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Short report

Is perceived racial privilege associated with health? Findings from the Behavioral Risk Factor Surveillance System☆

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ABSTRACT

While racial discrimination has gained increasing attention in public health research, little is known about perceived racial privilege and health. Using the Behavioral Risk Factor Surveillance System (BRFSS) data, this study explored the relationship of both perceived racial discrimination and privilege with well-being in the USA. Data were extracted from the BRFSS 2004 data set, in which 22,412 respondents in seven states and one major city provided data on perceived racial discrimination and privilege at work. Logistic regression analysis was conducted to examine the relationships of differential racial treatment to self-rated general health status and the number of physically and mentally unhealthy days. Racially stratified analyses found that perceived racial privilege was significantly associated with more days of poor physical and mental health. This relationship was consistent for Whites, but for racial minorities it appeared on only some outcome measures. Reports of being treated worse than other races in the workplace were associated with poor health for all racial groups, as had been reported in previous studies on racial discrimination. Because racial discrimination and racial privilege are both products of racism, this study's findings suggest that racism may harm all involved. Impacts of perceived racial privilege deserve more attention in the literature on racism and health.

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Racial discrimination exists when a dominant racial group restricts the lives of those whom they distinguish negatively based on race/ethnicity (Krieger, 2000). While health impacts of racial discrimination have gained considerable attention (for reviews, see Paradies, 2006b; Williams, Neighbors, & Jackson, 2003), racial *privilege* is rarely discussed in relation to health (Paradies, 2006a). Racial privilege is the reverse side of racial disadvantage (Paradies, 2006a); that is, when a certain group experiences racial disadvantage, at least one other group experiences racial privilege. Just as racial disadvantage operates at institutional to individual levels (Krieger, 2000), racial privilege too appears at various levels (Paradies, 2006a). A member of the dominant group can have difficultly in recognizing his/her privilege (Seiler, 2003). As Kobayashi and Peake (2000) point out, the dominant group has "the normative, ordinary power to enjoy social privilege by controlling dominant values and institutions" (p. 393). This normalcy makes it hard to recognize that racial privilege comes at someone else's expense. However, when racial privilege is recognized, how does it affect health? The current literature on racism does not provide an answer.

This lack of attention may imply an assumption that racial privilege, perceived or not, does not affect health. It is indeed plausible that racial privilege is harmless because the racially privileged are not subjected to the stress of social and economic disadvantages associated with racial discrimination. It is also conceivable that perceptions of racial privilege are positively associated with well-being. According to social identity theory, successful intergroup competition elevates self-esteem (Hogg & Abrams, 1990). Since perceptions of privilege come with the recognition that one's own group is superior to others', those who perceive their own racial privilege may feel enhanced self-esteem (Martin, 1999), which is associated with well-being (Baumeister, Campbell, Krueger, & Vohs, 2003). In other words, the association between perceived racial privilege and well-being may be mediated by self-esteem. Another possibility is that the racially privileged are likely to enjoy tangible advantages such as better quality healthcare (e.g., Schneider, Zaslavsky, & Epstein, 2002). Tangible advantages may not only bring about better health but also generate perceptions of one's privilege. In this case, perceived racial privilege is not causally associated with better health: they are both caused by

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tangible advantages. These potential associations have not been empirically tested.

This study explores the association between perceived racial privilege and health using the Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS offers a unique opportunity to examine the health impact of being treated *better* as well as worse than people of other races. The research question addressed in this study is whether perceived differential treatment at work, either better or worse than people of other races, is associated with well-being.

Methods

Data

This study analyzed data from BRFSS, an annual national telephone survey (National Center for Chronic Disease Prevention and Health Promotion, 2006). In 2004, seven states (Arkansas, Colorado, Delaware, Mississippi, Rhode Island, South Carolina, and Wisconsin) and Washington, DC collected data on the Reaction to Race module, a module addressing race relations that was optional for states. Because in more recent years only one to three states collected data on the Race module, this analysis extracted data from the 2004 data set (Centers for Disease Control and Prevention, 2004).

Respondents were 18 years of age or older, randomly chosen from residents in the seven states listed above and Washington, DC (for sampling details, see Centers for Disease Control and Prevention, 2004). The response rates in these states varied from 39% to 63%, with a median of 50%. Since the main variable of interest was differential racial treatment at work, those respondents who were employed for wages or self-employed at the time of data collection were selected ($n = 22{,}412$). A small number of respondents ($n = 575$, 2.6%) were excluded because of missing data on race or outcome variables. Characteristics of the resulting sample ($n = 21{,}837$) are presented in Table 1.

Measures

Racial treatment at work was measured by one of the questions in the Reactions to Race module: "Within the past 12 months at work, do you feel you were treated worse than, the same as, or better than people of other races?" BRFSS interviewers coded responses as either "better than other races", "the same as other races", "worse than other races", "worse than some races, better than others", or "only encountered people of the same race." In this analysis, the responses "the same as other races" and "only encountered people of the same race" were combined. Since BRFSS interviewers coded the "only encountered people of the same race" response only when the respondent volunteered the information, it was suspected that some of those who work in a racially homogenous environment might have responded as being treated as same as others. Because it is not possible to distinguish these potentially misclassified responses, responses of "same as others" and "encounter same race only" were combined and served as the reference group. As shown in Table 2, a very small proportion of the respondents (0.8–2.3%) reported that they "only encounter people of the same race."

Self-rated health status was measured with the following question: "Would you say that in general your health is excellent, very good, good, fair, or poor?" This item has shown predictive validity for mortality (Idler & Benyamini, 1997). The responses were dichotomized: excellent, very good, and good were combined together to indicate non-case (0), and fair and poor were combined to indicate case (1). *Number of unhealthy days* was asked for both physical and mental health. Respondents reported the number during the past 30 days for each question. The unhealthy day measures have shown good construct validity in relation to depression (Ôunpuu, Chambers, Patterson, Chan, & Yusuf, 2001) and chronic medical conditions (Zahran et al., 2005). The responses were categorized into three groups: no unhealthy days (the reference group), 1–13 unhealthy days, and 14 or more unhealthy days (Strine, Chapman, Kobau, Balluz, & Mokdad, 2004).

Self-identified race/ethnicity was categorized into four groups: non-Hispanic White, non-Hispanic Black, Hispanic, and Other (including multiracial).

Table 1
Demographic characteristics of the study participants.

Demographic characteristic	Unweighted *n*	Weighted *n*	Weighted %
Age			
18–24 years old	1325	1,312,556	12.6
25–34 years old	4563	2,381,234	22.9
35–44 years old	5583	2,736,462	26.3
45–54 years old	5939	2,444,069	23.5
55–64 years old	3468	1,206,504	11.6
65 or older	959	305,222	2.9
Sex			
Male	9392	5,669,931	54.6
Female	12,445	4,716,115	45.4
Race/ethnicity			
White	16,766	8,025,583	77.3
Black	3272	1,292,225	12.4
Hispanic	1005	604,864	5.8
Other	794	463,374	4.5
Language used in the questionnaire			
English	21,609	10,260,338	98.8
Spanish	228	125,708	1.2
Education			
Less than high school	1291	722,391	7.0
Graduated high school	6022	3,182,200	30.7
Attended college or technical school	5608	2,796,994	27.0
Graduated college or technical school	8899	3,675,540	35.4
Household income			
Less than $15 K	965	410,131	4.3
$15 K–$25 K	2510	1,291,305	13.6
$25 K–$35 K	2830	1,431,452	15.1
$35 K–$50 K	3882	1,835,876	19.3
$50 K or more	9752	4,540,375	47.7
Marital status			
Married, have a partner	12,846	6,919,772	66.8
Divorced, widowed, separated	4799	1,420,854	13.7
Never married	4138	2,030,638	19.6
Health Outcomes	**Unweighted *n***	**Weighted *n***	**Weighted %**
Self-rated general health status			
Excellent/very good/good	19,995	9,537,342	91.8
Fair/poor	1842	848,704	8.2
Physically unhealthy days in the past 30 days			
0 days	15,139	7,229,879	69.6
1–13 days	5419	2,576,871	24.8
14+ days	1279	579,296	5.6
Mentally unhealthy days in the past 30 days			
0 days	14,205	6,782,119	65.3
1–13 days	5682	2,715,406	26.1
14+ days	1950	888,522	8.6

Note. Unweighted $n = 21{,}837$, weighted $n = 10{,}386{,}046$.

Statistical analysis

After respondents with missing data on race/ethnicity or outcome variables are excluded, the remaining sample of 22,177 contained missing values on four study variables: racial treatment at work (11.7% missing), household income (8.8%), marital status (0.3%), and education (0.1%). Instead of excluding those who did