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An empirical analysis of White privilege, social position and health

Naa Oyo A. Kwate [a,*], Melody S. Goodman [b]

[a] Departments of Human Ecology and Africana Studies, Rutgers, The State University of New Jersey, 55 Dudley Rd, Cook Office Building, New Brunswick, NJ 08901-8520, USA

[b] Division of Public Health Sciences Department of Surgery, Washington University in St. Louis School of Medicine, 660 S. Euclid Avenue, Campus Box 8100, St. Louis, MO 63110, USA

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ABSTRACT

Accumulated evidence has demonstrated that social position matters for health. Those with greater socioeconomic resources and greater perceived standing in the social hierarchy have better health than those with fewer resources and lower perceived standing. Race is another salient axis by which health is stratified in the U.S., but few studies have examined the benefit of White privilege. In this paper, we investigated how perceptions of inequality and subjective and objective social status affected the health and well-being of $N = 630$ White residents in three Boston neighborhoods lying on a social gradient differentiated by race, ethnicity, income and prestige. Outcomes were self-rated health, dental health, and happiness. Results suggested that: neighborhood residence was not associated with health after controlling for individual level factors (e.g., positive ratings of the neighborhood, education level); objective measures of socioeconomic status were associated with better self-reported and dental health, but subjective assessments of social position were more strongly associated; and White residents living in the two wealthiest neighborhoods, and who perceived Black families as welcome in their neighborhoods enjoyed better health than those who believed them to be less welcome. However, those who lived in the least wealthy and most diverse neighborhood fared worse when reporting Black families to be welcome. These results suggest that White privilege and relative social position interact to shape health outcomes.

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1. Introduction

A substantial literature has shown that lower placement in the social hierarchy has deleterious health effects. But do those at the top of the hierarchy reap benefits because others are at the bottom? Subramanian et al., (2005) examined differences in self-rated health among Black and White residents in U.S. metropolitan areas with populations of 100,000 or more, finding significant variation in racial disparities across metro areas—with Black health rates more variable than Whites'. An unexpected finding was that areas with higher probabilities of poor health for Whites were those in which the White–Black health disparity was narrow. In other words, the absolute health of Whites was better where they held a larger health advantage relative to Black counterparts (Subramanian et al., 2005). Why might the health status of Whites depend on a relative health advantage to Blacks?

We may speculate that Whites may enjoy better health when the Black–White disparity is wide because of material opportunity hoarding. That is, if Whites disproportionately hold desired material resources, so that better quality of life is more tightly bound to White space and health-deleterious exposures are more acutely concentrated in Black communities, this may produce cities with wider racial disparities in health. For example, Black neighborhoods are more likely to contain liquor stores (Berke et al., 2010; LaVeist and Wallace, 2000) and other noxious exposures, raising the possibility that wider racial disparities benefit Whites because the disparities reflect geographically quarantined health risks from which Whites are protected.

It is also possible that per Du Bois, the psychological "wages" accrued from whiteness (see Harris, 1993) benefit health—and these wages find greater remuneration in areas where the distinction between social status among Blacks and Whites is greatest. At a psychological level, socioeconomic gradients in health among Whites may be linked to perceptions of appropriate life stations. That is, poor Whites may face health risks not merely due to meager resources, but because being poor disconfirms expected

* Corresponding author.
E-mail address: nokwate@rci.rutgers.edu (N.O.A. Kwate).

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rewards from being White. Those who then grow up to be better off may be healthier because they experience "relief at having fulfilled a cultural aspiration for wealth and from finding the rewards consistent with their expectations" (Pearson, 2008 p. 42). Indeed, McDermott's (2006) ethnographic work in Atlanta showed that White residents who lived among Black neighbors experienced their whiteness as an individual weakness or failure. Harris (1993) sees the expected rewards of whiteness as "a treasured property in a society structured on racial caste. In ways so embedded that it is rarely apparent, the set of assumptions, privileges, and benefits that accompany the status of being White have become a valuable asset … Whites have come to expect and rely on these benefits, and over time these expectations have been affirmed, legitimized, and protected by the law" (p. 1713). For Harris, whiteness has the characteristics of property, including a right to exclude, and rights, freedoms and privileges that are a legitimate and settled expectation.

These settled expectations have not been adequately addressed in racial health disparities research (Jones et al., 2008). Jones and colleagues argue that research tends not to interrogate White privilege—the benefits and unfair advantage accorded to whiteness—but rather focuses on the disadvantage of non-Whites. Unfair advantage includes benefit of the doubt, high expectations, trust, laxity in rule enforcement, and day-to-day breaks that Whites either see as luck or fail to notice at all (Jones et al., 2008). These advantages benefit health. Individuals who are seen by the public as White (socially assigned race)—regardless of their own racial self-identification—have better health outcomes than those who are not perceived to be White. Moreover, individuals socially assigned as White have essentially the same health status as individuals who self-identify as White (Jones et al., 2008).

Taken together, the health advantage experienced by Whites in the U.S. reflects their position in a racialized social system, which classifies Whites at the top of the hierarchy (Bonilla-Silva, 1996). Whiteness confers health advantages through material resources and opportunities, positive public regard, and a baseline of settled expectations that are codified in law. Thus, subjective social status is an appropriate way to explore why Whites might fare better in metropolitan areas where they experience a greater health advantage relative to those who are classified at the bottom of the hierarchy.

Subjective social status is typically assessed with a depiction of a ladder that represents where people stand in society; the top of the ladder represents people with the most money, education and best jobs, and the lowest rung the opposite. Respondents are asked to rank their social status by placing themselves on the ladder, and assessments generally represent a cognitive average of standard objective measures (e.g., income, education), as well as an assessment of current and future prospects (Singh-Manoux et al., 2005). In the Whitehall II Study, subjective social status was more strongly related to health than objective measures. We may interpret these findings as evidence that subjective social status more precisely measures socioeconomic position by allowing for inclusion of past and future status; or as evidence that it captures relative position in the social hierarchy (Singh-Manoux et al., 2005).

If whiteness confers expectations of privilege, then health advantages may stem from perceived ranking at the top of the social hierarchy. That is, after accounting for objective resources, perceptions of race-appropriate social status may account for health status. Whites may fare better in areas where the relative gap to Blacks is larger because those gaps are consistent with the settled expectations of whiteness. Therefore, although the literature on social gradients and health suggest that being (or perceiving oneself to be) at the top of the socioeconomic hierarchy is most beneficial to health, it may be the case that for Whites to accrue health benefits, living in contexts where one perceives a greater relative gap to others is more important.

To investigate these ideas, we examined the self-rated health of White residents of three spatially distinct Boston neighborhoods, each with different demographic profiles. First, we asked whether neighborhoods follow an inverse social gradient in health. The neighborhoods of Back Bay, South End, and Jamaica Plain are all affluent, and like Boston, predominantly White. However, they span a gradient income and wealth and percentage of White residents. If absolute resources were most important, residence in Jamaica Plain would be associated with the least favorable health profile, concordant with the standard social gradient. However, if living in contexts where inequalities are greater were especially conducive to the health of Whites (as shown in Subramanian et al. (2005), residing in Jamaica Plain would be associated with the most favorable health profile. Second, we assessed the interplay between subjective and objective social status, and associations with health and well-being.

2. Methods

2.1. Setting

The city of Boston is the 20th largest U.S. city, with a total population of approximately 617,000 in 2010. It is also one of the most segregated cities in the country, with a Black–White dissimilarity index in 2010 of 69.2 (Spatial Structures in the Social Sciences, 2011). Boston also has a history of contentious race relations. An iconic image of White response to desegregation is Stanley Forman's "The Soiling of Old Glory", in which a White protestor attacks a Black passerby with an American flag during a 1976 anti-busing rally at Boston's City Hall (Forman, 2013). In fact, neighborhood and school segregation has remained at high levels over time. During the 1990s, the city lost 47,000 Whites to the suburbs; in 2000, the city maintained a multi-ethnic core with suburbs that were over 90% White, and overwhelmingly less than 1% Black (McArdle, 2003). The Boston metropolitan area also has a high cost of living. In the first quarter of 2013, the median sales prices of single-family properties and condominiums were $388,250 and $415,000, respectively (Greater Boston Association of Realtors, 2013). Home prices vary substantially by neighborhood and are often racially patterned, as in the three target neighborhoods.

We selected census tracts to represent variation in race, ethnicity and socioeconomic resources. Although the census tracts are all predominantly White, given differing histories and more contemporary changes including gentrification, census demographics are heterogeneous, as shown in Table 1. Two of the three census tracts are from neighborhoods that retain coveted landmark district status, indicating physical features of historical, social, cultural, architectural, or esthetic significance and that lend the neighborhood a distinctive character in the city (City of Boston, 2013b).

The first neighborhood is the Back Bay Architectural District, designated in 1966. This neighborhood is described as a historically important center for American culture, home to artists, writers and philosophers. Back Bay is known for elegant residential architecture and street facades, (City of Boston, 2013a) and for international and boutique commerce (Boston Redevelopment Authority, 2013a). Real estate is among the highest priced in the city; two residential parking spaces alone sold in June 2013 for $560,000 (Johnston, 2013).

The second neighborhood is the South End landmark district, which is characterized predominantly by Italianate rowhouses (City of Boston, 2013c). Developed in the 1830s for wealthy

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