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Health care barriers, racism, and intersectionality in Australia

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ABSTRACT

While racism has been shown to negatively affect health care quality, little is known about the extent to which racial discrimination works with and through gender, class, and sexuality to predict barriers to health care (e.g., perceived difficulty accessing health services). Additionally, most existing studies focus on racial disparities in the U.S. context, with few examining marginalized groups in other countries. To address these knowledge gaps, we analyze data from the 2014 Australian General Social Survey, a nationally representative survey of individuals aged 15 and older living in 12,932 private dwellings. Following an intersectional perspective, we estimate a series of multivariable logit regression models to assess three hypotheses: racial discrimination will be positively associated with perceived barriers to health care (H1); the effect of perceived racial discrimination will be particularly severe for women, sexual minorities, and low socio-economic status individuals (H2); and, in addition to racial discrimination, other forms of perceived discrimination will negatively impact perceived barriers to health care (H3). Findings show that perceptions of racial discrimination are significantly associated with perceived barriers to health care, though this relationship is not significantly stronger for low status groups. In addition, our analyses reveal that perceived racism and other forms of discrimination combine to predict perceived barriers to health care. Taken together, these results speak to the benefits of an intersectional approach for examining racial inequalities in perceived access to health care.

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1. Introduction

Amidst a long history of massive social and scientific efforts towards constructing and legitimizing race as a biologically valid category, including the widespread politics of eugenics in Europe and the Americas in the late 19th and early 20th centuries (Levine and Bashford, 2010), the concept of racism emerged as an important counter-narrative for explaining racial inequities (Duckitt, 2010). It was not until the beginning of the 1980s, however, that a consistent body of work began to thoroughly examine racism as a public health issue, with lasting impacts on the health of disadvantaged social groups (Krieger, 2014). Since then, the persistence of racism across time and place, together with its strong association with population patterns of health, well-being, and health inequities, has been characterized as one of the greatest public health

challenges of our times. Through the development of varied frames of reference, empirical studies have systematically shown that racism is both a powerful driver of physical and mental health outcomes (Paradies et al., 2015), and a factor that underlies health inequities among dominant and subordinate racial categories (Krieger and Sidney, 1996).

While a large corpus of research examines the causes of racial disparities in health, existing scholarship is limited in four respects. First, few existing studies have the external validity required to determine the extent to which health-related outcomes are attributable to racism. Second, most large-scale studies of the health effects of racism focus on inequities between Blacks and Whites in the U.S. A third limitation concerns the dearth of studies examining how race works with other axes of inequality (e.g. gender) and other forms of discrimination (e.g., gender discrimination) to structure health outcomes. Fourth, few studies have examined the ways in which racial discrimination affects perceived access to health care.

Using the Australian context as a case study, we ask: (1) To what extent do perceptions of racial discrimination predict respondents'

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barriers to health care?; (2) Does the relationship between perceptions of racial discrimination and barriers to health care differ for high and low status groups?; and (3) To what extent do perceptions of racial discrimination work with other forms of discrimination to structure barriers to health care? Throughout this article, we use the term “racism” to refer to a macro-level system that “is manifested in societies through the unequal distribution of power (resources, opportunities, benefits, capacities etc.),” and “racial discrimination” or “perceived racism” to refer to the interpersonal interactions that maintain or reinforce power differentials, as well as their consequences (Paradies, 2016, 1).

1.1. Racism, health and health care

Existing research shows that racism works through a variety of micro- and macro-level processes to structure health outcomes. Studies focusing on the micro-level conceptualize racism as a social stressor, and emphasize cognitive, physiological, and emotional factors (Pascoe and Smart Richman, 2009). At the macro-level, researchers conceptualize the health effects of racism as resulting from multifaceted and intertwined processes, including exposure to economic and social deprivation, socially inflicted trauma, and inadequate health care (Krieger, 2014; Paradies, 2006). Conceptualizing health inequities from an “ecosocial” perspective, Krieger (2014) highlights the ways in which the health effects of institutionalized and interpersonal racism accumulate over the lifecourse, as well as over generations. According to this perspective, individuals “literally biologically embody exposures arising from our societal and ecological contexts” (Krieger, 2014, 73). In the aggregate, this embodiment gives rise to population patterns of health and disease that are structured not only by race, but also gender, sexuality, and class.

Research in the U.S. shows that Blacks receive significantly lower-quality health care than do Whites. Black patients are less likely to undergo coronary artery bypass, less likely to receive kidney transplantations, for example, and also experience greater delays in transfer between healthcare facilities (Penner et al., 2014; Phelan and Link, 2015). The strong connections between racism and health care also extend beyond the realm of individual-level experiences. At the societal level, the concentration of racial minorities in communities lacking high-quality healthcare facilities creates racially patterned barriers to high-quality care, as do occupational structures in which racial minorities are concentrated in low-paying jobs with less flexible work-schedules (Krieger, 2014; Phelan and Link, 2015).

Scholarship investigating the link between perceived racism and health care is limited by an almost exclusive focus on patients' race and the consequences of racial bias among physicians, leaving the effects of perceived racism on barriers to health care an under-researched topic in the field. A handful of studies show that racial discrimination may lead to disengagement with, and avoidance of, general (Lee et al., 2009) and dental care (Jamieson et al., 2013). Tanner et al. (2014) examined both race- and sexuality-based discrimination on access to health care, and found that sexuality-based discrimination, but not racial discrimination, was associated with perceiving access to urgent care as poor or fair.

Several mechanisms likely underlie the links between discrimination and perceived barriers to health care. In general, individuals' perceptions and anticipation of discrimination are positively associated with healthcare system distrust (A. D. Moore et al., 2013), which reduces the likelihood of seeking medical advice, utilizing preventive health services, and perceiving the healthcare system as accessible. Patients' prior experiences with discrimination in the healthcare system may also be associated with lower ratings of health care quality, and this may feed back

into higher perceptions of reduced access to care. Additionally, after facing discrimination in other systems (e.g., the educational or justice systems), individuals may be reluctant to expose themselves to similar experiences in the healthcare system. More indirectly, experiencing discrimination may reduce the time and energy needed to access health care (Richman and Lattanner, 2014). This can also occur through avoidance behaviors. Perceiving discrimination or harassment on public transportation, for example, could lead to avoidance of this domain, which might then limit individuals' access to health care.

1.2. Intersectionality and health

Intersectionality is a theoretical perspective which highlights the ways in which multiple systems of inequality work with and through one another, at multiple levels of society (Collins, 2000; Zinn and Dill, 1996). At the core of intersectionality is the contention that the *a priori* centralization of one system of inequality, social status, or identity, obscures the ways in which systems of inequality co-constitute and mutually reinforce one another (Crenshaw, 1989; Hankivsky, 2012). Studies that rely on a single-axis approach often contribute to “intersectional invisibility” (Purdie-Vaughns and Eibach, 2008), wherein a person or group holding multiple disadvantaged social statuses may be made “invisible,” relative to those characterized by a single disadvantaged status.

Most intersectional studies of health emphasize intersecting statuses and identities. Studies reveal that groups with multiple disadvantaged statuses (e.g., Black women) often – though not always – experience poorer health outcomes than groups with a single disadvantaged status (Calabrese et al., 2015). Intersectional research focusing specifically on discrimination emphasizes that individuals with multiple disadvantaged statuses frequently perceive multiple forms of discrimination (Grollman, 2014; Harnois, 2014), as well as forms of discrimination that are not reducible to a single axis of inequality (Crenshaw, 1989). Evidence increasingly suggests that, compared to those who perceive discrimination along a single axis of inequality, those who perceive multiple forms of discrimination tend to experience worse health outcomes (Bastos et al., 2014; Grollman, 2014; Szymanski and Owens, 2009).

By focusing on the intersection of multiple social statuses, intersectionality draws attention not only to the various forms of discrimination, but also to the ways in which the consequences of any particular form of discrimination may vary for high and low status groups. Though there are important differences among them, low status groups (e.g., women, low SES individuals) tend to have less power, less control over their environment, and are less able to avoid situations in which subsequent instances of discrimination may occur (Ridgeway, 2014). Individuals in low status groups often have fewer social, economic, and psychological resources to deal with the potential consequences of stressful events such as discrimination (Pearlin and Schooler, 1978; Ridgeway, 2014; Szymanski and Owens, 2009). Moreover, the consequences of discrimination accumulate over the lifecourse, and may take an especially large toll on disadvantaged social groups (Krieger et al., 2008). Taken together, these theories highlight (1) the combined effects of multiple forms of discrimination as experienced by disadvantaged groups, and (2) the possibility that the consequences of perceived racism differ across multiple axes of inequality.

1.3. The Australian context

As previously noted, most research on the health effects of

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