
- Cultural systems, such as cultural racism, undergird the social conditions that shape racial inequities in health, including social and health policy decision making, governance, practice, and public reception.
- Policies targeting racial health equity benefit from integrating social theory and meaningful assessments of the social context concerning race, racism, and health.

Context: Improving the health of the total population may be insufficient in eliminating racial disparities in population health. An expanding commitment to understanding social determinants of health aims to address the social conditions that produce racialized patterns in health inequity. There is also a resurging and evolving interest in the influence of cultural barriers and assets in shaping racial inequities in health. The meaning and function of culture, however, remains underspecified.

Methods: This paper synthesizes analogous but fragmented concepts of cultural threat related to social and racial inequity as examined in public and population health, psychology, sociology, communications, media studies, and law. It draws on an existing typology of culture and social inequity to organize concepts related to cultural racism. Employing a transdisciplinary approach, the paper integrates multiple scholarly perspectives on cultural threat to frame cultural

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racism as cultural systems that promote false presumptions of white superiority relative to non-whites.

Findings: The lack of shared conceptual grounding and language regarding cultural threats to health hinders a more precise identification and measurement of cultural processes as well as comparisons of relative prevalence and influence of pathways linking cultural processes and social inequity. Evaluating intersections among culture, structures, and racism is a valuable analytical tool for understanding the production of social and racial inequities in health. To adequately address health inequities rooted in systemic racism, it is imperative to discuss the function of cultural racism in shaping population health in the United States.

Conclusions: Building a culture of health and achieving health equity requires that we assess cultural racism in a more meaningful way. Cultural processes are commonly referenced in health inequity scholarship, but the empirical literature generally lags behind the conceptual emphasis. A rich literature across disciplines has substantively engaged conceptualizations of culture and cultural processes, the importance of these processes as part of a system of racism, and mechanisms that may link cultural threats to health. When integrated, this literature offers essential insights for ways population health may address the complex issue of eradicating racial disparities in health.

Keywords: racism, population health, disparities, culture.

Efforts to improve population health and reduce health inequities may require a more significant and specific emphasis on the burdens faced by racial and ethnic groups.[1] Findings from Healthy People 2010, for instance, suggest that health disparities will persist unless increased attention is dedicated to racial and ethnic populations.[1] Health and medical literatures widely acknowledge the importance of social contexts in producing health inequities.[1-4] There is also a growing commitment to understanding and addressing social determinants or the "social and physical environments" that impact health and health inequity as described in Healthy People 2020.[5] It is argued here that understanding and addressing the social conditions that lead to racial inequities in health will require the complement of social theories that account for the significance of race and racism. The underutilization of social theories of race and racism have impeded efforts to reduce and eradicate racial inequities in health.[6] Failing to meaningfully incorporate these theories into

research and practice "reif[ies] racial differences and obscure[s] connections to socially structured inequalities."[7]

Racism is a fundamental cause of inequities in health.[3,6-15] According to the Fundamental Cause Theory, reducing socioeconomic differences between black and white Americans alone will not counteract persistent racial differences in health.[6] For many health outcomes, racial differences in health persist after accounting for differences in socioeconomic gaps and in some cases (eg, birth outcomes, quality of sleep, mortality risk), racial disparities in health are more pronounced for blacks at the higher ends of the socioeconomic spectrum.[16-20] Colen and colleagues find that upwardly mobile non-Hispanic blacks, as well as Hispanics, were more likely to report experiencing acute and chronic discrimination compared to those in more stable socioeconomic positions and that this difference in exposure accounts for a substantial proportion of the non-Hispanic black/white difference in health.[19] In addition to disparities in material resources, as well as medical and other forms of maltreatment, higher levels of acute and chronic stress may play an essential role in explaining these associations between race, socioeconomic status, and health.[6-15]

The consideration of race in relation to health has relied mainly on the utilization of race as a demographic variable to describe racial differences "without fully grappling with race and racism in contemporary society."[21(p7)] The fields of public and population health have been criticized for failing to integrate a comprehensive conceptual analysis of racism. Despite the staunch resistance of racial disparities in health to existing efforts targeting health equity[6] pathways linking racism and health in empirical research[8] or utilizing racism-informed methodological tools and recommendations for practice and policy interventions[11] have been undervalued and underutilized.

The current paper is concerned with cultural racism or cultural systems that contribute to the production of racial inequities in health. This discussion employs a transdisciplinary approach[22] to integrate scholarship that frames culture in a structuralist tradition. This research includes scholarship that evaluates the broad influence of cultural structures on behavior, institutions, history, and social structures;[22] the role of cultural structures in shaping social inequity;[23,24] and structural and cultural theories that center race and racism in relation to racial inequities in health.[6,8,25-30] This discussion also considers empirical research that directly and indirectly draws on cultural frameworks to

examine cultural threats to health. Integrating these perspectives helps to support the argument that understanding the "true power and persistence of violence, domination, exclusion and degradation"[23(p7)] requires a nuanced and sophisticated understanding of cultural structures[23] as well as the ways those structures intersect with race and racism.

Culture and Population Health

The Healthy People goals for 2020 have been expanded to more explicitly evaluate social determinants of health.[5] Social environments are defined as "the aggregate of social and cultural institutions, norms, patterns, beliefs and processes that influence the life of an individual or community."[5] This definition encompasses social, economic, and cultural attitudes; norms, policies, and institutions; and structural racism, language, mass media, and emerging media. This description of social determinants is an important foundational shift in national health priorities but raises some empirical challenges. Conceptual and empirical standards for measuring associations between employment and health, for instance, are relatively well established compared to assessing concepts such as cultural attitudes and norms or intersecting social and cultural institutions. The long-standing commitment to addressing racial inequities in population health has recently been met with an expanding discourse emphasizing the significance of culture,[31] but there appears to be an ongoing resistance to meaningfully engaging racism. Effectively addressing the function of "culture" in racial inequities in health will require explicit conceptual and empirical links between cultural systems and macro-level inequity,[24] as well as an explicit conceptual grounding in social theories of racism.[6-12]

Cultural Racism and Population Health

Two broad approaches for representing cultural racism in health equity scholarship are highlighted in this section. The first approach embeds culture and cultural racism within multidimensional and structural models of racism,[12,32-42] and the second more clearly delineates cultural racism as a distinct dimension of racism.[9,10,26,33,43-48]

Structural and systemic models of racism are concerned with the social production of racial inequities, emphasizing sociological levels of racism that encompass institutions and policy (eg, social segregation, prison industrial complex) as well as other cultural phenomena (eg, media portrayals, social ideologies). Krieger describes structural racism as societies that reinforce racial inequities reflected in history, interconnected institutions, and culture.[37] Understanding how culture intersects with social structures to sustain systems of social, racial, and economic inequity is essential to eliminating racial inequities in health.[26] The following discussion examines ways cultural racism uniquely maintains structural inequities and also serves to obscure the significance of race to those inequities, effectively producing racially neutralized assessments of social inequity.[10] Structural racism encompasses both institutional and sociocultural processes that intersect but likely operate distinctly in producing health inequities. For instance, threats to health produced by formal institutional policy may function differently than cultural threats expressed through informal institutional practices or mass media.[25,26]

Cultural Racism Is a Cultural System

Multidimensional framings of racism emphasize the importance of multiple, intersecting interpersonal, structural, and cultural forms of racism.[9,30,46,49] Within these frames, cultural racism is generally described as derogatory cultural messaging that expresses beliefs of relative status and rights for different racial and ethnic groups. In his 1956 speech "Racism and Culture," Fanon states that we must reject the treatment of racism as a mental quirk or psychological flaw and that the consequences of racism should be observed on the cultural level.[50] He describes cultural racism as the deliberate and manipulative use of "enslavement doctrine" to systemically oppress non-whites and establish an assumption of white cultural superiority. A popular contemporary definition describes cultural racism as "societal beliefs and customs that promote the assumption that the products of white culture (eg, language, traditions, appearance) are superior to those of non-white cultures."[47] In both examples, white supremacy is framed as a broad sociocultural system as opposed to a personal ideology or fringe social movement.[32,33,39] According to Omi and Winant,[51] race is

dynamically constructed through social, economic, and political forces. Ansley describes white supremacy as whites having overwhelming control of "power and material resources, conscious and unconscious ideas of white superiority and entitlement . . . across a broad array of institutions and social settings"[32(p1024)] as opposed to being something possessed by individuals.

In each of these framings, cultural racism encompasses values, ideology, and practices that contribute to systems of racial oppression and, importantly, often center whiteness in evaluations of racism and racist frames. These perspectives are integrated here to define cultural racism as cultural systems that visibly and invisibly ground assumptions of white superiority and power across institutional, cultural, and social environments. It should be noted that while the dynamic of a dominant social group controlling cultural norms and processes is not unique to the United States, the myth of a meritocratic society combined with invisible structural barriers promoting disproportionate access and prosperity alters the function of cultural control in the US context. The current discussion examines this cultural dynamic as it uniquely manifests in the United States.

Cultural Racism Is Socially Toxic

Cultural racism may also distinctly foster toxic social environments that serve as a chronic exposure of psychosocial stress, directly impacting disease processes and health. Tatum likens cultural racism to smog that is both thickly visible and so ordinary that it becomes as if we are "breathing it in."[43(p6)] The socio-ecological concept of social toxicity describes threats experienced during childhood (eg, exposure to violence, traumatic experiences, and social dysfunction) as "social and cultural poisons,"[52] comparing them to environmental pollutants. The social environment can be so socially and culturally polluted that the "mere act of living in society is dangerous to the health and well-being of children and adolescents"[52] and arguably continues to pose a threat well beyond childhood. This more atmospheric form of cultural racism may serve a distinct role in producing racial inequities in health, perhaps significantly contributing to the weathering of physiological systems, psychological stress, and other observed racial disparities in health across the life course.[2,8,27,52,53]

Cultural Racism: Analytical Frames for Population Health

The current discussion of cultural racism privileges structural frames and emphasizes ways in which cultural and other structural processes and institutions intersect to produce racial inequity. From this perspective, culture is relational and dynamic. Social actors are influenced by culture but also "shape, use and recreate culture."[26(p72)] The importance of social actors, however, is not their individual beliefs and acts but rather the amassed individual behavior and shared social meanings that produce cultural systems. Accordingly, this discussion highlights structural and cultural (eg, collective frames, structural competence) as opposed to the individual (eg, personal beliefs or bias, cultural competence) analytical concepts and solutions.

Drawing from an organization of cultural repertoires proposed by Hall and Lamont,[24] the following discussion of cultural racism is organized into three categories: *symbolic boundaries* (proximity to center or margins of a community), *status hierarchies* (implicit principles determining social status and prestige), and *collective imaginaries* (representations composed of symbols, myths, narratives). Specifically, symbolic boundaries include identification and rationalization, racial frames and ideologies, stereotype threat, structural stigma, and aggregated bias. Status hierarchies focus on institutional practice, and collective imaginaries examine racialized symbols, imagery, and language. The use of these categories represents one approach for structuring assessments of cultural racism and for organizing disconnected bodies of scholarship addressing cultural threats to health.

Symbolic Boundaries

Identification and Rationalization

There are many processes through which cultural structures operate to influence racial inequities in health. Lamont and colleagues emphasize two cultural processes that maintain the production of social inequity: identification and rationalization, which they describe as ordinary processes that shape patterns of social inequity.[54] Hicken and colleagues apply these concepts to frame connections between cultural and

structural racism and racial inequities in health.[10] *Identification,* or the processes by which we delineate social actors and groups, includes the social meanings we attach to race and racialized bodies (racialization)[51] as well as determining the race-based values or basic stereotypes associated with those actors (stigmatization).[10,51,54] *Rationalization* encompasses both standardization and evaluation.[54] Whereas *standardization* refers to institutional efforts to standardize social norms and rules that are presumed to be fair and equally accessible across social groups but are rooted in historical inequities, *evaluation* refers to processes used to determine social merit or value. In conjunction, these processes, often invisibly, serve as the foundation for our social scripts, narratives, and ideologies around race.[51] Specifically, the processes are used to construct ahistorical views of racialized social patterns, assuming that social norms and rules are equally exploitable across groups and thus social status (or dominance) is a matter of individual merit and commitment rather than structural inequities.

Racial Frames and Ideologies

Racial frames may be broadly defined as schemas shaped by "collective memories and histories" that are used to guide meaning-making, action, and more specific attitudes and behaviors for a range of racial issues.[34(p8)] These frames underlie or may be considered the driving force behind a variety of cultural processes and practices. The white racial frame and color-blind racism focus on the rationalization of racial status by whites and are important guides for examining how cultural and institutional processes contribute to racial inequities in health.[34,45] The white racial frame encompasses a "broad and persisting set of racial stereotypes, prejudices, ideologies, images, interpretations and narratives, emotions, and reactions."[34(p3)] This framing includes, for instance, historical interpretations emphasizing whites' virtuousness or their being "more American, moral, intelligent, rational, attractive and hard-working than other racial groups."[34(p94)] Color-blind racism is an ideology that attempts to diminish or deny the significance of race in shaping social standing[45] and in turn implies that social standing is grounded in individual, group, or cultural failings of the lower status group. Abstract liberalism is a frame that elaborates on this concept and speaks to exploiting concepts of equal

opportunity, humanity, and sameness to ignore structures that maintain racial inequity.[45]

Racial frames and ideologies are collective pathologies rooted in "deep structural realities of this society's racial oppression"[34(p3)] and not merely "mental quirks" or "psychological flaws."[50] This approach is a deliberate paradigm shift from portraying racism as a problem of individualized racial attitudes in the form of prejudice, bias, and stereotyping. Racial frames can impact health through shaping (often invisibly) behavior and decision making, implicating institutions ranging from health care to criminal justice systems. Color-blind racism, for instance, allows individuals to form an "impregnable yet elastic ideological wall that barricades whites off from America's racial reality."[45(p241)] Concerning health, employing this sort of racial frame can result in locating the "problem" of disease in the bodies and behaviors of oppressed groups, while ignoring structures and processes that buoy relative health advantages among whites.[7] This approach, described as a "bio-racist frame,"[7] implies that the cause of disease lies in immutable differences between racial groups.[8] Griffith and colleagues describe this as "cultural schemas," or the race-informed story lines used to interpret health disparities and related policy.[26] Key decision makers established health-related policy in a context of race-conscious (or racially neutralized) ideologies that also reflect broader social and cultural norms.[26] Powerful policymakers also establish educational and professional norms of practice[55,56] to determine whether to focus on universal or "color-blind" health policies to reach population health goals versus targeting resources to racial and ethnic populations directly.[1] The influence of cultural schemas is also evident in the tendency to emphasize individual or group attitudes and behavior without considering the contributions of social structures, histories of racism, or struggles against oppression to negative health outcomes (eg, structural barriers to health care, education and exposure to noxious environments).[7,45,57]

Stereotype Threat, Structural Stigma, and Aggregated Bias

Cultural processes are an apparatus that automates racially biased beliefs, discriminatory messages, and behavior.[46,58] The social scripts produced through these processes may function as a form of situational threat.

Steele, who famously referred to stereotypes as a "threat in the air," suggests that these situational cues are present (and threatening) even if not actively or explicitly espoused.[58] Simply being in an environment in which others may view you stereotypically can pose a threat to health, well-being, and behavior.[59,60] Blascovich and colleagues found, for instance, that in conditions of heightened stereotype threat, African Americans exhibited larger increases in mean arterial blood pressure during an academic test in addition to performing more poorly than African Americans in lower threat situations.[61] Stereotype threat may also influence social interactions in health care settings, compromising service, care adherence, and physiological, psychological, and self-regulatory processes.[62]

Situational threats have also been assessed in the form of aggregated scores of implicit racial bias as well as Google searches for the "N-word" organized by geographic area.[63,64] Both approaches are believed to serve as proxies for anti-black sentiment. Higher geographic concentrations of anti-black sentiment have been associated with all-cause mortality rates for blacks, specifically heart disease, cancer, and stroke,[63] as well as black-white health disparities in access to health care and rate of death due to circulatory disease.[64] Area-level anti-immigration sentiment has also been prospectively associated with mortality risk.[65] In this study, anti-immigration sentiment was not associated with mortality risk for whites or blacks regardless of nativity status, but greater mortality hazard was observed for US-born respondents in the "other race" category, which was primarily composed of Asian or Hispanic respondents. The authors speculate that US-born respondents may be more exposed to these narratives for longer periods and during sensitive periods of development (eg, adolescence) with the racialized narratives assessed.[65] While these studies do not establish any causal relationship, they provide an empirical basis for associations between vicarious exposures to racism and health.

Models of structural stigma help explain how situational threat conditions (eg, aggregated bias) may translate into threats to health. Structural stigma or society-level conditions, cultural norms, and institutional practices constrain the opportunities, resources, and well-being for stigmatized populations and thus threaten health through multiple mechanisms.[66] This includes (1) the production of chronic stress, which can increase risk for adverse health outcomes such as cardiovascular disease, diabetes, mental disorders, and mortality risk, (2) impacting the

behavior of high-status individuals whose behavior may contribute to systemic disadvantage, for example, reductions in quality health care, and (3) impeded access to structural, interpersonal, and psychological resources that would otherwise support health. The promulgation of structural stigma is "entirely dependent upon social, economic and political power" including control of cultural resources.[66(p17)] The control of culture and cultural processes ensures recognition and acceptance of labels as well as the denigration of an "other," and it influences status, access to resources, and social animus.[66] Thus, the threat of stereotypes and the function of structural stigma rely on a public creation of a visible "other" whose virtues of color and culture (a) appear to be opposed to the dominant group and (b) go unchallenged as part of the social order—that is, they function invisibly.[67]

Although structural stigma and these assessments of situational threat are not explicitly framed as capturing cultural processes, they are used with the intent of capturing associations between macro-level social forces and health. Grounding this work in framings of cultural racism may provide valuable insights into cultural pathways contributing to health and health disparities. Although cultural processes are stable over time, specific forms of cultural expression shift to accommodate contemporary cultural mores,[10] and thus the cultural constructs we measure are also dynamic. For instance, Bonilla-Silva suggests that following the American civil rights movement cultural shifts contributed to decreased expression of blatant negative racial sentiment in exchange for verbal strategies that code or diminish the significance of race and racism.[45] Utilizing cultural frameworks that organize the principles underlying these measurable constructs offers a more stable guide for evaluating associations between cultural threat and health.

Status Hierarchies

In addition to formal laws and regulations, institutions have informal cultures that sanction norms for appropriate behavior and shape tacit agreements for perception and meaning-making. Harrell describes this as the *sociopolitical context* or racism manifested in the "nature of political debate and public discussion about race, racial ideology, policies and practices" that occur within institutions.[9(p43)] This is consistent with Feagin and Bennefield, who apply the white racial frame to medical and

public health institutions, emphasizing the ways in which "racist ideologies, images, narratives, emotions and inclinations to discriminate in practice" contribute to racial inequities in the provision of health care.[55(p11)] The authors also describe the ways in which notions of white superiority seep into the practice of public health efforts to "free people of color from 'destructive health habits'" to "convert people overseas to 'better' western folkways,"[55(p13)] and is also evident in the centering of whites (and dominant white culture) as the basis for establishing norms for health. Intentionally grounding racial disparities research and interventions in cultural and structural frameworks would, for instance, emphasize structural barriers (eg, access and quality of fruits and vegetables, educational and employment opportunities)[7] and cultural systems (eg, reductive racial narratives regarding health behavior) and would evaluate the related implications for health behavior and disease processes.[7,10]

Cultural symbols and processes also help to construct social memories, narratives, and norms, such as historical representation in textbooks, monuments, and conventions regarding language, values, dress, and behavior.[39,69] The sanitization of historical narratives, such as dilution and mis-education of atrocities of slavery, is reflective of the use of culture to misshape social memory.[70] Mohatt and colleagues suggest that contemporary cultural representations and symbols of shared historical traumas such as colonized indigenous groups and cultural genocide intersect with personal and public narratives of these traumas to sustain emotional and psychological wounds.[71] They, in turn, frame contemporary narratives of historical trauma as a significant threat to individual and community health.[71] References to racial microaggressions often emphasize subtle slights that occur between individuals, but "environment indignities" are also an important component of racial microaggressions.[72(p2)] This includes the ways cultural symbols and norms communicate racial hostility and degradation, such as emphasizing meritocracy while minimizing structural barriers, pathologizing non-white cultural values and communication (eg, disparaging certain styles of dress or behaviors), and foregrounding physical symbols of presumed superiority (eg, Confederate flag, university buildings and statues honoring only white men). The positioning of white cultural values as superior or normative perpetually positions non-whites as inferior "others" and may serve as a source of psychosocial stress in addition to informing racial ideologies that influence behavior and decision making. The use of

acculturation to explain Latino health, for example, has been criticized for centering white European culture as the norm for individual cultural shifts and locating "culture within individuals."[73(p38)]

Collective Imaginaries

Collective imaginaries are used to reference the myths and symbols we use to construct our understanding of our society's past, present, and future and also helps to define the boundaries and capabilities of a society's membership.[24] Hall and Lamont[24] contend that collective imaginaries are an important analytical tool for social change given the role in shaping values, action, community, and the basis for society's institutions. In linking collective imaginaries to health, Hall and Lamont suggest that the social inequities that undergird inequities in health are sustained by cultural structures that define worthiness and in turn shape resources and actions within and between social groups. The following discussion highlights the significance of language and mass media in shaping race-based definitions of social worth.

Language

Perhaps the broadest and most complex category of cultural communication involves language, discourse, and rhetoric. In this category, intricate patterns in language that rationalize the racial status quo and undermine attempts to address racial inequities preserve racial oppression.[45] De-racialized rhetoric or color-blind ideologies are also said to distort the reality of racial oppression, diminish empathy, and hollow the pragmatics of equal opportunity.[45,67] López contends that racial codes (eg, "inner city," "thug," "states' rights") are used to elicit negative racial sentiment surreptitiously and to reinforce negative racial stereotypes and ideologies.[74] Former Speaker of the House Paul Ryan, for instance, discussed strategies for addressing poverty, stating that there is a "real culture problem" for "lazy" men living in the "inner city," casually citing Charles Murray for support, whose work controversially claims African Americans are less intelligent than whites due to genetic differences.[75] Some discussions of cultural racism emphasize the mechanisms that communicate racist ideologies or how racist ideologies shape cultural systems.[9,15,46] These approaches highlight communication platforms,

such as television and film, used to disseminate beliefs about the social status of different racial and ethnic groups.[15,46] The use of imagery, symbolism, and language that embed notions of black inferiority and white superiority are cultural tools that persistently devalue, marginalize, and subordinate non-white racial populations.[76]

Mass Media

Cultural expressions of racism can occur in any institution or context.[9] Mass media has historically played a significant role in cultural communication.[76] An estimate that adults living in the United States now consume an average of nine hours of media per day magnifies the contemporary importance of media.[77] Harrell identifies the cultural-symbolic context of racism "expressed in images and impressions of non-dominant racial/ethnic groups that are portrayed in the news and entertainment media"[9(p43)] as a distinct context for racism and racism-related stress. Symbolic boundaries, status hierarchies, and collective imaginaries are mechanisms that assign value and meaning to race and racial groups and are perhaps dominantly constructed and maintained in media contexts. These mechanisms include media bias, such as the under-, narrowly, and biased representations of blacks, Latinos, Asian Americans, Native Americans, and other racial and ethnic minority groups who are often invisible or portrayed in a narrow range of negative roles such as "buffoons, criminals, or hypersexual non-professional individuals."[76(p187)] The implications of media representation are not merely unfair or inaccurate but may also play a significant role in shaping public health–related beliefs, bias, and behavior and may also function as a significant source of psychosocial stress that is directly associated with health status and disease processes.[46]

Characteristics of media portrayals can influence public perception and judgment. The activation of negative racial stereotypes, which may occur when exposed to racially biased or disparaging media, can influence behavior, cognition, and decision making.[78] The criminal justice literature provides two clear examples of this dynamic. Increased support for punitive crime policy (eg, stop and frisk practices), as opposed to policies addressing structural factors, has been associated with the overrepresentation of blacks as criminals in news media coverage.[79] An analysis of newspaper stories featuring defendants convicted of capital crimes over a 20-year period indicates that blacks were more likely to

(a) be implicitly portrayed as apelike (eg, described using "monster," "prowl") and (b) have been executed when portrayed using animalistic terms, even after adjusting for other factors contributing to sentencing such as crime severity.[80] Consumption of racist representations and ideologies via media may also have a more direct effect on health and health behaviors.[46,81] A modest body of research has demonstrated that observing or reading about racism is associated with increases and delayed recovery in systolic and diastolic blood pressure and salivary cortisol, as well as changes in heart rate variability among blacks.[60,82,83] These findings are consistent with framings of cultural racism as a source of psychosocial stress that engages and potentially taxes psychological and physiological stress response systems and ultimately health status.[10,26,83]

Research and Policy Implications

There are multiple pathways linking racism and health, including economic injustice, psychosocial trauma, behavior, differences in health care provision, and the activation of disease processes.[25,28] Although the empirical literature examining associations between cultural racism and health is relatively sparse, the long-standing assertion that cultural racism undergirds other forms of racism (eg, interpersonal, structural) suggests that it may function along similar pathways (eg, compromised access to material resources) concerning health. These overlaps should not suggest, however, that cultural racism is a secondary consideration but instead functions at the root of multiple dimensions of racism and warrants direct consideration. The following discussion of implications for policy and research focuses briefly on recommendations in three areas: (1) health policy and institutions, (2) psychosocial stress, and (3) measurement.

Health Policy and Institutions

Structural and cultural frameworks emphasize the historical and sociopolitical roots of racial health disparities. Scholarship applying Critical Race Theory to health equity and public health has charged health professionals with not only documenting population health burdens but also engaging multiple sectors to address the role of racism in producing health inequities.[8,83,84] Meeting this charge will inevitably require

critical reflection throughout the population health ecosystem and holds public health practice, scholarship, and policies accountable for their role in the perpetuation as well as the resolution of racial inequities in health.[8]

Medical and health institutions are important contexts for considering the effects of shifting institutional policy and culture, including the use of policy to shift institutional culture in the ways racial health disparities are framed and addressed. These shifts may include place-based, multisector, and equity-oriented initiatives (eg, community-based interventions targeting disenfranchised groups), multisystem policy reform (eg, multisector partnerships to concurrently address judicial parity and health care service), and reforming the training of health professionals.[25] Each of these targets requires a cultural shift in the framing of social determinants and the perceived scope of responsibility of health institutions. Hall and Lamont contend that "governments can improve the health of the population not only with policies directly aimed at it but by configuring a much wider range of policies to promote or redistribute social resources."[24(p17)] These policies may direct attention to the ways cultural processes intersect to produce racial inequity and to determine ways to buffer against these adverse effects.

Bailey and colleagues refer to culture as systems of inequality, highlighting cultural humility—challenging the tendency to center one's values and beliefs—and cultural safety—shifting power to the patient to define health and determine care—as critical cultural features of structural racism interventions.[25] There is also a push against relying on "cultural competence,"[31] or sensitivity to cultural norms within social groups, as an adequate representation of cultural threat.[25,54,55,85] Metzl and colleagues posit that medical education should emphasize structural competence, or an awareness of the ways "culture" and "structures" produce inequity, as opposed to an individual's awareness of cultural differences across groups or medical settings.[56] Medical education has also been criticized for treating social determinants of health as "facts to be known" rather than as "conditions to be challenged and changed" and talking about "poverty but not oppression, race but not racism."[85] One specific charge is for health and medical education to reorient their focus to structural competence, or the ability to meaningfully engage the structural roots of racial health disparities.[56,85] In practice, this cultural shift is effective only if complemented by structural support and the resources necessary to address racial inequities.[10]

Psychosocial Stress

In addition to being a system of processes that shape collective narratives and behavior, cultural racism arguably functions as a source of psychosocial stress as well. For instance, chronic denigration and dehumanization, particularly when communicated through cultural channels (eg, mass media),[86] may contribute to racially toxic social environments that directly threaten health. There is some evidence that virtual exposure to stressful racist encounters (eg, viewing racist material) negatively influences physiological reactivity among blacks.[28,83] Given the possibility of this influence, sociological shifts in access and use of media should change how we assess exposure and responses to racism-related stress as well as subsequent effects on health. These conditions change the landscape for the frequency and chronicity of exposure to racism, potentially compounding the effects of racism in other forms as well as posing a distinct threat to health. Further developing research that examines cultural racism as a source of psychosocial stress would also enhance our current understanding of pathways linking racism to health.[14,15] We currently know very little about the effects of exposure to cultural racism on psychological and biological processes that may affect health and health-related behavior, and thus the connection to racial disparities in health also remains unclear.

Measurement

The ambient nature of cultural racism can make it challenging to measure.[48] Effectively integrating cultural racism into empirical research examining racial inequities in health will require both a reimagining of existing measures as well as measurement innovation. Hicken and colleagues identify several research priorities for future research in this vein, including evaluating links between structural and cultural racism, the intentional use of cultural frameworks to guide the use of existing measures, and developing innovative measurement tools.[10] Establishing links between structural and cultural racism is imperative to reveal how cultural processes obscure the role of structures and institutions in the production of racial inequities in health.[10] The grounding of empirical research in cultural frameworks also necessarily complicates the ways we assess social and structural context. Employing this lens should shift, for instance, how we evaluate the contributions of social

spaces and institutional policy to observed racial patterns in health and disease.

The current discussion also highlights several examples of creative approaches for capturing situational threat or cultural norms that can contribute to (or protect) health among marginalized groups leveraging existing data.[63,68,87] This research does not, however, generally center cultural frameworks, which limits establishing connections to structural and institutional racism and also hinders the development of a cohesive body of literature.[10]

The development of measures specifically designed to assess various forms of cultural racism is also needed. Patterns and estimates of the prevalence of various collective imaginaries may be assessed, for instance, by leveraging data science approaches. Understanding the potentially harmful consequences of managing or coping with cultural racism is also an important area for development. Empirical evidence that conscious perception or attributions to racism are not necessary to produce deleterious effects becomes particularly important in this context.[28,88] It may be ineffective, for instance, to rely primarily on self-report measures to assess exposure or coping strategies in response to cultural racism. Research that assesses the socio-behavioral as well as physical effects of passive media consumption and media-based interventions[46,81] is ripe for further development. Individuals do, however, consciously perceive and respond to threats of cultural racism.[88,89] Vigilant coping—such as actively monitoring speech and dress, minimizing being perceived as a threat, or otherwise regulating one's exposure to whiteness—is a behavioral by-product of attempts to adapt to ubiquitous structural and cultural racism and is a source of racism-related stress.[10,89] Although functional in some ways (eg, avoiding interpersonal conflict), vigilance may nonetheless threaten health. Higher levels of vigilance have been linked to higher BMI and waist circumference,[90] hypertension,[91] and poorer cardiovascular functioning[92] and sleep.[93]

Conclusions

Building a culture of health requires that we directly and meaningfully assess culture. Cultural processes are commonly referenced in health inequity scholarship, but the empirical literature generally lags behind the conceptual emphasis. A rich literature across disciplines has

substantively engaged conceptualizations of culture and cultural processes, the importance of these processes as part of a system of racism, and mechanisms that may link cultural threats to health. When integrated, these bodies of literature offer essential insights into ways population health may examine culture in service of addressing the complex issue of eradicating racial disparities in health.

Thiong'o asserts that the struggle against oppression and exploitation is most powerfully resisted and maintained on cultural terrain.[94] The current discussion examines analogous concepts across multiple disciplinary perspectives on cultural threats to social equality and health. Structural models of both culture and racism are employed to highlight cultural processes that have the power to covertly and overtly threaten health through influencing control of material and social resources as well as the production of chronically toxic social environments that may be psychologically and biologically taxing. An enhanced focus on cultural racism complements the substantial empirical literature linking discrimination and health while also contributing to long-standing calls for more comprehensive assessments of racism in relation to health.[12,15] This framing of cultural racism also provides theoretical grounding to broadly support racial health disparity research that aims to describe racial patterns in health as well as understand and address the social conditions of race that produce these inequities.

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