Anti-black attitudes are a threat to health equity in the United States

Abstract

Objectives: To assess the extent to which persistent racism shapes perspectives on public health policies aimed at improving health equity in the United States. Specifically we evaluate the relationship between implicit and explicit anti-black attitudes and support for the ACA at the beginning of the Trump administration.

Methods: We use bivariate statistics to examine views toward the ACA, anti-black attitudes, and demographic variables. Using logistic regression, we examine how anti-black attitudes and demographic variables relate to participants stating that the ACA has worsened the quality of health care services in the United States

Survey Population: Data for this study come from the American National Election Studies 2016 Time Series Study, which targets U.S. citizens age 18 and older currently living in the United States (N=3,245).

Results: Implicit anti-black attitudes, particularly among whites, are strongly associated with negative feelings toward the ACA. A measure of explicit racial prejudice has the opposite relationship among whites. These results suggest that whites are most critical of the ACA when they hold positive attitudes toward blacks but hold negative stereotypes about blacks' work ethic and reject policies to eliminate racial inequalities.

Conclusions: Anti-black racial attitudes are a critical barrier to enacting health policies that stand to improve health equity in the United States. Public health practitioners and policymakers should consider racism as an essential barrier to overcome in the push for greater health equity in the United States.

Key words: Racism; Implicit bias; Affordable Care Act; Health Equity; Policy

Introduction

The 2010 Affordable Care Act (ACA) was President Barack Obama's signature legislation, implementing sweeping changes to the U.S. health care system for the first time in decades. One of the act's many reforms sought to address health equity in the United States through increased health care access and more robust public health funding. The ACA was passed by a party-line vote, and most of the analysis on its passing and continued repeal efforts has focused on the role of partisanship in health policymaking.[1] We argue that much of the resistance to the ACA is a result not just of partisan division, but of lingering racial resentment. Given that the legislation aims to eliminate race-based disparities and is so closely associated with the first U.S. president of color, understanding perceptions of this law is crucial for future health policy efforts. If we are to advance health equity in the United States, we must focus more on the relationship between racial attitudes and policy preferences. A burgeoning literature has shown that persistent racism is a pressing public health problem resulting in disparities in both health care quality and public health outcomes[2,3] but continued racism should also be explored by scholars, public health practitioners, and policymakers as an important barrier to enacting health policy legislation that promotes health equity.

The ACA and Potential Contributions to Health Equity

The most commonly discussed facets of the ACA relate to health insurance coverage. Indeed there is evidence that through the new insurance exchanges that help Americans purchase affordable and comprehensive plans and through Medicaid expansion, the ACA narrowed at least some socioeconomic and racial/ethnic disparities in health care access.[4,5] The ACA also strengthened existing rules to prevent discrimination in the insurance marketplace.[6] But the ACA's impact on health equity extends beyond health care access to funding for public health improvement. The ACA explicitly sets as goals the reduction of health

disparities and improvement of population health.[7] New investments include providing a permanent funding stream to boost public health infrastructure and supporting cross-sector community-based partnerships to improve population health.[8] Evidence shows that general increases in public health spending are associated with lower levels of preventable death, especially in vulnerable communities.[9]

Racism and Public Health

In the United States, many social, political, and economic resources continue to be stratified by race. These findings help us understand persistent race-based health disparities in both morbidity and mortality.[10] In recent decades, scholars have also elucidated how racism at individual and institutional levels contributes to poor health.[11,12] For example, the cumulative experience of microaggressions and individual prejudice is associated with chronic stress and weathering, a process by which biological age accelerates faster than chronological age.[13,14] Racism encoded in institutions from policing to schools and banks shapes residential location and a host of place-based social determinants of health that predispose individuals to illness.[15,16] Gee and colleagues[17] argue that time should be considered an additional social determinant, especially insofar as the cumulative effects of discrimination are incurred across the life course.

The impact of racism on health has also been assessed within health care settings, demonstrating that racial minorities experience discrimination in the quality and longevity of patient visits, in referrals to indicated testing or treatment, and in the prescription of analgesics.[18,19] These disparities in health outcomes and health care access persist although explicit and overt displays of racial bias have become less accepted in the United States since the civil rights era.[20] Scholars have described instead a pattern of implicit and covert racism that involves prejudicial behavior that bears little to no relationship to one's

stated values or beliefs.[21,22] That is, individuals who demonstrate pro-white bias in hiring practices or medical treatment would not report holding corresponding anti-black racial attitudes.[23,24] As Eduardo Bonilla-Silva explains, Americans have unconsciously internalized the emotions of a racialized society, which shapes fear, empathy, and warmth toward various racial groups.[25]

Within the medical, academic, and business sectors, a host of new tools are available to measure implicit bias, especially the Implicit Association Test.[26] Discussions on implicit bias reflect a general interest in understanding the persistence of discriminatory practices by individuals and institutions with the aspiration to be color-blind or race-neutral. Despite criticism of techniques to measure unconscious bias among individuals, general consensus is that racial discrimination is an enduring cause of health disparities in the United States. Once expressed in a belief in biological inferiority, racism is now more covert, so an appropriate response requires interrogating the persistence of racial stereotyping and the ways in which racial attitudes are internalized.[27] Such efforts are necessary to confront unconscious biases in the health care system and in perceptions of health policies that support health equity.

Racial Attitudes and the 2012 Election

Scholars disagree about the extent to which the ACA was overtly focused on reducing racial inequalities in health.[7,28] Although the ACA includes language regarding health disparities and efforts to reduce them, the act has provisions to help a large segment of Americans; following the 2012 Supreme Court ruling, individual states were left with the decision whether to expand Medicaid for underserved populations. Similar to previous social policies, politicians shaped public support for the ACA by framing who was most likely to benefit from new provisions. [29] Given the persistence of stereotypes related to race and public welfare programs, some Americans interpreted the ACA to be aimed primarily at

helping the poor and people of color.[30] Evidence suggests that health care debates were already racialized prior to discussions of the ACA but were intensified during Obama's presidency.[31,32] There is also evidence that racism, generally, predicts support for the ACA both during early policy discussions and at the time of its adoption.

For example, several studies found that racial resentment is associated with lower levels of support for the ACA's passing.[33,34] Additional studies indicate that support for the ACA declines when it is associated with Obama or called "Obamacare," suggesting that racial resentment may influence reception of the act.[35,36] These findings offer important evidence and are compatible with research on state adoption of Medicaid expansion; explicit racial resentment is higher in regions where fewer states expanded eligibility requirements.[34] Racism, however, has continued to evolve and we need additional studies to build on this past research. In particular, we need a better understanding of how implicit racial attitudes, which are more commonly held as compared to explicit bias, relate to support for the ACA after the policy was fully implemented.

Contemporary Racial Attitudes and Support for the ACA in 2016

Whether racism is intentional or unintentional is crucial for assessing support for the ACA and for linking contemporary forms of racism to policy support for health equity in the United States. Further, support for the ACA has changed since it came into effect. Generally, support has increased for the health care law, but partisan division remains. The ACA continues to be politically at risk with several attempts at complete repeal failing early in the Trump administration. Today just over 50% of Americans have a favorable opinion of the ACA, an increase of almost 10 percentage points from when the policy was implemented in 2012.[37] It is not clear whether the relationship between racial attitudes and support for the ACA has changed as the policy has gained public support and has been implemented fully.

Subjecting these questions to analysis is important, as feelings towards a policy in principle is likely qualitatively different than active opposition to policy that has been fully implemented. We question whether both implicit and explicit racial attitudes are related to rejection of the ACA. In contrast to previous studies which assessed support for the policy during its passing or shortly after it became law, we assess the relationship between different types of racism and negative feelings towards the ACA at the beginning of the Trump administration.

METHODS

Data

This study uses data from the American National Election Studies (ANES) 2016 Time Series Study, which targets U.S. citizens age 18 and older currently living in the United States[38] The preelection wave was collected between September 7 and November 7, 2016, and as many participants as possible were reinterviewed for the postelection survey between November 9, 2016, and January 8, 2017. The data include a face-to-face sample (1,180 preelection and 1,058 postelection interviews) as well as an internet sample (2,090 preelection and 2,590 postelection interviews). For this study, ANES-provided weights were applied. These weights help account for the larger number of internet sample cases and given the complex sampling design, ensure that results are generalizable to the national population. [38] Because the dependent and focal variables of interest were measured only in the postelection wave, this study sample comprises participants who completed both pre- and postelection surveys and provided responses to all variables of interest (N=3,245).

Variables

The dependent variable was measured by the question, “Has the 2010 health care law, also known as the Affordable Care Act, improved, worsened, or had no effect on the quality of health care services in the United States?” Because our focus is on understanding critical

attitudes toward the ACA, we coded responses stating that the ACA has worsened the quality of health services as 1, and those stating that the act improved quality or had no effect were coded 0.

The focal independent variables representing anti-black attitudes were coded using three measures. The first was the Symbolic Racism Scale, measured by four of the eight indicators used in Henry and Sears's (2002) Symbolic Racism 2000 Scale. Respondents were asked how strongly they agreed or disagreed with the following statements: (1) "Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favors." (2) "Generations of slavery and discrimination have created conditions that make it difficult for blacks to work their way out of the lower class." (3) "Over the past few years, blacks have gotten less than they deserve." (4) "It's really a matter of some people not trying hard enough; if blacks would only try harder they could be just as well off as whites." Responses to statements 1 and 4 were coded as 1 (strongly disagree), 2 (disagree somewhat), 3 (neither agree nor disagree), 4 (agree somewhat), and 5 (agree strongly), whereas responses to statements 2 and 3 were reverse coded. The Symbolic Racism Scale ranging from 1 to 5 was created using these four indicators, with higher scores representing greater adoption of symbolic racist attitudes (Cronbach $\alpha = 0.84$).

The second and third measures, which also identify anti-black attitudes, rely on what ANES calls a "feeling thermometer." Respondents were asked to rate people and movements on a 0- to 100-degree scale. They were told that ratings between 50 and 100 degrees represented warm and favorable feelings and ratings between 0 and 50 degrees represented unfavorable feelings, indicating that participants "don't care too much" for that person or group. Respondents' feelings toward both "blacks" and "Black Lives Matter" were divided by 10 to create a 0-10 scale on both measures.

We controlled for respondents' self-identified race (black; Hispanic; and other race/ethnic minority, including Asian/Pacific Islanders, Native/Alaskan Native, and multiple races, with white as the reference category) and whether the respondent had health insurance (no insurance = 1, has insurance = 0). Other controlled demographic factors included age (in continuous years), sex (male = 1, all other = 0), household income ($22,499 or less = 1; $22,500–$44,999 = 2; $45,000–$69,999 = 3; $70,000–$109,999 = 4; $110,000 and above = 5), education level (1 = high school or less, 2 = some college, 3 = associate's degree, 4 = bachelor's, 5 = master's or higher), state of residency (resides in a state listed by the census as in the South; southern state = 1, all others = 0), and political party (variables for Republican and Independent, with Democrat as the reference category).

Statistical Analysis

We performed descriptive analyses for views toward the ACA, anti-black attitudes, and demographic variables. Exploratory analysis confirmed a significant interaction association between participants' race and anti-black attitudes and the dependent variable, but only for white participants. As such, logistic regression analysis was performed for both the total sample, controlling for race, and the sample of white participants.

RESULTS

Descriptive Statistics

Table 1 presents univariate results for the full sample and the white sample (approximately 70% of the total sample). Close to half (49.34%) of the full sample and approximately 56% of the white sample stated that the ACA has worsened the quality of health care in the United States. The mean score on the Symbolic Racism Scale was slightly higher for the white sample than the total sample (3.34 and 3.19, respectively). For the feeling thermometer measures, white participants felt slightly colder toward blacks (6.68) and toward Black Lives

Matter (4.20) than did the full sample (6.89 and 4.92, respectively). On average, the white sample was more likely to be insured, be older, have a higher household income, have a college degree, and identify as a Republican or Independent rather than a Democrat. The white sample, however, was less likely to live in a southern state (34.95% and 38.14%, respectively).

[Insert Table 1 here]

Multivariate Analyses

Table 2 presents the results of the analyses that examined the associations of anti-black attitudes and demographic factors with stating that the ACA has worsened the quality of health care for the full and white samples. For the anti-black attitude measures, the Symbolic Racism Scale was significantly associated with negative feelings toward the ACA. Respondents who scored higher on the scale for the full (odds ratio, 1.83; 95% CI, 1.65-2.02; $P < .001$) and white (OR, 2.01; 95% CI, 1.77-2.28; $P < .001$) samples approximately doubled the likelihood of stating that the ACA worsened health care. Feelings toward blacks was not significantly associated with negative beliefs about the ACA for the full sample but was related for the white sample (OR, 1.07; 95% CI, 1.02-1.13; $P < .05$). Of interest, this went in an unexpected direction: those who had more favorable feelings toward blacks were more likely to state that the ACA worsened health care. In contrast, for both the full and white samples, those with more favorable feelings toward Black Lives Matter were approximately 14% less likely to state that the ACA worsened health care (OR, .86; 95% CI, .83-.89; $P < .001$, and OR, .86; 95% CI, .82-.89; $P < .001$, respectively).

[Insert Table 2 here]

In the full model, those who self-identified as black were more than 30% less likely to state that the ACA worsened health care than were participants who self-identified as white;

however, no significant differences occurred between Hispanic and other racial minority identity and white identity. Not having health insurance was related to having approximately two times higher odds of stating that the ACA worsened health care in both the full (OR, 1.98; 95% CI, 1.48-2.64; $P < .001$) and white (OR, 2.20; 95% CI, 1.49-3.26; $P < .001$) models.

In terms of demographic correlates, in the full model, older individuals and more educated individuals were slightly less likely to state that the ACA worsened health care. In both models, men were less likely to state that the ACA worsened health care, whereas those living in southern states and Independents were more likely. In both models, Republican identity was the strongest predictor of negative feelings toward the ACA; Republicans were more than four times more likely than Democrats in the full model, and more than five times more likely in the white model, to state that the ACA worsened health care (OR, 4.25; 95% CI, 3.37-5.35; $P < .001$ and OR, 5.25, 95% CI, 4.00-6.90 $P < .001$).

The Cox and Snell type pseudo-R-squared in both models is high in both the full (pseudo-$R^2 = .30$) and white (pseudo-$R^2 = .32$) models, indicating that the independent variables and correlates are explaining a large portion of the variation in feelings toward the ACA.

Discussion

Our findings provide insight into support for the ACA at a time when public support has increased, but partisan groups remain focused on dismantling core facets of the health care law. The results of this analysis reiterate that political affiliation strongly shapes support for the ACA, with Republican identification greatly increasing the odds of disapproving of the policy and Independent identification increasing the odds of believing that the ACA worsened health care. Individuals with no health insurance also reported less favorable

feelings toward the ACA, suggesting that people who perceive the act as not helping them personally become insured may hold more critical attitudes. But specific types of racial attitudes, particularly among whites, also are strongly associated with ACA support, which has been only minimally investigated in the literature on public health policy and health equity.

Although previous studies at the time of the ACA's adoption found a relationship between support for the ACA and racism more generally, scholars have not yet investigated the relationship between various types of racial attitudes that may be more common among white Americans.[27] Specifically, previous studies have not assessed the extent to which modern forms of racial bias, such as unconscious or implicit attitudes, shape views on the ACA. Our findings suggest that the Symbolic Racism Scale, measuring racial stereotypes often at odds with professed preferences for egalitarianism, is strongly related to views about the ACA. This is the case in our full model as well as the whites-only model. Although higher scores on this scale are associated with lower support for the ACA, a measure of explicit racial prejudice has the opposite relationship among whites. That is, the more warm feelings that whites have for blacks, the more likely they are to reject the ACA. This suggests that whites are most critical of the ACA when they hold positive attitudes toward blacks but hold negative stereotypes about blacks' work ethic and reject policies to eliminate racial inequalities.

Our finding that whites who do not respond warmly to the Black Lives Matter movement are more likely to reject the ACA is important. The Black Lives Matter movement evolved specifically to confront systemic racism in the criminal justice system and other institutions. Whites may interpret this movement as an attempt to give special treatment to blacks and interpret the ACA also as a policy intervention aimed at reducing race-based inequities in the United States. As racism has evolved subsequent to the civil rights

movement, many whites view policies that aim to remove racial disparities as inappropriate, even as they express preferences for greater racial equality. In other words, many whites may consciously believe that all Americans should be treated equally but do not favor government interventions that seek to promote equality.

Why might explicit pro-black attitudes and implicitly held anti-black stereotypes be associated with decreased support for the ACA? The way the ACA has been framed in public debates over health care reform provides insight into our findings. The ACA is not unique, but follows a longer history of social policies being discredited if they help, or are perceived to help, racial minorities.[29] Although the ACA provided specific help for the poor and near poor in terms of the optional state Medicaid expansion, this policy also targeted health care access among working Americans and vastly expanded U.S. public health infrastructure. Although increases in insurance coverage occurred at slightly higher rates among African Americans (8% as compared to 6% among whites), in absolute terms, more whites (around 10 million) were helped by this policy than any other racial/ethnic group.[39] Despite the fact that the ACA was not explicitly framed as a social welfare policy, opponents often used coded language in describing the policy, implicitly reinforcing many anti-black stereotypes. In other words, despite the lack of explicit framing, the ACA has often been interpreted in policy debates as an attempt to funnel public resources toward poor and non-white Americans.[28,30]

Although the ACA was not overtly framed as a policy to ameliorate racial disparities in health care outcomes and access, many white Americans seem to interpret this policy as an attempt to unfairly benefit racial and ethnic minorities. Ian Haney Lopez argues that many politicians have engaged in what he calls “dog whistle politics,” using coded language to discredit social programs by implying that they unfairly benefit undeserving recipients.[29] He argues: “They are dog whistles: silent about race on one level, but stirring racial anxiety

on another."[40] Although race is not explicitly mentioned, these appeals engage implicitly held racial stereotypes and convince individuals that policies are inappropriate and inconsistent with abstract ideals such as fairness and hard work. Because it is not often politically tenable to demonstrate overt racism in attacks of social policies, politicians are able to engage implicit anti-black stereotypes that are persistent within the American population. Implicit forms of anti-black attitudes are more common among Americans and in studies have not been found to be strongly related to explicit racial attitudes.[27,41] The changing salience of different types of racial attitudes in the United States helps explain why policies that do not explicitly engage race, but engage implicit racial resentment, may be discredited.

Perhaps the most clear example of how the ACA was imbued with racial undertones, was in the use of the term "Obamacare" to describe the policy. Given previous attacks on Obama's ethnicity, nativity, and religious identity, the use of this moniker carried subtle messages that the policy was an attempt to funnel resources toward other Black Americans. Other scholars have argued that attitudes toward this policy were shaped significantly by it being drafted by the first U.S. president of color.[32] Indeed, our post hoc statistical analyses (available by request) show that rejection of the ACA is associated only with anti-black attitudes and not racism toward other minority groups. These findings are important because they suggest the salience of anti-black attitudes, in particular, for shaping support for the ACA. We caution readers that the ACA is not unique in terms of its connection to implicit anti-back attitudes; the legacy of anti-black attitudes in the United States should continue to remain a focus of public health scholars and advocates. As we advance new policies to promote health equity, understanding the role that implicit racial attitudes play will be essential.

Limitations

There were several limitations in this study. First, this research uses cross-sectional data, and as such, causation cannot be inferred. Next, more than 70% of our sample identified as non-Hispanic white, which is higher than the national total listed in the 2018 census (60.7%),[42] and there was an underrepresentation of blacks and Hispanics in our sample. In terms of the anti-black variables, the data included indicators for only half of the symbolic racism measures listed in Henry and Sears' Symbolic Racism 2000 Scale.[43] The ANES uses both internet and face to face interviews which may elicit different responses, particularly on sensitive questions. In our sample, we did find slight differences in feelings toward Black Lives Matter between the two interview formats, suggesting that social desirability bias may exist among respondents. We did not, however, find any significant differences in our other focal independent variables by interview type.

Public Health Implications

Discussions of racism in public health have increased in recent years and for good reason. Racism on both individual and institutional levels is associated with significant health disparities. Anti-black racial attitudes, however, are a critical barrier to enacting health policies that stand to improve health equity in the United States. Although fewer whites are comfortable espousing overtly racist attitudes, concerns still remain over whether structural initiatives, such as public health policies, are necessary to help promote racial equity. This type of racism is less noticeable and is often accompanied by explicit beliefs that are in sharp contrast to implicit prejudices. The persistence of implicit anti-black attitudes among Americans has tremendous consequences for adopting systemic approaches to improving health equity, which is the cornerstone of public health. Public health practitioners and policymakers should consider racism to be an essential barrier to overcome in the push for greater health equity in the United States.

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Compliance with Ethical Standards

Funding: No funding was received.

Conflict of Interest: The Authors declare that they have no conflict of interest.

Ethical Approval: This article does not contain any studies with human participants or animals performed by any of the authors. The study utilizes data from the American National Election Studies (ANES) 2016 Time Series Study, a publically available dataset with identifying information removed to protect respondent confidentiality. Participation in the ANES is voluntary, and the procedures for the ANES are overseen by the ANES advisory board, University of Michigan, and Stanford University.

Table 1. Sample Characteristics

	Full Sample (N=3647)		***White Sample (N=2529)***	
	Mean /N	**Std Dev/%**	**Mean /N**	**Std Dev/%**
Variables				
ACA worsened health care	1767	49.34%	1392	56.11%
Symbolic Racism Scale (1-5)	3.19	1.13	3.34	1.12
Feeling Thermometer: Blacks (0-10)	6.89	2.14	6.68	2.08

Feeling Thermometer: Black Lives Matter (0-10)	4.92	3.25	4.20	3.08
R identifies as black	397	10.94%		
R identifies as Hispanic	432	11.91%		
R identifies as other racial minority	268	7.04%		
No health insurance	364	9.98%	209	8.25%
Age	47.39	17.69	49.20	17.92
Male	1733	47.94%	1202	47.78%
Household income	$57,500	1.44	$61,300	1.42
College degree or higher	1156	31.88%	878	34.89%
R resides in southern state	1391	38.14%	884	34.95%
Republican	1016	28.09%	869	34.61%
Independent	1161	32.08%	837	33.37%

Table 2. Odds Ratios for Logistic Regression Stating ACA Worsened Health Care

	Full Sample (N=3245)		***White Sample (N=2388)***	
	OR	**95% CI**	**OR**	**95% CI**
Variables				
Symbolic Racism Scale (1-5)	1.83***	1.65, 2.02	2.01***	1.77, 2.28
Feeling Thermometer: Blacks (1-10)	1.04	1.00, 1.09	1.07*	1.02, 1.13

Feeling Thermometer: Black Lives Matter (1-10)	.86***	.83, .89	.86***	.82, .89
R identifies as black	.68*	.49, .93		
R identifies as Hispanic	.83	.63, 1.08		
R identifies as other racial minority	.80	.58, 1.10		
No health insurance	1.98***	1.48, 2.64	2.20***	1.49, 3.26
Age	.995*	.990, .999	.996	.99, 1.00
Male	.78**	.65, .92	.78*	.63, .96
Household income	1.03	.97, 1.10	1.07	.99, 1.16
Education	.93*	.87, .99	.94	.87, 1.02
R resides in Southern state	1.33**	1.11, 1.58	1.32*	1.06, 1.64
Republican	4.25***	3.37, 5.35	5.25***	4.00, 6.90
Independent	1.50***	1.23, 1.82	1.82***	1.42, 2.32
Pseudo R Squared	.30		.32	

*** p < .001 ** p < .01 * p < .05