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Michigan BRFSS/Health Disparities Surveillance Brief

Reactions to Race: Results from Michigan and Wisconsin

Reactions to Race

Racial and ethnic health disparities have been widely documented across the US and in the upper Midwest. For many communities of color, morbidity and mortality is disproportionately high, even though race is widely recognized as a social construct with no impact on the biological health of an individual. "White privilege," the concept of unearned higher status in American society based on perceived Whiteness, is proposed as one reason for unequal health outcomes as it disadvantages minorities for resources that are necessary for optimal health (Jones et al, 2008; Fujishiro K, 2009).

We used data from the Behavioral Risk Factor Surveillance System (BRFSS) Reactions to Race module, created by Dr. Camara Jones from the Centers for Disease Control and Prevention (CDC), to examine the effects of self-described vs. socially-assigned race on overall health and mental health. Data from the 2006 Michigan and Wisconsin BRFSS were used for this study. We were limited to Michigan and Wisconsin data because they are the only two upper Midwest states to have completed the Reactions to Race module at this time.

Table 1. Frequency Distribution of Unweighted Self-Assigned Race and socially assigned race

	Socially-Assigned Race						
Self-Assigned Race	**White**	**A.A**	**Hisp.**	**AI/AN**	**Asian**	**Other**	**Total**
White	8511	23	11	16	7	33	8601
A.A.	11	765	3	5	0	9	793
Hispanic	78	6	86	0	1	5	176
AI/AN	30	1	4	28	0	1	64
Asian	8	0	3	0	60	2	73
Other	24	25	4	7	2	7	129
Multi.*	84	25	4	7	2	7	129
Total	8746	823	112	56	71	63	

*** Multiracial not an option for socially assigned race**

Socially-Assigned Race and Health Status

Methods

We followed Dr. Jones' methodology outlined in her 2008 "White Advantage" article (Jones et. al. 2008), as closely as possible to see if there is an advantage in overall health status and mental health for those minorities in Michigan and Wisconsin who are socially assigned as White. Groups were defined using both self- and socially-assigned racial classifications, based on the following two questions: "What is your race?" and "How do other people in this country usually classify you?", respectively. We used a *self-assigned—socially-assigned* naming convention for these groups, i.e., self assignment is listed first followed by social assignment. We performed analysis on groups that have 50 or more discordant individuals—any group where social assignment and self assignment did not match. The resulting sample size distributions (unweighted) are presented in Table 1. We used logistic regression analysis adjusted for age and education level. Analysis weights was used to account for survey design.

Figure 1. % Reporting Very Good or Excellent Health

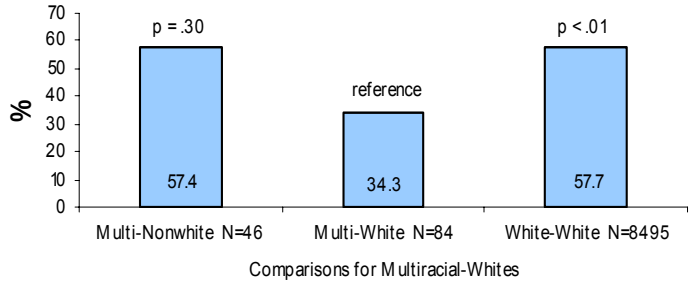
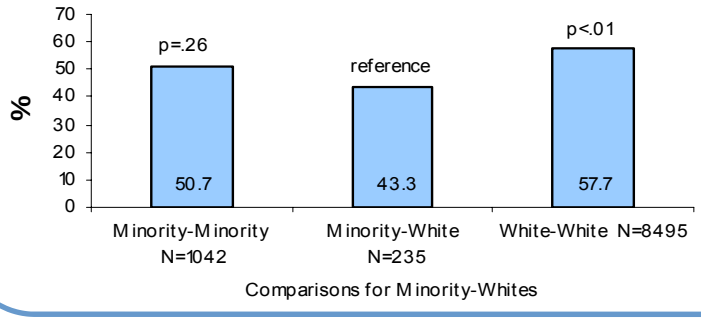


Figure 2. % Reporting Very Good or Excellent Health



Results

Based on our respondent frequencies (Table 1) we performed analysis using those who self assigned as Multiracial or Hispanic and are socially-assigned White, as well as a combined group of all Minority respondents who are socially assigned White (N=235).

We found that the Multiracial-White (i.e., self-assigned Multiracial—socially-assigned White) group had overall health status not statistically different compared with that of the Multiracial-Nonwhite group, but statistically different compared with the White-White group (Figure 1). P-values (α=.05) are reported for each group as compared to the referent discordant group.

We found similar results for the Minority-White comparison (Figure 2): the Minority-White group had overall health status that is not statistically different than Minority-Minority, but is statistically different than the White-White group.

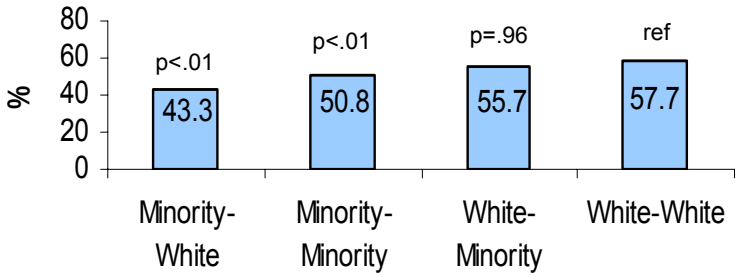
Comparison for the Hispanic-White group yielded no statistically significant results.

We then repeated this analysis with mental health as the outcome, defined as an individual having 14 or fewer days of mental health symptoms in the last month. We found similar results to that of our overall health analysis: the Multiracial-White group did not have statistically different mental health status compared with that of the Multiracial-Nonwhite group (p=.55), but statistically different health status than the White-White group (p=.03). The Minority-White comparison showed no statistical difference from the Minority-Minority group (p=.09) but statistical difference from the White-White group (p=.01).

What about the White-Minority Group?

After looking at results from the previous described analysis, we decided to investigate how the White-Minority group, which had been left out of the previous investigation, compared to the other groups when looking at excellent or very good health. Our sample size was not large enough to test by individual race/ethnic group so we combined all respondents who self identified as White but were socially assigned any non-white group to the White-Minority group (N=93). Using the methods described earlier we found that for overall health status, the Minority-White and Minority-Minority groups were statistically different than the White-White group (Figure 3) while there was no statistical difference between the White-Minority and White-White group.

Figure 3. % Reporting Excellent/Very Good Health by Self– and Socially-Assigned Group, Including White-Minority



Discussion

We found that White social-assignment was not associated with better health status. For both overall health status and mental health, the percent responding positively was lower for the discordant group and was statistically different than the White-White comparison group. Thus, those who self identify as minority and are socially assigned as White have a health status more like that of their corresponding concordant minority group (Minority-Minority) than that of the White group (White-White). In our further examination including the White-Minority group, we found a trend suggesting the same thing: the White-Minority group was not different than White-White, but was different than Minority-Minority and Minority-White. This suggests to us that self-assignment of race is more predictive of health and mental health than social-assignment, when compared to the corresponding concordant groups (White-White or Minority-Minority). These findings are the opposite of what previous national-level studies have found. We propose several reasons why this may be. White privilege in health can be gained both at the personal and community level. Much of the privilege associated with Whiteness is not only found in interpersonal interactions but also in the community-level aggregation of privilege, which is expressed in larger social constructs such as city planning, environmental policy, and transportation. The historical exclusion of minorities from the governmental process (both local and national) and leadership positions, combined with a changing but prevalent societal racism, contribute to this structural privilege system. Consequently, this community-level system may prevent even those socially assigned as White from benefiting in Minority communities that have not been historically advantaged. Detroit, Michigan and Milwaukee, Wisconsin are two of the most segregated cities in the US (Racial Residential Segregation Project, 2009). In such areas, there may be little opportunity for White privilege to aggregate to the community level, and thus the potential privilege from being socially-assigned as White may be partially or wholly un-realized. In addition, the impact of history and its resulting segregation may aggravate personal perception of opportunities for minority individuals. We would like to recognize the limitations of this study: sample sizes are small and there is inherent error in sampling and estimation techniques for surveys such as the BRFSS. We were unable to investigate the health status of the discordant Black—White group due to small sample size, despite African Americans representing the largest minority population in Michigan. The resulting impact on health of discordant racial assignment may differ by minority population, and we were unable to investigate these differences with this analysis.

References

Jones CP, Truman BI, Elam-Evans LD, Jones CA, Jones CY, Jiles R, Rumisha SF, Perry GS. Using "Socially Assigned Race" to Probe White Advantages in Health Status. *Ethnicity and Disease*. 2008; 18: 496-504.

Fujishiro, K. Is perceived racial privilege associated with health? Findings from the Behavioral Risk Factor Surveillance System. *Social Science and Medicine*. 2009; 68: 840-844.

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The Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS comprises annual, state-level telephone surveys of adults aged 18 years and older and is coordinated by the CDC. The annual surveys follow the CDC BRFSS protocol and use the standardized English core questionnaire that focuses on various behaviors, medical conditions, and preventive health care practices related to the leading causes of mortality, morbidity, and disability. Data are weighted to adjust for the probabilities of selection and a poststratification weighting factor that adjusts for the sex, age, and race distribution of the adult population.

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