USING "SOCIALLY ASSIGNED RACE" TO PROBE WHITE ADVANTAGES IN HEALTH STATUS

Objectives: We explore the relationships between socially assigned race ("How do other people usually classify you in this country?") and health. We derive self-identified race/ethnicity, and excellent or very good general health status. We then take advantage of subgroups that are discordant on self-identified race/ethnicity and socially assigned race to examine whether being classified by others as White conveys an advantage in health status, even for those who do not self-identify as White.

Methods: Analyses were conducted using pooled data from the eight states that used the Reactions to Race module of the 2004 Behavioral Risk Factor Surveillance System.

Results: The agreement of socially assigned race with self-identified race/ethnicity varied across the racial/ethnic groups currently defined by the United States government. Included among those usually classified by others as White were 26.8% of those who self-identified as Hispanic, 47.6% of those who self-identified as American Indian, and 59.5% of those who self-identified with More than one race.

Among those who self-identified as Hispanic, the age-, education-, and language-adjusted proportion reporting excellent or very good health was 8.7 percentage points higher for those socially assigned as White than for those socially assigned as Hispanic (P=.04); among those who self-identified as American Indian, that proportion was 15.4 percentage points higher for those socially assigned as White than for those socially assigned as American Indian (P=.05); and among those who self-identified with More than one race, that proportion was 23.6 percentage points higher for those socially assigned as White than for those socially assigned as Black (P<.01). On the other hand, no significant differences were found between those socially assigned as White who self-identified as White and those socially assigned as White who self-identified as Hispanic, as American Indian, or with More than one race.

Conclusions: Being classified by others as White is associated with large and statistically significant advantages in health status, no matter how one self-identifies. (Ethn Dis. 2008;18:496-504)

Key Words: Behavioral Risk Factor Surveillance System, Racism, Self-rated Health

INTRODUCTION

Racial health disparities have been documented in the United States since data on "race" and health have been jointly collected.1-4 The question remains, however, why the variable "race" is such a potent predictor of health outcomes, especially when it is widely acknowledged that "race" is a social construct, not a biological descriptor.5-9

We gain some insight into this question by observing that the "race" noted by a hospital admissions clerk on a medical record is the same "race" noted by a sales clerk in a store, a taxi driver or police officer on the street, a judge in a courtroom, or a teacher in a classroom,10-12 and, in our opinion, this "race" is quickly and routinely assigned without the benefit of queries about self-identification, ancestry, culture, or genetic endowment. Indeed, this ad hoc racial classification has been an influential basis for interactions between individuals and institutions in our society for centuries.13

We posit that "race" acts on health through race-associated differences in life experiences and life opportunities in our race-conscious society. That is, we posit that "race" is a potent predictor of health outcomes in this country because of racism, which Jones has defined as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks."12 Jones proposes that "race" be formally understood as the social interpretation of our physical appearance in a given place and time, and she suggests that it can be measured by a person’s response to the question "How do other people usually classify you in this country?"12 Note that this “socially assigned race” is distinct from self-identified race/ethnicity, and could be a useful tool for probing the impacts of racism on health because it measures the ad hoc racial classification upon which racism operates.

In this article, we explore the relationships between “socially assigned race,” self-identified race/ethnicity, and excellent or very good general health status. We then take advantage of subgroups that are discordant on self-identified race/ethnicity and “socially assigned race” to examine whether being socially assigned as White conveys an advantage in health status, even for those who do not self-identify as White.

Using “socially assigned race” to probe advantages in health status associated with being classified by others as White, we aim to further elucidate the impacts of racism on health.

METHODS

The Behavioral Risk Factor Surveillance System (BRFSS), developed by
the Centers for Disease Control and Prevention (CDC), is an ongoing state-based system of health surveys administered by telephone to a representative sample of non-institutionalized persons aged ≥18 years. Details on the objectives, design, use, and limitations of the BRFSS can be found elsewhere.14–16 The Reactions to Race module is a six-question optional module first developed for the BRFSS in 2001 by the CDC Measures of Racism Working Group.17 The questions include assessments of socially assigned race (“How do other people usually classify you in this country?”) and race consciousness (“How often do you think about your race?”), as well as perceptions of differential treatment at work and when seeking health care, and reports of emotional upset and physical symptoms as a result of race-based treatment. The Reactions to Race module underwent three rounds of cognitive testing, one round of field testing, and pilot testing by six invited states on the 2002 BRFSS. This article presents analyses of pooled data from the eight states (Arkansas, Colorado, Delaware, District of Columbia, Mississippi, Rhode Island, South Carolina, and Wisconsin) that used the Reactions to Race module in 2004, the first year it was made available to all states.

The self-identified race/ethnicity variable was constructed from two separate questions included on the BRFSS core questionnaire: “Are you Hispanic or Latino? [Yes, No]” and “Which one or more of the following would you say is your race? [White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, Other (specify)].” If respondents answered Yes to “Are you Hispanic or Latino?” their self-identified race/ethnicity was coded as Hispanic or Latino regardless of their response to the following question on race. If respondents answered No to “Are you Hispanic or Latino?” and selected only one group in the following question on race, their self-identified race/ethnicity was coded as the racial group they selected (White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, or Other). If respondents answered No to “Are you Hispanic or Latino?” and selected more than one racial group, their self-identified race/ethnicity was coded as More than one race.

The socially assigned race variable was based on responses to the first question asked on the BRFSS Reactions to Race module: “How do other people usually classify you in this country? Would you say White, Black or African American, Hispanic or Latino, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, or Some Other Group?” Response categories included all of the federal Office of Management and Budget (OMB) “race” categories as well as the OMB and ethnicity categories.18

General health status was assessed using the self-rated health question from the BRFSS core questionnaire: “Would you say that in general your health is Excellent, Very good, Good, Fair, or Poor?” Response categories Excellent and Very good were combined in this study to serve as a measure of optimal health, the outcome of interest, in contrast to response categories Good, Fair, and Poor, which do not represent optimal health. Higher levels of Excellent or Very good health are considered an advantage in health status.

Data analysis

Analyses were organized to answer three research questions: 1) What is the relation between self-identified race/ethnicity and socially assigned race? 2) How do levels of optimal health vary between subgroups jointly defined by self-identified race/ethnicity and socially assigned race? 3) For those who are discordant on self-identified race/ethnicity and socially assigned race because they self-identify with a non-White group but are socially assigned to the White group, does their general health status differ from a) the health of those who both self-identify with and are socially assigned to the particular non-White group, and b) the health of those who both self-identify with and are socially assigned to the White group?

Post-stratification weights were used to adjust for probability of selection and nonresponse.19,20 SAS version 8.2 (SAS Institute, Inc., Cary, NC) with SU-DAAAN version 9 (RTI International, Research Triangle Park, NC) was used for statistical analyses to account for the complex sampling design. Comparisons of the outcome between subgroups jointly defined by self-identified race/ethnicity and socially assigned race were adjusted for reported age in years, education level (none or kindergarten, grades 1–8, grades 9–11, grade 12 or GED, college 1 to 3 years, or college 4 or more years), and respondent preference for questionnaire language (English or Spanish) using predicted margins from logistic regression models.21 Differences were considered statistically significant at P≤.05.

RESULTS

Table 1 presents the joint distribution of the 34,775 respondents in our sample by self-identified race/ethnicity and socially assigned race, as well as the weighted percent distribution of socially assigned race within each self-identified racial/ethnic group. The agreement of socially assigned race with self-identified race/ethnicity varied across racial/ethnic groups. Of those who self-identified as White, 98.4% were usually classified by others as White; of those who self-identified as Black or African American (Black), 96.3% were usually classified by others as Black; and of those who self-identified as Asian, 77.0% were usually classified by others as Asian. In contrast, of those who self-identified as Hispanic or Latino (His-
panic), 63.0% were usually classified by others as Hispanic, while 26.8% were usually classified by others as White, of those who self-identified as American Indian or Alaska Native (American Indian), 35.9% were usually classified by others as American Indian, while 22.5% were usually classified by others as Black.

Table 2 presents the estimated proportions of the underlying population whose general health status was excellent or very good, by self-identified race/ethnicity and socially assigned race. Data are shown for only those subgroups which included 50 or more respondents (sample sizes presented in Table 1).

The highest levels of excellent or very good health were found for those who self-identified as Asian and were socially assigned as Asian (60.6%) (Table 2), followed closely by those who self-identified as White and were socially assigned as White (58.6%). The next-highest levels of excellent or very good health were clustered and were found for other groups that were socially assigned as White: those who self-identified as Hispanic and were socially assigned as White (53.7%), those who self-identified with More than one race and were socially assigned as White (53.5%), those who self-identified as American Indian and were socially assigned as White (52.6%), and those who self-identified as Other and were socially assigned as White (50.4%).

Table 1. Percent distribution of socially assigned race within each self-identified racial/ethnic group

<table>
<thead>
<tr>
<th>Self-identified race/ethnicity</th>
<th>Socially assigned race</th>
<th>Row totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>Weighted row %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>98.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Sample size</td>
<td>25,951</td>
<td>81</td>
</tr>
<tr>
<td>Black</td>
<td>0.4</td>
<td>96.3</td>
</tr>
<tr>
<td>Sample size</td>
<td>28</td>
<td>4,998</td>
</tr>
<tr>
<td>Hispanic</td>
<td>26.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Sample size</td>
<td>404</td>
<td>72</td>
</tr>
<tr>
<td>American Indian</td>
<td>47.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Sample size</td>
<td>146</td>
<td>22</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
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<tr>
<td>Sample size</td>
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<tr>
<td>NHOPI</td>
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<td>Sample size</td>
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<tr>
<td>Other</td>
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<tr>
<td>Sample size</td>
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<tr>
<td>More than one race</td>
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<td>Sample size</td>
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<tr>
<td>DK/NS/Refused</td>
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<td>Sample size</td>
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<tr>
<td>All respondents</td>
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<tr>
<td>Sample size</td>
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</tbody>
</table>

Entries are weighted row percents, and are bolded in the diagonal cells in which the self-identified race/ethnicity is the same as the socially assigned race. The actual number of respondents in each cell is shown in italics. Entries are shown for cells whose estimated weighted row percent has a relative standard error less than 30%. The row and column totals include all respondents, including those from suppressed cells.

NHOPI = Native Hawaiian or Other Pacific Islander
DK/NS = Don’t Know/Not Sure
* This estimate has a relative standard error of 33.8% and may be unstable.
who self-identified as White and were socially assigned as Hispanic (50.3%) and those who self-identified as White and were socially assigned as Other (49.2%). The next-lower levels of excellent or very good health were found for those who self-identified as Hispanic and were socially assigned as Black (44.4%) and those who self-identified as Black and were socially assigned as Hispanic (44.3%), followed by those who self-identified as Hispanic and were socially assigned as Hispanic (39.8%). The lowest levels of excellent or very good health were found for those who self-identified as American Indian and were socially assigned as American Indian (32.0%) and those who self-identified with More than one race and were socially assigned as Black (30.7%).

There were insufficient numbers of those who self-identified as Asian and were socially assigned to other groups to further explore the apparent Asian health advantage. Within each of the other self-identified racial/ethnic groups, general health status appears to be related to socially assigned race. To address the final research question, we go beyond description to explicitly test for differences in levels of optimal health for those subgroup comparisons which inform us about the health correlates of being socially assigned as White.

This final analysis focused on those self-identified non-White groups for which we had at least 50 respondents who were usually classified by others as White and for which we had another comparison group (unshaded entries in Table 2). These included those who self-identified as Hispanic, those who self-identified as American Indian, and those who self-identified with More than one race. (A note on nomenclature: Henceforth we will describe subgroups jointly defined by self-identified race/ethnicity and socially assigned race by first naming the self-identified race/ethnicity, then the socially assigned race.)

The unshaded bars in Figure 1 graphically display the differences in age-, education-, and questionnaire language-adjusted proportions reporting excellent or very good health for the Hispanic-Hispanic vs Hispanic-White, American Indian-American Indian vs American Indian-White, and More than one race-Black vs More than one race-White subgroups. Among those who self-identified as Hispanic, the adjusted proportion with excellent or very good health status for those subgroup comparisons which inform us about the health correlates of being socially assigned as White.
health was 8.7 percentage points higher for those socially assigned as White than for those socially assigned as Hispanic ($P=.04$). Among those who self-identified as American Indian, the adjusted proportion with excellent or very good health was 15.4 percentage points higher for those socially assigned as White than for those socially assigned as American Indian ($P=.05$). Among those who self-identified with More than one race, the adjusted proportion with excellent or very good health was 23.6 percentage points higher for those socially assigned as White than for those socially assigned as Black ($P<.01$).

The middle and right-hand (shaded) bars in Figure 1 graphically display the differences in age-, education-, and questionnaire language-adjusted proportions reporting excellent or very good health for each of the Hispanic-White, American Indian-White, and More than one race-White subgroups compared to the White-White subgroup. A higher proportion of White-Whites reported excellent or very good health than was the case for each of the other three groups also socially assigned as White, but the differences were small and not statistically significant. The difference for the Hispanic-White vs socially assigned as White, and those who self-identify as White and are socially assigned as White. The bottom three bars display data for those who self-identify with More than one race and are socially assigned as Black, those who self-identify with More than one race and are socially assigned as White, and those who self-identify as White and are socially assigned as White. Frequencies of reporting excellent or very good health are adjusted for age, educational level, and questionnaire language. Within each set of three bars, $P$ values are reported for comparisons using those who self-identify with the non-White group but are socially assigned as White as the reference group.

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Fig 1. Percent of the population whose general health status is excellent or very good, adjusted for age, educational level, and questionnaire language. The top three bars display data for those who self-identify as Hispanic and are socially assigned as Hispanic, those who self-identify as Hispanic and are socially assigned as White, and those who self-identify as White and are socially assigned as White. The middle three bars display data for those who self-identify as American Indian and are socially assigned as American Indian, those who self-identify as American Indian and are socially assigned as White, and those who self-identify as White and are socially assigned as White. The bottom three bars display data for those who self-identify with More than one race and are socially assigned as Black, those who self-identify with More than one race and are socially assigned as White, and those who self-identify as White and are socially assigned as White. Frequencies of reporting excellent or very good health are adjusted for age, educational level, and questionnaire language. Within each set of three bars, $P$ values are reported for comparisons using those who self-identify with the non-White group but are socially assigned as White as the reference group.
White-White comparison was 2.1 percentage points ($P=.54$), for the American Indian-White vs White-White comparison, 5.8 percentage points ($P=.28$), and for the More than one race-White vs White-White comparison, 5.4 percentage points ($P=.19$).

**DISCUSSION**

The degree to which socially assigned race agrees with self-identified race/ethnicity varies across the racial/ethnic groups currently defined by the United States government. Furthermore, within each self-identified racial/ethnic group, self-rated general health status appears to be related to socially assigned race. Indeed, being socially assigned as White is associated with large and statistically significant advantages in health status, even for those who self-identify with a non-White group. Additionally, the level of excellent or very good health reported by those who self-identify with a non-White group but are socially assigned as White is statistically indistinguishable from the level reported by those who both self-identify with and are socially assigned as White.

The finding of a White advantage in health status is replicated within each of three different self-identified racial/ethnic groups (Hispanic, American Indian, and More than one race). In addition to being adjusted for age, the comparisons in this analysis are adjusted for education, the best available social class marker in our dataset. Education data were missing for only 0.2% of respondents in this study, while income data were missing for 13.7% of respondents. The comparisons are also adjusted for the effects of acculturation among Hispanic groups using respondent preference for questionnaire language.

The variable which we introduce in this paper, “socially assigned race,” captures the “race” to which individual people and institutions in our society react, the on-the-street race that is automatically registered by people socialized in our race-conscious society and that operates in our daily lives to either constrain or facilitate opportunity. Recognizing that there is no a priori reason why those who are viewed as White should experience better health, higher education, or any other societal good compared to others, and accepting the definition of racism as a system of structuring opportunity and assigning value based on the social interpretation of how one looks, we take our research findings as preliminary but compelling evidence of the impacts of racism on health.

Racism is an important aspect of our social environment that is increasingly being discussed at both national and international levels. Indeed, a growing number of scientists have hypothesized racism as a fundamental cause of racial and ethnic disparities in health outcomes. Yet the scientific investigation of the role of racism in contributing to health disparities must not be simply an academic exercise of establishing a causal relationship or decreasing the amount of unexplained variance in our statistical models. This work will have its greatest value when it identifies the pathways and structural mechanisms by which racism has its effects.

In particular, the health effects of “whiteness” in this country have rarely been discussed. Even when racial/ethnic health disparities are conceptualized as resulting from unfair disadvantage experienced by stigmatized and oppressed racial/ethnic groups, the reciprocal unfair advantage experienced by members of the dominant White racial group is rarely fully examined. In discussing “whiteness,” we acknowledge that everyone has a race in this society, and that White is not just “normal” or neutral. Perhaps racial health disparities are not due just to the disadvantages experienced by members of non-White groups but also to the advantages experienced by White people. These may include the benefit of the doubt, the high expectations, the trust, the laxity in enforcing the same rules with which non-White people must strictly comply, the day-to-day breaks which White people often experience as “luck” or never even notice, and the sense of entitlement.

We expand on previous research on the effects of racism on health by examining “socially assigned race” rather than perceived discrimination or reports of unfair treatment as the risk factor of interest, and by using a measure of positive health rather than negative health as the outcome of interest. We also expand beyond an examination of the effects of racism on Blacks to investigate the effects of racism on Hispanics, American Indians, and those who identify with More than one race. Indeed, there were not enough respondents in this sample who self-identified as Black but were socially assigned as White to include in this analysis, because some people of African descent who are socially assigned as White have chosen to “pass” rather than endure the hardships of living Black in this country.

A major strength of this study is the use of the BRFSS, a conventional public health data source and the world’s largest ongoing telephone health survey system, to examine with scientific rigor the sensitive and potentially controversial issue of racism. The BRFSS provides a large, population-based sample from each state, uses methods for sampling and survey administration that have been refined over years of experience, and collects data using standardized questions. An additional strength of the present study is the use of self-rated health as our outcome measure. Self-rated health is a multidimensional concept that includes physical health, functional capacities, health behaviors, and psychological factors. A growing body of literature shows that self-rated health predicts morbidity, health care
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utilization and hospitalization, and mortality, and single-item measures of general self-rated health have been shown to be comparable to multi-item measures for predicting mortality, morbidity, and utilization of outpatient services.

This study has at least four limitations that must be considered. First, while the state-specific data have been weighted to make them representative for the given states, the eight states that used the Reactions to Race module on the 2004 BRFSS may not be a representative sample of the 50 United States. As additional states use the Reactions to Race module on the BRFSS, we can further examine the observed associations. Second, the fact that we combine excellent and very good health for our outcome measure differs slightly from the way self-rated health has generally been used in the literature. Most researchers focus on adverse health outcomes and combine the responses fair and poor health in contrast to excellent, very good, or good health. We have chosen to combine the two most positive ratings, excellent and very good, because we are interested in a measure of optimal health. Third, our measure of socially assigned race is actually the respondents’ perceptions of how other people usually classify them in this country rather than a classification assigned by an outside observer. We invite further work comparing socially assigned race as assessed by questionnaire with socially assigned race as assessed by a third party.

Fourth, we had small samples for some combinations of self-identified and socially assigned race, limiting our ability to examine health outcomes for all subgroups.

Future work needs to identify the key elements of the “whiteness” experience that confer an advantage in health status. We need to define the mechanisms of white privilege, both in personal interactions and in systems of structuring opportunity and community value. We need to understand the ways in which personal and community experiences associated with socially assigned race translate into physiologic reactions and their sequelae. We also need to understand how education and income enter the pathway between socially assigned race and health. The goal is to identify the benefits that accrue to “whiteness” so that these benefits can be extended to everyone.

Future work should also aim to understand how the strength of association between race and important health outcomes varies by how “race” is measured: self-identification, respondent perception of social assignment, or social assignment by an observer. Which is the best predictor of health outcomes? Does it vary by outcome? Does it give us insight into the mechanisms by which “race” influences health outcomes?

Finally, we recommend that investigators measure “socially assigned race” in addition to self-identified race/ethnicity. We urge inclusion of the question assessing socially assigned race on national health interview surveys so that data from all 50 states and the territories can be studied. We also urge inclusion of this question on national health examination surveys so that data from physical examinations become available to expand upon our interview-based findings.

CONCLUSION

We have explored the relationship between being socially assigned as White and optimal health in order to open new areas of inquiry with regard to the effects of racism on health. Instead of just talking about unfair disadvantage, we can also address the reciprocal unfair advantage. Instead of “whiteness” being invisible or neutral or normal, we can talk about it as an asset in this race-conscious society. Attention to the ways in which opportunity is structured and value assigned so that “whiteness” is favored may suggest new levers for intervening on health disparities. Using “socially assigned race” to probe the health benefits of living White, we aim to catalyze a shift to bold new strategies for achieving health equity in the United States.

ACKNOWLEDGMENTS

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REFERENCES

7. Cooper R, David R. The biological concept of race and its application to public health and
25. Barnes-Josiah DL. Undying racism in public health: a blueprint for action in urban MCH. Omaha (NE): CityMatCH at the University of Nebraska Medical Center; 2004.
27. Jones CP. Socioeconomic status and health: isolating the impacts of racism. Presented at the 128th annual meeting of the American Public Health Association; November 14, 2000; Boston, Massachusetts.

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*Data analysis and interpretation:* CP Jones, Truman, Elam-Evans, CA Jones, CY Jones, Jiles, Rumisha, Perry  
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*Administrative, technical, or material assistance:* CP Jones, Truman, Elam-Evans, CA Jones, CY Jones, Jiles, Rumisha, Perry  
*Supervision:* Elam-Evans, Perry