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Racism, Health, and Politics: Advancing Interdisciplinary Knowledge

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Racism and health predominated political agendas across (and beyond) the United States in the spring of 2020. The simultaneous calamities of the COVID-19 pandemic and the murder of George Floyd underscored the urgency and interconnectedness of racism and health. Even as COVID-19 was disproportionately devastating Black, Latina/o/x/e, Pacific Islander, and Native communities, people across the United States were participating in massive, historic protests against racialized state violence (Barber 2020, 2021; Buchanan, Bui, and Patel 2020; Escobar et al. 2021; Lopez, Hart, and Katz 2021; Putnam, Chenoweth, and Pressman 2020). In this context, racism was declared a public health crisis, states and cities discussed policy solutions, institutions of all stripes had moments of "racial reckoning," and partisan politics became even more divided over whether and how to address racism (Andrews 2021; Blake 2021; Vestal 2020; Yearby et al. 2020).

Notwithstanding the urgency of these events, the intersecting forces of racism, health, and politics were central features of American life long before the spring of 2020. Throughout US history, political institutions, markets, and social structures have developed, maintained, embodied, and enforced practices of racial categorization and differentiation (Bailey, Feldman, and Bassett 2021; Bateman, Katznelson, and Lapinski 2018; King and Smith 2005; Omi and Winant 2014; Rothstein 2017; Williams 2003). This has been particularly evident in the realm of health, where policies, politics, laws, and ideas have produced racial inequities (Bailey and Moon 2020; Hahn, Truman, and Williams 2018; Hardeman, Hardeman-Jones, and

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Medina 2021; Mateo and Williams 2021; Michener 2020; Phelan and Link 2015; Pirtle 2020; Wailoo 2014; Washington 2006; Williams and Collins 2001; Williams, Lawrence, and Davis 2019). Systems of racial stratification shape whether you live in a neighborhood that will promote your health, have access to resources to sustain your health, have daily experiences that will threaten your health or make you vulnerable to illnesses that will weaken your health, and they influence the political processes that can be activated to protect your health (Carter et al. 2017; LaVeist 1992; Mateo and Williams 2021; Wailoo 2014; Wallerstein 1992; Williams and Collins 2001; Williams and Mohammed 2013; Zelner et al. 2021).

Though many of these social processes are now widely recognized as drivers of health and health inequities (IOM 2003; Smedley, Stith, and Nelson 2003), they have proven resistant to change (Lurie 2005; Zimmerman and Anderson 2019). Despite advances in knowledge about racial health inequities (Kneipp et al. 2018), progress toward effective solutions has been slow and sometimes inverted. Politics is a key reason for the chasm between what we know about health and racism on the one hand, and what we have (and have not) changed on the other. This dynamic is vividly illustrated by the COVID-19 pandemic. In response to the emergence of the novel coronavirus, researchers developed abundant scientific knowledge about vaccines, masking, other mitigation efforts, social determinants of health, and structural determinants of racial health inequities. Such knowledge has proven crucial for identifying strategies to fight the pandemic and related inequities that have disparately burdened low-income communities and communities of color (Akee and Reber 2021; Hooper, Nápoles, and Pérez-Stable 2020; Ong et al. 2020). Yet the reach and influence of science was constrained by politics. Politics emerged in partisan divisions over policy responses to COVID-19, ideological rifts over the role of the government, the politicization of data collection, controversies over the interpretation and veracity of scientific research, and much more (Clinton et al. 2021; Gadarian, Goodman, and Pepinsky 2021; Michener 2021). Nearly all these political battles have implications for racial (in)equity. In this way, COVID-19 highlights integral connections between racism, health, and politics (Bailey and Moon 2020; Hooijer and King 2021).

Such connections are evident in many policy domains. For example, scholars who study immigration have identified critical linkages between politics, processes of racialization, and health (Kline 2019; LeBrón et al. 2018a; LeBrón et al. 2018b; LeBrón et al. 2019; Lopez 2019; Cruz Nichols,

LeBrón, and Pedraza 2018a, 2018b; Novak, Geronimus, and Martinez-Cardoso 2017; Pedraza, Cruz Nichols, and LeBrón 2017; Young, Beltrán-Sánchez, and Wallace 2020). Similarly, a small but burgeoning literature on Medicaid policy has amplified the tripartite significance of racism, health, and politics in that arena (Franklin 2017; Grogan and Park 2017; Lanford and Quadagno 2016, 2021; Leitner, Hehman, and Snowden 2018; Michener 2018, 2020, 2021; Snowden and Graaf 2019).

These examples only scratch the surface. Close examination of many policy areas underscores the imperative and intersecting importance of racism, health, and politics. Nevertheless, popular and scholarly discussions of these topics tend to be siloed. Substantive engagement with the health implications of racism is often divorced from larger questions about politics and policy. At the same time, scholarship centered on politics and policy is often disconnected from the realities of structural racism in health—the ways it is perpetuated through public health and health care systems, experienced by racially marginalized populations, mitigated through policy channels, and more.

Recognizing these lacunae, this special issue of the *Journal of Health Politics, Policy and Law* assembles a leading group of multidisciplinary scholars. Bringing together researchers who might otherwise operate in separate spheres, the special issue augments and integrates scholarship that advances knowledge of health, racism, and politics across disciplines and fields of study.

Conceptual Clarification

To situate and contextualize the topical focus of this special issue, we offer some conceptual clarification. The complexities, confusion, and even convolution endemic to discourse around race and racism make this an important first step. Health and politics are also variably comprehended and worth elucidating. Though the articles in this special issue proffer (either explicitly or implicitly) their own distinct conceptualizations, we lay complementary groundwork to facilitate coherence and critical understanding.

Racism

We define racism as the interconnected social, political, economic, and ideological systems that create, maintain, and exacerbate stratification in access to opportunities and resources based on a group's or individual's

location in a socially constructed racial hierarchy (Bonilla-Silva 1997).[1] Social science literature identifies several key components of racism. Racialization is one fundamental component, illustrating the relational nature of racism. Through processes of racialization, societies establish differences between social groups, create boundaries between the groups, and assign differential value to these groups on the basis of race (Bonilla-Silva 1997; Omi and Winant 2015; Schwalbe et al. 2000). In turn, these processes create subordinate and dominant racial groups, and social actors and institutions leverage differential value to justify the stratification of life chances based on race (Bonilla-Silva 1997; Omi and Winant 2015; Schwalbe et al. 2000).

Across race-conscious societies, racism is context- and time-specific (Bonilla-Silva 1997). While systems of racial stratification have historical roots, they rely on contemporary processes to shape each racial group's position in the racial strata (Bonilla-Silva 1997). Though race is often the most salient social category in race-conscious societies, other social statuses and identities, such as gender, class, and nativity, also shape one's location in those racial strata and one's experiences of racism (Bonilla-Silva 1997; Collins 2015; Crenshaw 1991). Race is also a unit of identity and group membership (Bonilla-Silva 1997; Nagel 1994). Experiences of racism are not unidirectional: groups and individuals are continuously navigating racial classifications and racism, and they are working to assert, attenuate, resist, and/or transform racial categories and hierarchies.

Racism functions at multiple socioecological levels including across systems, institutions, and ideologies, and at the individual level (e.g., individual beliefs, behaviors, or practices) (Gee and Ford 2011; Jones 2000). Notably, racism can operate in the absence of individuals who perpetrate interpersonal racism (Bonilla-Silva 1997; Jones 2000). Accordingly, the elimination of racial inequities requires addressing structural racism: the interconnected systems, institutions, ideologies, and processes that create, preserve, and augment discriminatory ideologies and values and that in turn shape access to life chances and resources and that structure inequities across racial groups (Bailey, Feldman, and Bassett 2021; Bonilla-Silva 1997; Gee and Ford 2011; Jones 2000, 2003).

This special issue features scholarship focused on understanding how structural racism shapes conceptualization of the drivers of racial

1. Under the umbrella of "racism," we include related terms such as structural, institutional, and systemic racism. All these point beyond individual acts of discrimination or personal sentiments of prejudice and toward the systems and structures that perpetuate racial inequality (which include and rely on individual ideas and actions but amount to much more than the sum of those individual parts).

differences in health, the collection of public health data to inform the monitoring of racial health inequities, the politics of health outcomes, and the policies that affect health and well-being.

Health

In 1948, the World Health Organization defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization 2021). This oft-cited definition highlights the importance of a multidimensional understanding of health. Yet this definition still reflects Western medical models by characterizing "health" as the absence of a disease or illness.[2] Moreover, the World Health Organization's conceptualization of health focuses narrowly on the health of individuals, overlooking community and population health. In contrast, Indigenous definitions of health highlight the limits of medicalized conceptualizations. While definitions vary, notions of health articulated by indigenous communities often offer more holistic perspectives. Such definitions may link individual health with the well-being of family, kin networks, and community, and may incorporate the natural world and sociocultural factors into understandings of physical, mental, spiritual, and ecological well-being (Arquette et al. 2002).

In this special issue we view health as pertaining to individual, community, and population-level well-being, and we embrace conceptualizations of health as a process. Several of the empirical analyses featured in this special issue incorporate a life course perspective (Halfon and Hochstein 2002) that recognizes the embodiment of social inequities borne out of structural racism, the intergenerational transmission of embodied inequities, short- and long-term health outcomes, and how inequities may accumulate or intersect to shape health trajectories. Two articles in this special issue (Robinson and Pearlman 2021; Rodriguez et al. 2021) examine health outcomes that are highly sensitive to acute life events, such as birth outcomes. One study (Morey et al. 2021) chronicles cases of and deaths due to COVID-19, an emerging infectious illness that can have enduring physiological effects. Another study (LeBrón et al. 2021) explores how navigating racialized identities can shape mental and physical well-being in the short, intermediate, and longer term.

2. The COVID-19 pandemic may spur some theorists and practitioners to revisit this definition of health, particularly as a larger share of the population lives with the intermediate- and longer-term physical, mental, and social effects of COVID-19.

Politics

In addition to studying health as a process, the articles in this special issue demonstrate the value of approaching politics as a process. Though politics is often understood in terms of elections and voting, it is much more than an electoral or behavioral outcome. Politics is a process through which policies and other institutions shape a variety of life outcomes, including health. Political processes at the national, state, and local levels structure the economic and social outcomes that create (or impede) the conditions necessary for health. Politics directly influences core elements of the public health system (e.g., through appropriations, regulation, administration, subsidization), including the resources and human infrastructure necessary to support community-based prevention efforts; monitor the health of the population; address social determinants of health and health inequities; and develop and implement timely, robust, equity-centered interventions during public health crises. Politics also affects the health care system through myriad policies that impact health care workforces, health care organizations (e.g., hospitals, clinics), corporate actors (e.g., insurance providers, pharmaceutical companies), and more. Further still, political processes influence indirect factors that are critical to health and well-being, including the accessibility and generosity of social welfare benefits, the prevalence of conditions that threaten health (e.g., poverty, gun violence, air pollution, lead poisoning), and the cultivation of conditions that foster health (e.g., safe neighborhoods, clean air, broad access to social and material resources).

These political processes operate through a range of actors and governance institutions. Relevant actors include political elites (e.g., the president, state governors, state and local legislators), bureaucrats (at agencies such as the Centers for Disease Control and Prevention, the Food and Drug Administration, the Centers for Medicare and Medicaid Services, etc.), interest groups (e.g., hospital associations, health advocacy groups), and ordinary people. These and other actors operate within an array of institutions that shape and constrain their choices and behavior. Such institutions range from large and encompassing (political parties, federalism) to concentrated and focused (local health departments, "street level" public-serving bureaucracies, municipal governments, community-based organizations). Actors and institutions across these levels and venues drive political processes that shape health, and they do so in ways that are affected by structural racism, with marked implications for racial (in)equity. Examples of this abound. Federalism is a profoundly racialized institution (i.e., it

reinforces processes of racial stratification), with consequences for health equity (Michener 2018). Political parties are also racialized institutions (Mason 2018; McDaniel and Ellison 2008; Philpot 2009, 2017; Valentino and Zhirkov 2018), with ramifications for the politics of health (Grumbach 2018; Henderson and Hillygus 2011; Morone 2016; Wilkes 2015; Rodriguez, Bound, and Geronimus 2014). Likewise, a wide variety of political actors engage with health politics in ways that have discernible implications for racial health (in)equity. This includes everyone from ordinary white Americans whose racial biases shape their attitudes toward Medicaid expansion and work requirements (Grogan and Park 2017; Haeder, Sylvester, and Callaghan 2021; Lanford and Quadagno 2016), to state governors who are more likely to be politically rewarded for expanding Medicaid when they govern states with larger populations of white Medicaid beneficiaries (Fording and Patton 2019), to policy makers who invest less in Medicaid enrollees with disabilities in states where levels of racial resentment are higher (Leitner, Hehman, and Snowden 2018), to Medicaid bureaucrats who treat Black Medicaid beneficiaries less fairly in hearings contesting their removal from the program (Franklin 2017).

In the face of such complexity, nuanced and systematic attentiveness to how health politics intersects with structural racism is crucial. One challenging imperative is to account for racism, health, and politics through integrated approaches that consider all three phenomena. The bulk of existing research emphasizes two of the three, at most. There are many studies that examine racism and health (Mateo and Williams 2021; Phelan and Link 2015; Williams and Collins 2001; Williams, Lawrence, and Davis 2019; Williams and Mohammed 2013). There is also an important corpus of research on racism and politics/policy (Bensonsmith 2005; Katznelson 2005; King and Smith 2005; Lieberman 1995, 1998, 2005; Matsubayashi and Rocha 2012; Michener 2019; Orloff 2002; Schram, Soss, and Fording 2010; Soss, Fording, and Schram 2011; Williams 2003). Finally, there is a strong and growing body of work on politics, policy, and health, much of which has been prominently featured in this journal (Carpenter 2012; Gollust and Haselswerdt 2019; Grogan and Patashnik 2003; Hacker and Skocpol 1997; Haselswerdt 2017; Haselswerdt and Michener 2019; Jacobs and Mettler 2011; Michener 2017; Oberlander 2001, 2003; Ojeda and Pachecho 2019; Pachecho and Fletcher 2015; Patashnik and Oberlander 2018).

Notwithstanding each of these distinct areas of analysis, it is comparatively uncommon for scholars to simultaneously emphasize race/racism, health, and politics/policy. Even scholars who do such work are often not

aware of one another (as reflected in citation practices and as a result of disciplinary boundaries) and are not robustly engaged by scholars in other related areas; for example, scholars of health policy too easily overlook work related to racism and health policy (for notable examples of scholarship that does address work on racism and health policy, see Cruz Nichols, LeBrón, and Pedraza 2018a, 2018b; Grogan and Park 2017; Hooijer and King 2021; Kline 2019; Lanford and Quadagno 2021; LeBrón et al. 2018; LeBrón et al. 2019; Lopez 2019; Michener 2018, 2020; Pedraza, Cruz Nichols, and LeBrón 2017; Novak, Geronimus, and Martinez-Cardoso 2017; Young, Beltrán-Sánchez, and Wallace 2020). Putting this array of literatures and approaches into conversation and engagement with one another is an important step in producing knowledge useful for advancing health equity.

Interdisciplinary Approaches to Racism, Health, and Politics

The articles in this special issue draw on a range of disciplinary perspectives and methodological approaches to make substantive empirical and theoretical contributions at the nexus of racism, health, and politics. Chowkwanyun opens this special issue with a review of historical and contemporary analytic frameworks and tropes for understanding racial differences in health. This review highlights how explanatory frameworks held by scholars and practitioners shape discourse, research, and policy approaches to addressing population health inequities. By offering a critical analytical perspective on the concept of a "racial health disparity," Chowkwanyun helpfully unsettles the larger research ecosystem, pushing both scholars and practitioners to closely examine the first principles structuring their interpretive prisms.

Pivoting the emphasis of this special issue from concepts to data, Morey and colleagues illuminate how structural racism shapes the politics of being counted and categorized, demonstrating the consequences for the reporting of COVID-19 cases and deaths for Native Hawaiians and Pacific Islanders. Morey and colleagues discuss the role of racially color-blind policies in perpetuating failures of data collection and reporting, which in turn diminishes the chance to leverage data on racial health inequities to inform health equity efforts. Their analysis points not only to the importance of implementing policies designed to collect and report information about race and ethnicity but also to the imperative of monitoring and requiring compliance with such policies.

As this special issue turns to substantive analyses of how racialization processes affect health outcomes, Rodriguez, Bae, Geronimus, and Bound assess the linkages between federal- and state-level political parties in power and implications for Black-white inequities in birth outcomes. The authors argue that the partisan political agendas of US presidents and state legislatures have helped to maintain institutional racism that permeates the social determinants of health. Through quantitative empirical work, they articulate a historically and institutionally grounded analysis of racial differences in a critical health outcome. Ultimately, this research challenges readers to consider the idea that transforming US politics and its racialized nature is essential to promoting health equity.

In a complementary analysis, Robinson and Pearlman evaluate how social policy affects birth outcomes for Black and white mothers. They find that state spending on the earned income tax credit and state laws raising the minimum wage reduce the risk of low birthweight and preterm births for Black mothers (with a less consistent effect for white mothers). This work underscores the extent to which social and economic policies are public health interventions. Cash and in-kind transfer programs that benefit racially and economically marginalized populations can ameliorate racial inequities in the structural determinants of health. Even in a larger context of "bounded justice," where advances in health equity are limited by enduring institutional commitments to white supremacy and capitalism (Creary 2021), Robinson and Pearlman demonstrate the continued importance of a more generous and robust welfare state (Michener, SoRelle, and Thurston 2020).

This special issue closes with a methodological shift. Through a qualitative inquiry, LeBrón and colleagues examine immigration and immigrant policies as a form of structural racism that determines the opportunity to migrate to the US via authorized migration pathways, contributes to the long-standing and growing deportation regime against unauthorized immigrants, and restricts the rights of unauthorized and other immigrants. Analyzing data from interviews with immigrant and US-born Mexican-origin women, they trace how racialization occurs in a raced, classed, and gendered society and unfolds in ways that implicate political actors, systems, and policies. Instructive to both researchers and practitioners (e.g., advocates, organizers, policy makers), this study explores how Mexican-origin women respond to and navigate racialization processes, where they find agency and opportunity for action, and the short-, intermediate-, and long-term health implications thereof.

Looking Forward

Taken together, the papers in this special issue generate insights that other scholars can apply, critically assess, and build upon. This work is a springboard toward the continuing development of knowledge that advances the study of racism, health, and politics. With an eye toward such development, we conclude this introductory article with thoughts on directions for future thinking and research.

Populations, Topics, and Methodological Considerations

The study of racism, health, and politics in the United States is most advanced in understanding the health of Black Americans relative to white Americans (as the Robinson and Pearlman article in this special issue demonstrates). Yet, in addition to the enslavement and sustained oppression of people of African descent, the economic and political growth of the United States was also rooted in the genocide of Native peoples and the conquest of both Latin American and Polynesian territories. Thus, greater attention is needed to characterize and grasp the interconnections between racism, health, and politics for indigenous peoples, Latinas/os/xs/es, Asians, and Native Hawaiians and Pacific Islanders. This also includes necessary research on the health of racially minoritized groups who are currently classified as "white" by the standards of the Office of Management and Budget, such as Arab and Persian peoples.

In addition, research on health, racism, and politics requires recognizing the many complexities produced by long-standing practices and institutions of racial oppression. For example, scholars should attend to heterogeneity *within* racial categories, the importance of time and change (e.g., cohort studies, longitudinal research), the relevance of place-based processes of racialization, the significance of national or territorial origin or descent, and much more. Comparative analyses are especially critical: even as scholars expand the purview of research to more robustly include a wider range of racially minoritized groups, we might consider the function of anti-Blackness by juxtaposing health experiences and outcomes for Black people with those of other racially minoritized groups. Intersectional analyses are also essential. Intersectional perspectives account for the experiences of numerous social identities and positionalities (e.g., class, gender, sexuality)—identities that are multiplicative, not additive (Al-Faham, Davis, and Ernst 2019; Crenshaw 1991; Michener, Dilts, and Cohen 2012). Finally, the multiracial population in the United States is

often omitted from studies of racism, health, and politics. Given the substantial growth of the multiracial population (Jones et al. 2021), studies of how racism shapes the politics and health of multiracial persons are long overdue (Davenport 2018).

On an institutional level of analysis, empirical studies are needed that capture dynamic and interconnected systems and processes that create, perpetuate, preserve, and/or reduce structural racism. This will require studying how structural racism operates and is upheld across multiple social and ecological levels and several dimensions of population health and via numerous mechanisms by which social inequities shape health simultaneously. Big data (e.g., health system, social media, and federally reported data) is often perceived as being well positioned to explore the role of multiple mechanisms and processes simultaneously. However, it is important to consider both the opportunities and the limitations of big data for capturing both the blunt and the stealthy ways in which structural racism operates as well as the unique and shared impacts for racially minoritized groups. Moreover, racism is contextually and temporally specific, taking on different shapes across time and place, and is influenced by historical and contemporary processes. Studies involving big data must grapple with how to incorporate these important components of racism into the analytic inquiry and data. More critical attention is needed to ways big data may further marginalize racially minoritized groups for whom data collection and reporting is problematic and/or cases where population sizes may be small. Additionally, we need more studies that investigate the health equity implications of political efforts to reduce structural racism, considering simultaneously the role of federal, state, and local processes in shaping health outcomes.

Reflecting the understanding that health is a process, the study of racism, health, and politics requires analysis of longitudinal and intergenerational data that illuminate how racism and politics shape health across the life course, and how health shapes racism and politics. Such studies have the potential to disentangle the role of time, temporality, and directionality in shaping when and how the health consequences of structural racism materialize in clinical indicators of health status, and how health shapes politics and policies.

This special issue brings into conversation scholarship representing researchers across disciplines such as political science, public health, ethnic studies, and economics, and it includes the voices of nonacademic scholars who are leaders of community-based efforts to address structural

racism. The next generation of interdisciplinary scholarship on the study of racism, health, and politics must integrate multiple positionalities and disciplines to advance the science of interdisciplinary scholarship. This will require valuing, funding, and creating opportunities for cross-sector and cross-discipline exchange and collaboration, such as encouraging and supporting the publication of interdisciplinary scholarship; securing a commitment from journals to publish works that transcend disciplinary boundaries and provide adequate space to explain and unpack interdisciplinary concepts and analyses; ensuring that journal reviewers are equipped to assess the strengths and weaknesses of interdisciplinary scholarship as well as scholarship that studies the interconnections between racism, health, and politics; and rewarding scholars for publishing in interdisciplinary journals and/or outside of their fields.

Finally, what is the study of racism, health, and politics without attention to translating this knowledge into action? The effective translation of scholarship on racism, health, and politics will involve building the capacity of scholars to discuss, and even coproduce research findings with affected communities and policy designers; valuing and funding the investment in capacity-building and translational research efforts; and ensuring that scholarship is free and open access for community-based leaders and policy-making institutions.

Scientific research about health outcomes, health care systems, public health, health inequities, and other phenomena related to health and racism provides a necessary but insufficient foundation of knowledge. To facilitate change, politics and policy must also be incorporated into the purview of scholarly inquiry on health and racism. Knowledge about how politics and policy structure the relationships between racism and health is vital for understanding how to redress racism and thwart its devastating health consequences. Ida B. Wells-Barnett, a trailblazing journalist of the late 19th and early 20th centuries, famously said that "the way to right wrongs is to turn the light of truth upon them" (Wells 1892). This insight reverberates nearly 130 years later. Health inequities are a product of the persistent wrong of structural racism. We cannot change this wrong without seeing it clearly: its political causes and consequences, its policy mechanisms and repercussions, its material significance in the lives of racially marginalized communities. This special issue is a call for scholars across disciplines and traditions to further illuminate the wrong of structural racism, its effects on health and well-being, and the role of politics and policy in producing and/or mitigating those effects.

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