

THE FOUNDATION OF MODERN RACIAL CATEGORIES AND IMPLICATIONS FOR RESEARCH ON BLACK/WHITE DISPARITIES IN HEALTH

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The persistence of black/white disparities in health outcomes has led some to question the approaches public health, biomedical and clinical researchers use to classify, describe, and analyze race. Although these fields appear ready for the emergence of new strategies for studying race, they must first develop a solid understanding of the historical bases for the concept. This article adds to the health disparities discourse by explaining the origins of the US race and ethnicity concepts and clarifying ways in which race is 'real.' The idea of distinct and hierarchically valued races is a dominant, though problematic paradigm for explaining human diversity. We propose that the construct of race is inseparable from the term's origins and, in research must be treated as such. Doing so appropriately may enhance cross-disciplinary efforts to target the fundamental causes of racial disparities in health. We draw on multi-disciplinary research to explain how race became fixed within the American mind, describe how it structures human interactions, and highlight limitations of the official racial/ethnic categories enumerated by the US Office of Management and Budget. (*Ethn Dis.* 2009;19:209–217)

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INTRODUCTION

Inconsistent progress in narrowing the black/white racial gap in health outcomes^{1,2} has led many to question how health researchers classify, describe, and analyze race in their efforts to understand racial disparities in health. As Braun explains, "the notion of 'inequality' or 'disparity' implies group difference in the experience of health"; therefore, "much of the debate over health disparities has necessarily centered on the issue of human classification."³ p. 557 Researchers have recommended a focus on ethnic rather than racial variation,^{4,5} proposed alternative terminology for racial and ethnic categories,^{6–8} questioned the exchangeability assumptions intrinsic to efforts to explain racial disparities,⁹ suggested abandoning racial comparisons altogether,⁴ and debated whether strong associations between genetic markers, continental ancestry, and standard racial/ethnic categories validate the latter's biologic relevance.^{3,10–12} Researchers and the public, however, lack a uniform understanding about what the terms race and ethnicity refer to and how they should be categorized.^{6,10,13,14} Furthermore, despite the current national focus on understanding and reducing health disparities between racially designated groups, terse attention is given to the origins of racial terminology and classifications. Advancing our ability to address racial/ethnic disparities in health requires an historically informed understanding of these issues, including how the notion of fixed and distinct races became fixed in the American mind.

Example

A dark-skinned Dominican-American woman may be viewed as black by a police officer pursuing a black

suspect, Dominican by an employer who subscribes to the belief that Hispanics/Latinos possess a better work ethic than do African Americans, and simply Dominican by herself and her family. In other words, the manner in which she self identifies may rarely involve race, but ideas about race and ethnicity may affect her likelihood of being subjected to police surveillance or brutality, opportunities for employment, self-identity, cultural milieu, and associated stressors.

As demonstrated by research on social and contextual health influences, all of these factors may affect her health and life expectancy. Health investigations that seek to understand the mechanisms through which racial and ethnic factors operate must recognize and differentiate the various aspects of identity outlined in this example.

The inclusion of race/ethnicity in an epidemiologic triad with age and sex has become routine.^{14–17} For example, from 1996 through 1999, 77% of studies published in the *American Journal of Epidemiology* and the *American Journal of Public Health* made some reference to race or ethnicity.¹⁴ Race, sex and age, all may be thought of as physical attributes with social relevance. Race, however, differs conceptually from both sex and age because it lacks agreed-upon criteria for classification¹⁶ or a direct biological component. Because no set of biological traits determines race¹⁸ and because racial/ethnic designations represent the needs of various stakeholders, racial categories change over time^{19,20} and are used inconsistently and unreliably.^{14,21,22}

There is no 'gold standard' for the use of race in health research; however, the Office of Management and Budget (OMB) establishes racial and ethnic