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(En)gendering racial disparities in health trajectories: A life course and intersectional analysis

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ABSTRACT

Historically, intersectionality has been an underutilized framework in sociological research on racial/ethnic and gender inequalities in health. To demonstrate its utility and importance, we conduct an intersectional analysis of the social stratification of health using the exemplar of hypertension—a health condition in which racial/ethnic and gender differences have been well-documented. Previous research has tended to examine these differences separately and ignore how the interaction of social status dimensions may influence health over time. Using seven waves of data from the Health and Retirement Study and multilevel logistic regression models, we found a multiplicative effect of race/ethnicity and gender on hypertension risk trajectories, consistent with both an intersectionality perspective and persistent inequality hypothesis. Group differences in past and contemporaneous socioeconomic and behavioral factors did not explain this effect.

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Introduction

Stratification scholars widely acknowledge that social status dimensions, such as race/ethnicity, gender, and socioeconomic status (SES), structure lived experience by constraining or bolstering resources, opportunities, and life chances. If we view health as a life chance (Haas, 2006), then it becomes clear that these dimensions also structure susceptibility and resilience to illness. As a result, racial/ethnic, gender, and socioeconomic disparities in health have been increasingly recognized as both consequences of and contributors to social stratification processes across the life course (Haas, 2006; House et al., 1994). What is less well acknowledged is the need for a multidimensional—or intersectional—approach to understanding social stratification generally and the social stratification of health in particular. Instead, it is more common for race/ethnicity, gender, and other dimensions of inequality to be treated as separate categories of analysis or, when examined together, viewed as additive rather than mutually reinforcing and inseparable. Likewise, considering the inextricable linkages among social status dimensions is an uncommonly pursued approach to health disparities research. This neglect may obscure the social processes underlying these disparities.

To demonstrate the utility and importance of an intersectional approach to longitudinal research on health disparities, we use the exemplar of hypertension. In the U.S., hypertension is the leading cause of cardiovascular disease and a major contributor to high medical and work productivity loss costs, home productivity loss, and consequent family financial and caregiving burdens (Druss et al., 2001; Heidenreich et al., 2011; Kessler, Ormel, Demier, & Stang, 2003; Merikangas et al., 2007). Racial/ethnic and gender disparities in hypertension prevalence have been well-documented, suggesting that it is a key contributor to inequalities in life chances. Although many studies have been conducted to identify determinants of hypertension, our understanding of the determinants of hypertension disparities remains incomplete (Flack, Ferdinand, & Nasser, 2003; Minor, Wofford, & Jones, 2008; Rieker, Bird, & Lang, 2010). Not only have previous studies frequently considered race/ethnicity and gender as separate (rather than intersecting) categories of analysis (see the Canadian study by Veenstra (2013) for an exception), but they also have focused primarily on contemporaneous risk factors rather than risk histories. Moreover, much of what we know about gender and racial/ethnic differences in hypertension—and their age patterns—comes from cross-sectional data (e.g., Cutler et al., 2008; Geronimus, Bound, Keene, & Hicken, 2007), which are not well-suited for testing hypotheses about group differences in intra-individual change with age.

Thus, we extended previous research by using panel data and integrating intersectionality and life course perspectives to

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examine how race/ethnicity, gender, and age combine to shape hypertension risk trajectories between mid- and late-life among Black, White, and Mexican Americans. Specifically, we sought to determine whether and how racial/ethnic disparities in hypertension trajectories are (en)gendered. Using seven waves of data from the Health and Retirement Study (1992–2004) and multilevel logistic regression models, we investigated whether race/ethnicity and gender combine in a multiplicative fashion—i.e., the intersectionality hypothesis—to produce disparate trajectories of hypertension risk net of early life and contemporaneous social, economic, and behavioral factors. We also tested the alternate hypothesis—i.e., the double jeopardy hypothesis—that the relationships among race/ethnicity and gender are additive. In addition, we tested whether group differences in hypertension risk trajectories are consistent with cumulative advantage/disadvantage, aging-as-leveler, or persistent inequality hypotheses.

Racial/ethnic, gender, and age disparities in hypertension prevalence

Racial/ethnic disparities in hypertension prevalence in the U.S. are well-documented. Non-Hispanic Blacks have had consistently higher rates of hypertension than Whites (Minor et al., 2008; Ong et al., 2007). Conversely, although the prevalence of hypertension has been rising among Mexican Americans (Ghatrif et al., 2011), they typically have rates of hypertension similar to or lower than those of Whites (Gillespie & Hurvitz, 2013). Age-related increases in hypertension prevalence also differ by race/ethnicity, as well as gender. Blacks have an earlier average age of hypertension onset than Whites (Minor et al., 2008; Ong et al., 2007). Moreover, the Black–White gap in hypertension is wider at older ages, particularly among women (Cutler et al., 2008). In fact, using cross-sectional data, Geronimus et al. (2007) identified both an earlier age of onset and more pronounced increase in hypertension prevalence with increasing age among Black women compared to other racial/ethnic-gender groups.

Known risk factors for hypertension do not fully explain hypertension disparities (Flack et al., 2003; Minor et al., 2008; Rieker et al., 2010). In addition, our understanding of the age patterns of hypertension disparities is incomplete due to a dearth of longitudinal studies. Unlike the cross-sectional studies of hypertension that have been conducted to date (e.g., Cutler et al., 2008; Geronimus et al., 2007), longitudinal studies would enable testing hypotheses about group differences in intra-individual change with age and including risk histories instead of limiting potential explanations for disparities to contemporaneous risk factors. Research on hypertension disparities in the U.S. also has not considered race/ethnicity and gender as intersecting (rather than separate) categories of analysis.

Intersectionality as a key mechanism in the social stratification of health

Intersectionality, a concept coined by legal scholar Kimberle Crenshaw (1989), suggests that dimensions of social inequality—such as race/ethnicity and gender—vary as a function of each other, are interconnected or interlocked, and are mutually reinforcing/constitutive. As a result, these “interlocking systems of oppression” (Ore, 2003) simultaneously create unique social locations and structure the lived experience and life chances of the people who occupy them (Collins, 2000). With regard to Black women, for example, intersectionality refers to this group’s simultaneous positioning at the disadvantaged ends of both race/ethnicity and gender hierarchies, and consequently class hierarchies (Collins, 2000; Davis, 1981). Intersectionality, therefore, predicts that Black women are more likely to experience disadvantage than other race/ethnicity-gender groups—a prediction

that runs counter to popular notions about the low social status of Black men. Indeed, Black women experience the greatest disadvantages of all racial/ethnic-gender groups across multiple indicators of life chances, including poverty rates (Elemelch & Lu, 2004), income (U.S. Census Bureau 2012), wealth (Chang, 2006), and marriage (Warner & Brown, 2011). This relative disadvantage is posited to result from Black women’s experiences of “a double [or triple] load of discrimination” (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006), and/or “gendered racism” (Essed, 1991), as well as additional burdens stemming from the plight of their male counterparts, who suffer disproportionate incarceration, unemployment, and premature mortality (U.S. Department of Labor & U.S. Bureau of Labor Statistics, 2011; Guerino, Harrison, & Sabol, 2011; Xu, Kochanek, Murphy & Tejada-Vera, 2010) (Mullings & Wali, 2001).

These chronic stressors, together with Black women’s perpetual and often unsuccessful attempts to cope with them, could precipitate poor health (Geronimus, 1992; Mullings & Wali, 2001; Thomas, Witherspoon & Speight, 2008). In fact, studies have found that Black women experience multiple chronic stress-related morbidities at a higher rate than other racial/ethnic-gender groups, including Black males (e.g., Bird et al., 2010; Brown & Hargrove, 2013; Geronimus et al., 2007; Geronimus, Hicken, Keene & Bound, 2006b; Read & Gorman, 2006; Warner & Brown 2011). Thus, while Black men live shorter lives than their female counterparts on average, Black women have the shortest *healthy* life expectancy of all racial/ethnic gender groups.

While there is growing interest in bringing intersectionality to bear on health disparities research (Schulz & Mullings, 2006), few empirical studies have adopted this approach. The vast majority of studies on intersectionality and health have been within-group qualitative studies and/or considered health outcomes other than hypertension (e.g., Haldeman, 2005; Mullings & Wali, 2001). Fewer quantitative studies of health disparities have *explicitly* applied intersectionality (e.g., Ailshire & House, 2011; Veenstra, 2013; Hinze, Lin & Andersson, 2012; Brown & Hargrove, 2013). Among them, however, are at least two studies that found support for intersectionality, revealing a potential need for more frequent use of this framework. Using cross-sectional data from the National Social Life, Health and Aging Project (2005–2006), Hinze et al. (2012) showed the overlapping and simultaneous impacts of race, gender, and education on self-rated health among Black and White older adults. They found that Black women with less than a high school education had the lowest self-rated health compared to other race-gender-education groups. Using longitudinal data instead, Ailshire and House (2011) found interactive effects of gender, race, SES, and age on body mass index (BMI) trajectories among 25–84 year old Blacks and Whites in the American’s Changing Lives study (1986–2001/2002). Specifically, they found that low-educated and low-income Black women experienced the greatest increase in BMI with age compared to other race-gender-SES groups.

The latter study foreshadows the need for an intersectionality approach to research on hypertension, given that BMI (particularly at levels indicative of obesity) lies along the pathway to hypertension. Racial/ethnic and gender patterns of hypertension prevalence also suggest the need for this approach. Yet when both race/ethnicity and gender have been included in previous quantitative research on hypertension (and other health) disparities, researchers have frequently examined gender effects while stratifying by race (or vice versa); used a “configurational” approach (Alon, 2007)—i.e., one that compares gender-race/ethnicity combinations to one reference group, usually white men (as Ailshire and House did); or, more often, assumed an additive relationship between race/ethnicity and gender.

Intersectionality, however, suggests that the simultaneity of social status dimensions is a multiplicative—not additive—

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