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Public Health's Approach to Systemic Racism: a Systematic Literature Review

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Abstract

Objectives Recently, public health has acknowledged racism as a social determinant of health. Much evidence exists on the impact of individual-level racism and discrimination, with little to no examination of racism from the standpoint of systems and structures. The purpose of this systematic literature review is to analyze the extent to which public health currently addresses systemic racism in the published literature.

Methods Utilizing the PRISMA guidelines, this review examines three widely used databases to examine published literature covering the topic as well as implications for future research and practice.

Results A total of 85 articles were included in the review analysis after meeting study criteria.

Conclusions Across numerous articles, the terms *racism* and *systemic racism* are largely absent. A critical need exists for an examination of the historical impact of systemic racism on the social determinants of health and health of marginalized populations.

Keywords Systemic racism · Systematic review · Health equity · Health disparity gaps

For centuries, people of color have suffered mentally and physically from the impact of systemic racism—a social, moral, and public health issue. As Nelson [1] details in one of the key findings from the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, "health care occurs in the context of broader historic and contemporary social and economic inequality and persistent racial and ethnic discrimination in many sectors of American life." These racial and ethnic health care inequalities are pervasive in the social determinants of health and should most definitely be assessed in the context of society's white-racist roots and contemporary structural-racist realities [2]. Ture and Hamilton [3] define racism as "the predication of decisions and polices on considerations of race for the purpose of *subordinating* a racial group and maintaining control over that group" [3]. Racism is covert and overt. It exists in two forms: "individual whites acting against individual Blacks [individual racism], and acts by the total white community against the Black community [institutional racism]" [3]. The latter, for the purpose of this study, termed "systemic racism," operates within "established and respected forces in the society, and receives far less public condemnation than the first type" [3].

Current events and dialogues in the United States (U.S.) highlight the salience of these issues. In this Post-Jim Crow era, "the white commonsense view on racial matters is that racists are few and far between, that discrimination has all but disappeared, and that most whites are color blind" [4]. Today, "new racism" has emerged and is evident in "more sophisticated and subtle" practices [4]. Bonilla-Silva [4] found that this racial structure consists of five elements:

> (1) the increasingly *covert* nature of racial discourse and racial practices; (2) the avoidance of racial terminology and the ever-growing claim by whites that they experience 'reverse racism;' (3) the elaboration of a racial agenda over political matters that eschews direct racial references; (4) the invisibility of most mechanisms to

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reproduce racial inequality; and (5) the reticulation of some racial practices characteristic of the Jim Crow period of race relations.

Colorblind racism is an ideology that "explains contemporary racial inequality as the outcome of nonracial dynamics" [5]. Instead of overtly showing racism, it is expressed in covert ways, where whites "enunciate positions that safeguard their racial interests without sounding 'racist'" [5]. This new racism has given us phrases such as "post-racial America" or "I don't see color," especially with the election of President Barack Obama [4]. However, neglecting to address race or creating practices and policies which do not include the contextualization of race will likely continue to yield inequities in crime rates, educational attainment, and health outcomes.

For example, Braveman et al. [6] speaks to Black-white disparities in premature birth and low birth weight, acknowledging biological mechanisms contributing to the disparities that "reflect phenomena shaped by social contexts and thus are, at least theoretically, avoidable" [6]. However, Braveman et al. [6] and the practitioners who provide the data for the claim do not namely identify racism as a part of the social context. The article, which proposes a definition of health disparities, mentions how health disparities are avoidable, "but causality need not be established" [6]. This perpetuates systemic racism remaining invisible as a causal factor shaping the social context in which Black mothers live. Causality should be established to draw attention to root causes of the inequity and inform avenues for remediation.

According to Feagin and Bennefield [2], many systems in the U.S., including public health, operate within a *white racial frame* which encompasses "a broad and persisting set of racial stereotypes, prejudices, ideologies, images, interpretations and narratives, emotions, and reactions to language accents, as well as racialized inclinations to discriminate" which have aggressively defended this social inequality [2, 7]. The white racial frame exists to help society define, interpret, confront, and act in everyday world [7]. In this frame, whiteness is centered and normalized throughout many institutions—social, home, public spaces, the media, workplaces, courts, policies, and the corporate world. Operating at both the interpersonal and institutional level, this rationalizes the structures that perpetuate inequities, injustices, and racial patterns. Today, whites and whiteness are viewed positively and virtuous by those who consider themselves white and often by those who do not: "White narratives of the U.S. historical development still accent whites' superiority—that is that whites are typically more American, moral, intelligent, rational, attractive, and/or hard working than other racial groups—and courage over centuries" [7]. At the institutional level, the white racial frame conceals and normalizes social inequities [7]. For centuries, institutions have continued to operate within this frame and justify their continued separation of people by race to continue to elevate whites as superior.

Policy-makers are majority white. Public health decision-makers are majority white. Whether consciously or not, most have likely been socialized into a white racial frame that is invisible to them yet shapes their worldview. This worldview affects the creation and implementation of policies and practices that account for institutionalized inequalities in health and health care [2]. Research into these issues classifies inequalities in terms of racial "disparities," failing to explain the foundational and systemic racism of the U.S. in creating the inequalities [7].

Recent literature identifies racism in the context of health care and health disparities [2, 8–11]. The earliest mentions of racism in the public health literature were published by Jones [12] as she describes three levels of racism: institutionalized, personally mediated, and internalized. While a critical advancement in the field, the majority of discussions of racism focus on individual experiences of racism and fail to contextualize these experiences within broader systems of racism. Extensive research exists surrounding the impact of self-reported racism and discrimination and health [9, 10, 13–18]. If public health is concerned with systems and structures that influence population health, studying racism on the individual level only is inadequate. Fullilove [19] points out that in the U.S., "social systems organize around racial inequality and clearly shape health outcomes." She poses the question, "if racism is a principal factor organizing social life, why not study racism, rather than race?" This position is supported by Bailey and colleagues, who published a clarion call in the *Lancet*, arguing that a "focus on structural racism is essential to advance health equity and improve population health" [20]. Additionally, it adds to the discussion of Nelson's [1] third recommendation by providing an outlook on progress towards the elimination of health care disparities. This paper responds to that call by employing a systematic review to analyze the extent to which public health currently addresses systemic racism against Black Americans in the published literature.

Methods

According to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), a systematic review "is a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review" [21]. In public health, a great deal of literature exists regarding race and health or racial disparities, but a dearth of literature explicitly focuses on systemic racism as a public health issue. Current literature focuses on perceptions of racism and discrimination but not the impact of racism within systems. The purpose of this systematic review is to examine racism within the public

health literature from the context of the systemic/structural/institutional level (policies and practices) rather than the individual level (perceived racism and discrimination). The systematic review process reduces bias and offers more objective findings, allowing us to assess the extent to which public health literature and research addresses systemic racism.

Studies that examine the impact of systems on Black populations were included based on interventions that looked at a variety of health outcomes in quantitative and qualitative studies along with conceptual and theoretical articles.

Eligibility Criteria

Ture and Hamilton [3] provide the definition for systemic racism for this study; therefore, only studies published after 1968 were eligible for review. Only studies in English and conducted within the U.S. were eligible because the foundation of this study reviews systemic racism within the context of U.S. systems. Only peer-reviewed studies in pre-identified public health journals were included to ensure that rigor and scrutiny of others within the field of public health were a part of assessing the research. Only including studies within public health journals excludes the influence of the importance of the topic within other disciplines, but examines what the leading public health journals are publishing regarding the topic. Additionally, only studies that address systemic, institutional, or structural racism were eligible for inclusion.

Information Sources

At the advice of a health sciences reference librarian, MEDLINE (PubMed), Embase, and EBSCO databases were used for the systematic literature review. The MEDLINE database was the first to be searched as it is known as one of the most comprehensive databases with only peer-reviewed articles. Embase was the second database searched, which is typically used to check the work of what was found in MEDLINE, and lastly, EBSCO was searched to ensure identification of possible articles outside of those in MEDLINE and Embase. The literature review was completed on March 31, 2017, and includes articles from January 1968 until the date of completion. No authors were contacted to determine if they had published additional articles that fit the criteria, as we were specifically interested in articles circulating in the peer-reviewed public health literature.

Search

The search strategy used for this literature review was standard across all platforms with few variations, most of which were based on the database options. Once databases were identified, a comprehensive Excel spreadsheet was created to track articles based on four criteria: (1) identification, (2) screening, (3) eligibility, and (4) inclusion. Prior to starting the search, each database was cleared so items from previous searches were not inadvertently included.

Identification

The search began by typing in the following key words separately: systemic racism, structural racism, institutional racism, racism, racist, racial trauma, racial stress, racial discrimination, racial oppression, racial marginalization, systemic racial disparities, structural racial disparities, and institutional racial disparities. After the initial search for each key word, the number of articles returned was recorded. Next, using the database option of time range, articles published before 1968 ($N = 150$) and articles that were not in English ($N = 514$) were eliminated. In the MEDLINE (PubMed) database, articles can be sorted based on journals, so the articles were sorted alphabetically based on journal titles. Articles in journals on the pre-identified list were selected for the screening process. Table 1 is the list of public health journals eligible for the systematic literature review.

Screening

During the screening process, the abstracts for articles in eligible public health journals were examined, and those that did not fit the eligibility criteria were excluded. Articles did not have to have the exact words of systemic, institutional, or structural racism; however, they had to address systems or structures that influence health inequity. Articles meeting the inclusion criteria were moved to the eligibility category.

Eligibility

Full articles were reviewed to ensure they met eligibility criteria to be included in the study. After further review, articles that indirectly addressed systemic or institutional impacts of racism on health problems were also included in the results section of this paper because they have implications for systemic causation or systemic change.

Results

Initially, 70,273 articles were identified with the key terms of the literature review. After applying eligibility criteria, 2961 articles were screened, and 1711 were eligible after initial screening. Ultimately, 85 articles met the inclusion criteria for this review. Each article was re-read and summarized into the comprehensive excel sheet to identity themes and connections amongst the articles. Key words for each article were also recorded to determine if certain terms were used more frequently when describing the article and their connection

Table 1 Public Health Journals identified for systematic literature review

American Journal of Epidemiology	American Journal of Public Health
Annual Review of Public Health	Critical Public Health
Community Development Journal	Environmental Health Perspectives
Ethnicity and Disease	Ethnicity and Health
Family and Community Health	Frontiers in Public Health
Global Public Health	Health Affairs
Health and Place	Health Communication
Health Education & Behavior	Health Education Research
Health Promotion Practice	Health Promotion Perspective
Health Services Management Research	Health Services Research
Journal of Community Health	Journal of Community Practice
Journal of Education & Health Promotion	Journal of Epidemiology and Community Health
Journal of Health and Social Behavior	Journal of Healthcare for the Poor and Underserved
Journal of Healthcare Management	Journal of Prevention & Intervention in the Community
Journal of Primary Prevention	Journal of Public Health
Journal of Public Health Management and Practice	Journal of Public Health Policy
Journal of Racial Ethnic Health Disparities	Journal of Social Issues
Journal of Urban Health	Perspective in Public Health
Preventing Chronic Disease	Prevention Science
Progress in Community Health Partnerships	Public Health Reports
Public Health Reviews	Qualitative Health Research
Social Science and Medicine	Social Science Quarterly

to search terms. Synthesizing the purpose of each article and implications were key in thematic analysis of the articles. Four major themes emerged during the review of included articles: (1) approaches to address systemic racism, (2) the impact of residential and racial segregation on health outcomes, (3) policy implications for reducing health inequities, and (4) systemic racism's impact on health outcomes. Many articles fit into multiple themes. Figure 1 depicts the flow of article identification, and themes along with which articles represent those themes are reflected in Table 2.

Approaches to Address Systemic Racism

Practitioners provide a range of conceptual and theoretical models for not only addressing systemic racism, but also conducting research that provides context on the impact of systemic racism on a variety of health issues. For example, Smedley and Myers [40] provide an overview on the methodological challenges in research and policy of the systems level. Others provide an anti-racism praxis to address inequities in public health to train and support allies [27, 32, 34, 37]. Ford and Airhihenbuwa [29] adapted the Critical Race Theory (CRT) approach to create a Public Health Critical Race Framework for research and practice. This approach, founded in the field of law, is utilized in other disciplines such as sociology and education and provides a critical examination of the relationships between race, racism, and power [105]. Bowleg [24] details the importance of using an intersectional theoretical framework in public health theory, research, and policy to fulfill its commitment to social justice. These theoretical perspectives are useful for moving towards addressing systemic racism's impact on health outcomes and moving towards creating policies and practices that examine how systems and structures make certain identities (race, gender, sexuality, disability, etc.) more vulnerable [106]. Along with including approaches that examine the impact of systemic racism on health outcomes, the importance of including community in not only undoing racism [39], but also including the voice of marginalized individuals in the understanding the impact [36] is evident in the literature.

Impact of Residential and Racial Segregation on Health Outcomes

While the Home Owner's Loan Corporation (HOLC) program was implemented in 1933, nearly 85 years later, many marginalized communities are still living with the negative impacts of the program. The HOLC program inevitability birthed residential and racial segregation throughout the 200 cities that participated in the program. Through analysis, it was evident that many practitioners acknowledge the impact of residential and racial segregation on a variety of health outcomes. Many articles did not specifically link residential and racial segregation to redlining or that the program promoted systemic racism. Additionally, some articles discuss its impact in terms of social class [76], neighborhood disadvantage [65,

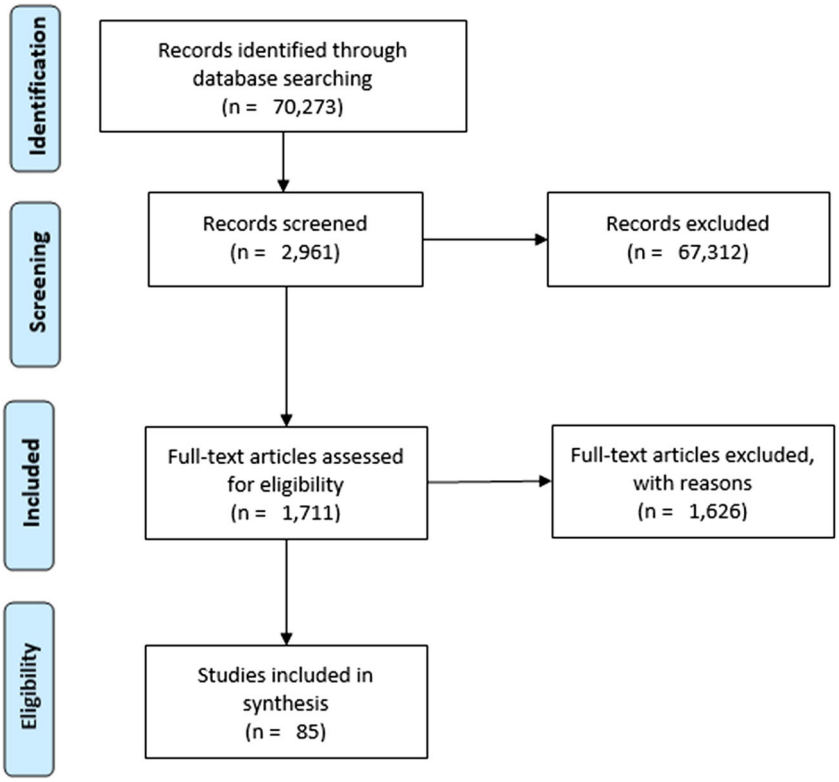

Fig. 1 Systematic literature review PRISMA flow diagram

69], and neighborhood characteristics [51]. Most of which are weighted averages of individual-level economic indices, and there was less emphasis on systemic characteristics that created neighborhoods that have high concentrations of people who live in poverty or lower social classes. Many of their implications point to the creation of certain neighborhoods that disproportionally impact Black residents, failing to explicitly name the issue of systemic racism. There were several articles that did not directly name residential segregation; however, their definitions and findings directly align with the practice of residential and racial segregation [55, 69].

Policy Implications for Reducing Health Inequities

While much of systemic racism is rooted in policies, only seven articles addressed policy implications within this study. It is important to view systemic racism from the perspective of environmental factors that impact behavior. Menefee [46] analyzes major health policies to argue that the health system is rooted in racial discrimination and perpetuates racial discrimination in education, employment, and housing. Bliss et al. [70] describe the Minnesota Department of Health's shift from traditional behavioral public health approach, to addressing the factors that create health with a Health in All Policies approach to addressing the social determinants of health. Other practitioners provide illuminate how structural changes are necessary to improve the health of Black people [35, 47] and that Black people with a system-blaming orientation live longer than those who self-blame for racism [107]. It is important to detail the impact policies and practices from many of the historical systems have had on populations to determine how they can be rectified in a macro-level approach.

Systemic Racism's Impact on Health Outcomes

Lastly, several articles pointed directly at the impact of systemic racism on overall health [9, 82, 87] and a variety of distinct health outcomes. As with not directly naming residential or racial segregation, authors do not specifically name systemic racism; however, for example implications of the

Table 2 Systematic review themes

Themes	Articles represented
Approaches to address systemic racism [9, 22–50]	29
The impact of residential and racial segregation on health outcomes [51–69]	19
Policy implications for reducing health inequities [40, 47, 48, 70–73]	7
Systemic racism's impact on health outcomes [2, 9, 12, 41–48, 72–104]	43

health care system on the overall health of ethnic minority women is detailed [44]. Iguchi et al. [91] provide insight on how racial inequity within the criminal justice system translates into health disparities for minorities. Wallington et al. [101] describes the influence of news coverage on health topics and agenda setting at the institutional and policy levels and provide insight on how public health practitioners can inform communication with local media to advance the dialog on health disparities. This example illustrates how the media often times operates within the white racial frame, perpetuating certain stereotypes and messages, as well as the role public health practitioners can play in changing that narrative.

Shavers et al. [42] also conducted a literature review to examine system-level factors that contribute to discriminatory health care services. The literature review did not find any studies that suggest a connection between institutional racisms impact on health care delivery to racial/ethnic minority populations. These findings support the findings of the current review. Additionally, Feagin and Bennefield [2] provide an overview of systemic racism in U.S. health care and public health institutions. Their review of public health is minimal in that public health rarely addresses the structural forces that create the conditions in which disparities are present. Feagin and Bennefield [2] point out that the majority of public health decision-makers are white, and the focus of research on racism is sparse. Buckner-Brown and collegues [26] provide an overview of Centers for Disease and Control Prevention's (CDC) Racial and Ethnic Approaches to Community Health (REACH) programs that have implemented policies and organizational practices to improve the social conditions that can reduce health disparities. It is important to understand how the leading federal public health institution approaches race to improve social conditions; however, in much of overview, the CDC does not contextualize health issues under the auspices of the systemic impact of race on health outcomes.

Discussion

Across most of the articles reviewed, a consistent pattern was a lack of using the term *racism*, or even naming systemic racism as a root cause of health outcome disparities. *Discrimination*, *stigma*, and *bias* were used to describe racism or inferences of systemic racism, but most did not provide implications for changes at the systemic level. Public health is at a critical point of acknowledging systemic racism as determinant of health [10, 45, 108–110]. Overwhelming evidence exists at the individual level of the impact of racism, discrimination, and bias; however, more research is needed focusing on the influence of systemic racism on health and the social determinants of health. A critical examination and implications for changing systems and structures that continue to produce health outcome disparities is necessary to change the state of public health practice.

Articles eliminated from the search mostly focused on behavioral implications of racism on health and provided individual or interpersonal implications for reducing health disparities. While it is important to focus on how behavior or implicit bias contributes to health disparities, it is more important to understand how these disparities are created. Many of the behaviors and even implicit bias practices are in direct response to the systems and structures created to produce health outcomes. Additionally, many of the behavioral recommendations are not conducive to environments that are plagued with the effects of systemic racism. For example, the behavioral recommendation of eating more fruits and vegetables to reduce the risk of obesity cannot be practiced effectively if one lives in a food desert where s/he cannot easily access fruits and vegetables. The recommendation does not account for the environment or systems surrounding the individual, especially marginalized communities with barriers to access.

Rice and colleagues [64] found in their study that Black residents (half the participants) felt they have little control over things that happen in their neighborhood and little confidence in their ability to change things where they live. The authors suggest that participants have little confidence and control over changing their neighborhood because they are not aware of the "social and political procedures that are involved in developing, implementing, and evaluating public policies or limited capacity to engage in activities to improve or control things that happen in one's neighborhood" [64]. Much of this lack of confidence and control can be attributed to *internalized racism*—"acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth" [12]. This internalized racism is manifested through a sense of hopelessness and helplessness [12], inhibiting the marginalized community from advocating for public policy that can change the built environment.

Browne et al. [25] examined how community members responded to health disparities research and created pedagogical strategies for examining racialized contexts to prepare students to understand and address health disparities as future health care professionals. Interestingly, the themes amongst the responses were (1) naming health disparities is a tool for dividing, (2) structural racism does not exist, (3) naming of health disparities is a political act, and (4) health disparities exist because of individual-level deficiencies. Responses to the health disparities research felt that health disparities were created to divide and segregate populations and that many community members do not see the larger context in which health is impacted. They felt that differences in health outcomes based on race was a "manufactured truth" constructed by "leftist liberal" researchers and the media [25]. If respondents acknowledged disparities, "they were attributed to individual-level factors and negative perceptions of Blacks" [25]. From this article,

it is evident that even those of privileged groups do not understand how the history of systemic racism and discriminatory practices impact health outcomes.

The differences in how marginalized and privileged groups view health disparities are a contrast importance in communicating research that highlights the impact of systemic racism on health outcomes, and also how we approach equity. While marginalized groups will see they have little to no control over changing their environment or that equity may never be achieved, privileged groups will assume that certain groups are being catered to or that a group or individual has failed to do something that could reflect individual change. While it is important to address health outcomes from the systemic level, it is equally as important to acknowledge the wrongs of the past through action as well as education (community and health care professionals). This calls for further examination of the impact of white racial framing on communities and how to navigate conducting and disseminating research within a racialized context.

With residential and racial segregation emerging as a theme in this systematic literature review, it is important to view how Black residents feel in making changes or even the implications for change in their community. While most are surviving within the conditions that were imposed upon them, many are hopeless in seeing that a change will ever happen. Liu et al. [111] provide some hope in that they found that school desegregation legislation decreased common-cause mortality rates for Black male adolescents. This offers evidence in how structural changes can improve health (life expectancy); however, it is important to conceptualize and make systemic and structural changes that impact multiple health and social outcomes.

Public health practitioners are starting to recognize systemic racism as a root cause of health outcomes; however, the mainstream field does not include the implications of systemic racism or create interventions or recommend policies that address this root cause. Public health has focused on changing behaviors rather than changing the environments in which the behaviors are "necessary" to survive. Intervention approaches often demonstrate a tendency towards victim blaming [112–115]. "Victim-blaming misinterprets the structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victim" [113]. With the earlier example of eating more fruits and vegetables. In addition to access to healthier options, it is equally as important to account for other structural barriers such as the neighborhood has a high density of fast food restaurants, living on a fixed income, and relying on public transportation—which can be unreliable in underserved neighborhoods. There are many access barriers to creating healthy eating behaviors, yet individuals are typically blamed for their habits. Victim blaming denies an examination of the impact of the social determinants of health on decision making.

Throughout the included literature, there is an absence of discussion surrounding the social determinants of health. There is an examination of many determinants separately (education, health care system, neighborhood/environment, etc.), but not a collective examination of the impact of systemic racism on the social determinants. It is important for public health practitioners to look at the impact of systemic racism across all determinants of health and address it through systemic and policy changes. The public health approach to issues needs to expand beyond taking an approach to changing behaviors to include changing the systems and structures that influence the environments in which certain behaviors are necessary to survive. More importantly, public health practitioners need to actively call out racist practices and move towards utilizing practices that are racially and socially equitable. Additionally, there needs to be more minority representation within public health decision making, and not as figureheads with borrowed power [116], but actually centering minority experiences in decision-making, research methods, analysis, and practice.

This article focuses mainly on the impact of systemic racism on health outcomes; however, there is a need to examine intersecting forms of systemic discrimination— sexism, classism, ableism, ageism, heterosexism, and xenophobia alongside racism as well. Bowleg [24] acknowledges the importance of public health being intersectional in their approaches and how "acknowledging the existence of multiple intersecting identities is an initial step in understanding the complexities of health disparities for populations from multiple historically oppressed groups." Additionally, an intersectional approach allows for examination of public health and other systems connected to the social determinants that maintain health inequities in oppressed groups [24]. In addition to Bowleg [24], Frye [55], and Hogan [57] are the only other articles present in this study that acknowledge or approach an examination of health outcomes through an intersectional examination. Although the majority of articles did not undertake an intersectional examination of health and health outcomes, there is possibility for this examination. For example, the articles that address infant mortality [34, 35, 69 (birth weight), 100] can address how racism, sexism, and classism impact health outcomes. While advancing our understanding of the impact of systemic racism, it is equally as important to understand the discrimination that happens amongst other marginalized identities as well.

While the concept of examining systemic racism is not new within many disciplines, the field of public health can benefit from advances in thinking and practice in other disciplines and theories, such as sociology, women's studies, and feminist legal studies. For public health practitioners, it is always important to view health within the socioecological framework; however, much work exists up until the community level with a primary focus on behavioral interventions. Through a macro-level approach, with ratification of policy and systems,

we will see meaningful gains in achieving health equity. Above all, it also takes public health practitioners actually being champions of social justice and calling out racism, sexism, classism, ableism, ageism, heterosexism, and xenophobic practices and policies that continue to create racial and social disparities that practitioners work tirelessly to eliminate and protect where people live, work, worship, learn, and play. It will take continuous critical examinations of the systemic and structural implications of racism, but also conversations on the impact of race, racism, and power past, present, and future to move towards reducing racial, health, and social disparities.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human participants or animals performed by any of the authors.

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