Using "Socially Assigned Race" to Probe *White* Advantages in Health Status

Camara Phyllis Jones, MD, MPH, PhD; Benedict I. Truman, MD, MPH; Laurie D. Elam-Evans, PhD, MPH; Camille A. Jones, MD, MPH; Clara Y. Jones, MD, MPH; Ruth Jiles, PhD; Susan F. Rumisha, MSc; Geraldine S. Perry, DrPH

Objectives: We explore the relationships between socially assigned race ("How do other people usually classify you in this country?"), self-identified race/ethnicity, and excellent or very good general health status. We then take advantage of subgroups which are discordant on self-identified race/ethnicity and socially assigned race to examine whether being classified by others as *White* conveys an advantage in health status, even for those who do not self-identify as *White*.

Methods: Analyses were conducted using pooled data from the eight states that used the Reactions to Race module of the 2004 Behavioral Risk Factor Surveillance System.

Results: The agreement of socially assigned race with self-identified race/ethnicity varied across the racial/ethnic groups currently defined by the United States government. Included among those usually classified by others as *White* were 26.8% of those who self-identified as *Hispanic*, 47.6% of those who self-identified as *American Indian*, and 59.5% of those who self-identified with *More than one race*.

Among those who self-identified as *Hispanic*, the age-, education-, and language-adjusted proportion reporting excellent or very good health was 8.7 percentage points higher for those socially assigned as *White* than for those socially assigned as *Hispanic* (*P*=.04); among those who self-identified as *American Indian*, that proportion was 15.4 percentage points higher for those socially assigned as *White* than for those socially assigned as *American Indian* (*P*=.05); and among those who self-identified with *More than one race*, that proportion was 23.6 percentage points higher for those socially assigned as *White* than for those socially assigned as *Black* (*P*<.01). On the other hand, no significant differences were found between those socially assigned as *White* who self-identified as *White* and those socially assigned as *White* who self-identified as *Hispanic*, as *American Indian*, or with *More than one race*.

Conclusions: Being classified by others as *White* is associated with large and statistically significant advantages in health status, no matter how one self-identifies. (*Ethn Dis.* 2008;18:496-504)

Key Words: Behavioral Risk Factor Surveillance System, Racism, Self-rated Health

INTRODUCTION

Racial health disparities have been documented in the United States since data on "race" and health have been jointly collected.[1–4] The question remains, however, why the variable "race" is such a potent predictor of health outcomes, especially when it is widely acknowledged that "race" is a social construct, not a biological descriptor.[5–9] We gain some insight into this question by observing that the "race" noted by a hospital admissions clerk on a medical record is the same "race" noted by a sales clerk in a store, a taxi driver or police officer on the street, a judge in a courtroom, or a teacher in a classroom,[10–12] and, in our opinion, this "race" is quickly and routinely assigned without the benefit of queries about self-identification, ancestry, culture, or genetic endowment. Indeed, this *ad hoc* racial classification has been an influential basis for interactions between individuals and institutions in our society for centuries.[13]

From the Division of Adult and Community Health (CPJ, LDEE, RJ, GSP) and Office of Minority Health and Health Disparities (BIT), Centers for Disease Control and Prevention, Atlanta, Georgia; Cincinnati Health Department, Cincinnati, Ohio (CAJ); Department of Public Health and Family Medicine, Tufts University School of Medicine, Boston, Massachusetts (CYJ); National Institute for Medical Research, Dar es Salaam, Tanzania (SFR).

Address correspondence and reprint requests to: Camara Phyllis Jones, MD, MPH, PhD; Centers for Disease Control and Prevention; 4770 Buford Highway NE; Mailstop K-67; Atlanta, Georgia 30341; (770) 488-5268; cdj9@cdc.gov

We posit that "race" acts on health through race-associated differences in life experiences and life opportunities in our race-conscious society. That is, we posit that "race" is a potent predictor of health outcomes in this country because of racism, which Jones has defined as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks."[12] Jones proposes that "race" be formally understood as the social interpretation of our physical appearance in a given place and time, and she suggests that it can be measured by a person's response to the question "How do other people usually classify you in this country?"[12] Note that this "socially assigned race" is distinct from self-identified race/ethnicity, and could be a useful tool for probing the impacts of racism on health because it measures the *ad hoc* racial classification upon which racism operates.

In this article, we explore the relationships between "socially assigned race," self-identified race/ethnicity, and excellent or very good general health status. We then take advantage of subgroups that are discordant on self-identified race/ethnicity and "socially assigned race" to examine whether being socially assigned as *White* conveys an advantage in health status, even for those who do not self-identify as *White*. Using "socially assigned race" to probe advantages in health status associated with being classified by others as *White*, we aim to further elucidate the impacts of racism on health.

METHODS

The Behavioral Risk Factor Surveillance System (BRFSS), developed by