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# Racial Context, Black Immigration and the U.S. Black/White Health Disparity

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## *Abstract*

*The United States' black/white health gap is an important consequence of racial inequality. The gap is large, shows little signs of declining, and explanations have been limited by lack of theory and data. A new direction that offers potential for theoretical development is a focus on black immigrants, a group that shares the same racial status as U.S.-born blacks but experiences significantly better health. Using new data on the 2000–2002 National Health Interview Surveys, we disaggregate black immigrants by region of birth and develop a thesis that emphasizes the interplay of selectivity and racial context of origin for understanding health disparities among black Americans, namely that majority white contexts have deleterious health effects. The results indicate that grouping together foreign-born blacks conceals important health differentials among this population. Compared to U.S.-born blacks, black immigrants from minority white (Africa, South America) and racially mixed (West Indies) regions have superior health, while those from majority white (Europe) regions fare no better. A similar gradient exists among black immigrants, with Africans faring the best, followed by South Americans, then West Indians, with European blacks having the poorest health. Though these findings are not the definitive test of our theory, they are suggestive. They point us to understanding the mechanisms in the United States – racial context – that worsen the health and well being of black Americans, foreign- and native-born alike.*

## **Introduction**

Though race relations in the United States have undergone improvements since the 1964 Civil Rights Act, racial inequality remains. Nowhere is the black/white disparity more striking than in population health, perhaps the ultimate indicator of success in American society (Hummer 1996; Rogers 1992; Rogers, Hummer, and Nam 2000). Compared to all other U.S. major racial groups, blacks have the highest rates of morbidity and mortality for almost all diseases, highest disability rates, shortest life expectancies, least access to health care, and startlingly low rates of the use of modern technology in their treatment (Feagin and McKinney 2003; Hayward et al. 2000). Moreover, even though the health of all U.S. populations has improved over the past century, the gap between blacks and whites has actually widened (Williams 2001). A substantial body of research has attempted to account for these disparities, yet numerous questions about the causes of these differences remain.

Analyzing the black immigrant population holds much potential for theoretical development.

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The foreign-born segment of the U.S. black population has doubled over the past 20 years, from three percent in 1980 to six percent in 2000 (U.S. Bureau of the Census 1980, 2000). However, beyond gross descriptive comparisons, surprisingly little is known about the health of black immigrants, a group that shares the same racial status as U.S.-born blacks but experiences significantly better health (David and Collins 1997; Fang, Madhavan and Alderman 1997; Singh and Shiapush 2002). There are three major unknowns in our knowledge about the health of black immigrants: 1) whether the immigrant advantage applies to blacks uniformly or varies by region of birth; 2) whether the immigrant advantage is due to selectivity, sociodemographic factors, cultural characteristics, or other factors; and 3) whether the black immigrant advantage follows the same path as other groups and erodes over time. In this study, we extend existing research to address these gaps. We are the first to disaggregate the health status of black immigrants by their region of birth. We compare the health of African, South American, West Indian, and European black immigrants to that of U.S.-born blacks and to each other, allowing us to assess whether the black immigrant advantage applies to black immigrants broadly, or is largely driven by one group. Second, we draw on existing theories of immigrant selectivity and health (e.g., Hummer 2000; Landale et al. 1999; Landale, Oropesa, and Gorman 2000) and racism and health (e.g., Feagan and McKinney 2003; Jones 2001; Postmes and Branscombe 2002; Williams 2001) to posit explanations for observed patterns. In combining these approaches, we offer a new conceptual tool – racial context of origin – to help understand observed disparities in health among black Americans. We conclude by discussing the utility of racial context of origin for pushing forward theoretical understanding of U.S. racial disparities in health.

## **Background**

### ***Theorizing Black Immigrant Health***

Knowledge about racial disparities in health derives mainly from research on blacks and whites (Hummer 1996; Rogers et al. 2000; Rogers 1992; Williams and Collins 1995; Williams 1999, 2001). Persistently, blacks experience poorer health than whites across the dimensions of health status (Hayward et al. 2000; Kington and Nickens 2001). For example, in 1999, death rates from cardiovascular disease were 29 percent higher among blacks than among whites, and death rates from stroke were 40 percent higher (Centers of Disease Control 2000).

Compared to research on U.S.-born blacks, considerably less is known about the health status of black immigrants. The few existing studies indicate that black immigrants, on average, have better health than native-born black Americans (Fang et al. 1997). They have significantly lower risks of hypertension, obesity, chronic conditions, and activity limitations; and in terms of mortality and health behaviors, they have even better health profiles than U.S.-born white Americans (Singh and Siahpush 2002). For example, with respect to reproductive outcomes, birth-weight patterns of foreign-born black women are more closely related to U.S.-born white women than to U.S.-born black women (David and Collins 1997).

Whether and how the health profile of black immigrants varies by their region of birth is unknown. More than half (54 percent) of black immigrants come from the West Indies, 16 percent from Africa, 6 percent from South America, 6 percent from Europe, and 2 percent from Asia (U.S. Bureau of the Census 2000). They are further diverse by national origin and migration history, which are known to be important predictors of health variation among other immigrant groups such as Hispanics (e.g., Hummer 2000). We believe that it is the possibility that region of origin matters that provides promise for moving forward our understanding of the black/white health gap.

We draw on two bodies of literature to hypothesize about health variations among black immigrants and theorize about their long-term implications for the U.S. black/white health divide. Theories of immigrant selectivity help explain the advantaged health status of immigrant groups compared to their U.S.-born peers (Cho et al. 2004; Landale et al. 2000). Studies consistently document that immigrants enjoy better health outcomes than the comparable U.S.-born population, whether health status is conceptualized in terms of morbidity or mortality (Singh and Siahpush 2002). In explaining these patterns, the two principal arguments are that immigrants are positively selected such that only those persons with good health can recoup the costs of migration and that the cultural values of the sending countries “buffer” immigrants from the adverse effects of U.S. lifestyle (Cho et al. 2004; Hummer et al. 1999; Landale et al. 1999). With increased duration in the United States, the advantage erodes as a result of increased risk-taking behavior, such as poor diet and exercise, and loss of protective factors, such as family support and cultural orientation (Marmot and Syme 1976; Singh and Siahpush 2002).

Research on Hispanic, and to a lesser extent Asian, populations provides the bulk of evidence for theories of immigrant selectivity and health (Frisbie, Cho and Hummer 2001; Hummer et al. 1999; Landale et al. 1999). As early as the 1970s, studies of Japanese Americans demonstrated a selective migration of healthy individuals and found deteriorating health with increased acculturation in U.S. society (Marmot and Syme 1976). Improvements in data collection since these early works have allowed researchers to further refine our knowledge of immigrant health patterns by highlighting substantial subgroup variability within racial and ethnic populations. Among Hispanics, for example, Mexicans have the best health profiles, followed by Cubans, with Puerto Ricans experiencing health outcomes that parallel those of U.S.-born black Americans (Hummer 2000; Vega and Amaro 1994). Differences in migration circumstances, human and social capital, context of reception, and lifestyle characteristics help explain these patterns.

The second body of research that we draw on underscores the negative effects of racism on the well being of U.S.-born black Americans (Hummer 1996; Jones 2001; Postmes and Branscombe 2002; Williams 2000). This flourishing literature emerged in the 1990s as a critique of socioeconomic explanations that downplayed the significance of race in understanding black/white health disparities (Williams and Collins 1995). Because race and socioeconomic status are strongly related in American society, controlling for the latter reduces racial differences in health, leading some to argue that race is merely a proxy for class (e.g., Kaufman, Cooper, and McGee 1997). However, socioeconomic status fails to explain the entire racial gap in health – blacks have worse health than whites at comparable levels of education and income, an indication that race plays a larger role than socioeconomic status (Williams 2000). But the argument that “it is class not race” requires further examination. Some scholars claim that race is a contextual variable that conditions life chances in society, of which socioeconomic status is merely one outcome. In other words, socioeconomic status does not explain the effects of race, but rather, race is causally prior to socioeconomic status and specifies one’s socioeconomic position.

Racism, especially at the institutional level, is argued to be the key mechanism through which race operates to perpetuate differences in socioeconomic status (Hummer 1996; Ren, Amick and Williams 1999; Williams 2001). Racism is a powerful determinant of health status because it operates on many different levels: by limiting access to socio-economic goods through residential segregation, which in turn determines access to education and employment opportunities (Hayward et al. 2000; Williams and Collins 2001); by discriminating in the medical treatment of black Americans (Williams and Neighbors 2001); and by creating a stigma of inferiority that elevates individuals’ stress and affects both physical and mental well-being (Feagin and McKinney 2003; Geronimus 1996; Kreiger 2000; Williams 2001).

When taken together, despite not having direct, longitudinal measures of racism, these studies point to an important role that race and racism play in population health.<sup>1</sup>

### ***Toward an Alternative Explanation: Racial Context of Origin***

Though less is known about variations in black immigrants' health status, scholars have advanced theoretical and empirical understanding of variations in black immigrants' socioeconomic achievements, which have indirect implications for their well being over the long-term (Butcher 1994; Dodoo 1997; Kalmijn 1996; Waters 1999). The relative economic success of black immigrants compared to U.S.-born blacks was once considered evidence of a "black success story," not unlike the model minority image of Asian immigrants. Increasingly, however, studies highlighting within-group variation are calling into question homogenous descriptions of black immigrant success. Significantly, African immigrants are well educated but receive much lower returns for their education than do those from the Caribbean, a disparity that some argue is the result of differential acceptance by American society (i.e., discrimination). Caribbean blacks are believed to benefit from favorable perceptions that white employers have about them, relative to U.S.-born blacks, whereas African immigrants do not appear to have the same advantage (Dodoo 1997).

In a similar vein of research, Mary Waters (1999) followed Caribbean immigrants in New York City and found that they are more likely to be employed, work more hours, and have higher incomes than U.S.-born blacks. Exploring why, she argues that since these immigrants come from cultures in which blacks are the majority, they have accumulated more social and cultural capital than U.S.-born blacks. They have higher self-esteem, are more prepared to resist efforts to discriminate against them, and their accents allow them to be perceived by others as different from U.S.-born blacks. In short, they are not beaten down from a history of being a "second-class" minority, giving them more capital and more resilience against racism. But Waters finds that over time, these advantages erode. For the immigrants themselves, their resilience to racism is often pierced in the long term. Though they arrive ready to resist discrimination and armed with self-esteem and capital from their countries of origin, they often falter in their ability to withstand the negative impacts of racism. Just as telling, Waters finds that their children, no longer having accents and having been raised in the United States, are more similar to U.S.-born blacks in terms of identity, experiences of racism and educational outcomes. The advantages the parents brought with them wash away because their children grow up in the U.S. context.

Context, then, seems important. In studies of Hispanics and health, that context often is suspected to be the poorer dietary and exercise habits of Americans. But in light of work on racism and health, we think that for black Americans it is vital to focus on the *racial context of origin*. The key mechanism associated with racial context of origin is the level of exposure to racism, which is lower in regions that are minority white and higher in regions that are majority white (Williams and Collins 2001; Winant 2001). Blacks living in minority white contexts typically are afforded the advantages Mary Waters discusses; blacks living in majority white contexts typically suffer esteem issues, the lower end of the socioeconomic ladder, and the receiving end of individual- and structural-level racism. For U.S.-born black Americans, the context of origin is the United States and more broadly, North America. For black immigrants, the context of origin is their region of birth.

There are several potential pathways through which racial context of origin may influence the health status of black Americans. It may affect health through exposure to stressful events that accumulate over the life course (e.g., discrimination). Social epidemiologists have shown that early life experiences, especially sub-desirable ones, become permanently embedded and have

negative consequences in all phases of human development (Power and Hertzman 1999). Likewise, positive early life experiences may result in greater resilience and better health over the life course. Racial identity formation is another early life experience that may link racial context of origin to health outcomes. For racial minorities, the conflict between identity and the developing reality of adulthood – that one’s aspirations are often unachievable *because* of one’s racial category – has negative consequences for both physical and mental health.

### ***Hypotheses for Black Immigrant Health***

Together, the literatures on immigrant selectivity, racism and health, and black socioeconomic achievement allow us to posit several hypotheses for black immigrant health status. We are most directly concerned with possible variation in health status among black immigrants by their regions of origin. Using the best existing data available – the National Health Interview Survey (see the Data and Methods section for details) – we are able to disaggregate black immigrants by their region of origin (Africa, the West Indies, South America and Europe), but not by country or smaller units. To address this limitation and get a clearer picture of the racial and demographic characteristics in these four broad regions, we draw on information from the U.S. Census Bureau, Office of Immigration Statistics, and World Factbook.

Of all black immigrant groups, the newest and most selective stream comes from Africa (Dodoo 1997). African-born blacks comprise 16 percent of the U.S. foreign-born black population and are considerably more educated than other black immigrant groups (U.S. Bureau of the Census 2000). The vast majority comes from minority white countries in East and West Africa (e.g., Kenya and Nigeria), and less than 2 percent originate from North or South Africa (World Factbook 2004; Yearbook of Immigration Statistics 2003). African immigrants are considerably more likely than other black immigrants to migrate through diversity programs and much less likely to be admitted on the basis of family-sponsored visas, all of which points to importance of U.S. immigration policies in affecting selectivity. Specifically, policies that favor family reunification increase migration opportunities for populations with larger, more established networks in the United States (i.e., less selectivity for these groups) and limit migration opportunities for groups with fewer numbers of U.S. residents (i.e., greater selectivity for these groups). In 2000, African immigrants represented the smallest proportion of all foreign-born persons in the United States at 2 percent, followed by South Americans at 7 percent, West Indians at 10 percent, and Europeans at 16 percent (U.S. Bureau of the Census 2000).<sup>2</sup>

Compared to black immigrants from Africa, those from South America and the West Indies are less highly selected, with far more entering the United States each year on the basis of family-sponsored preferences (Yearbook of Immigration Statistics 2003). Further, black immigrants from these regions have lower levels of educational attainment than African-born blacks (though still higher than U.S.-born blacks). For example, 20 percent of blacks from Guyana and 17 percent of blacks from Jamaica have a bachelor’s degree or higher compared to 29 percent of black Ethiopians and 32 percent of black Kenyans (U.S. Bureau of the Census 2000). However, a major difference between South American and West Indian black immigrants is in the racial contexts in their regions of origin. Here, South American blacks more closely resemble African blacks, with the majority hailing from Guyana (80 percent), a nation with a large African and East Asian presence and very small white population (less than 1 percent). Colombians (6 percent) and Brazilians (4 percent) make up the next largest groups, and both nations are also minority white (World Factbook 2004). West Indians, in contrast, are considerably more likely to originate from countries that are more racially mixed and/or have greater interaction with whites (e.g., tourism). Jamaica, Haiti,

Trinidad, Tobago, the Dominican Republic and Barbados are among the most common West Indian points of origin.

European-born black immigrants represent the only group that originates from majority white racial contexts: 56 percent from Germany, 26 percent from England, 4 percent from France, and 3 percent from Italy (Yearbook of Immigration Statistics 2003). They are similar in size to South American blacks, making up 6 percent of the U.S. foreign-born black population. The evidence is mixed in terms of selectivity. On the one hand, Europeans have had the greatest opportunities to immigrate over the past two centuries; of the 69 million total migrants to the United States since 1820, 57 percent originate from Europe (Yearbook of Immigration Statistics 2003). On the other hand, European blacks are well educated (27 percent of German blacks and 47 percent of British blacks have a bachelor's degree or higher), indicating a fair degree of selectivity. We combine this demographic information with the theoretical frameworks set forth at the beginning of the article to make the following four hypotheses:

***Selectivity Hypothesis:*** Theories of immigrant selectivity would lead us to hypothesize that black immigrants will be healthier than U.S.-born blacks, and that among black immigrants, their health status will vary by region of birth. This is because the costs of migration, and hence selectivity, are directly tied to the proximity and characteristics of the sending region. The costs of the journey to the United States are substantially higher from Africa, not simply because of the higher transportation costs, but also because the United States has greater control over immigration flows from Africa, and immigrant networks that can assist with resettlement are less established from African compared to South American, West Indian and European sending areas.

*H1: Compared to U.S.-born blacks, black immigrants from each region (Africa, West Indies, South America and Europe) will have superior health given that migration processes are selective of healthy individuals.*

*H2: Among black immigrants, African-born blacks will have significantly better health than other immigrant blacks given the spatial distance of the region from the United States, higher costs of migration and restrictive U.S. immigration policies. South American- and European-born blacks will be healthier than West Indians given the greater selectivity in their characteristics (i.e., education and spatial distance), but not differ from each other given their similar profiles (i.e., education and admittance categories).*

***Racial Context of Origin Hypothesis:*** Theories of racism and health underscore the deleterious effects of lifelong minority status on the health of black Americans. Transposing this to black immigrants would lead us to hypothesize that the racial context (minority vs. majority white) in their region of origin will contribute to differential health outcomes. Specifically, we should expect black immigrants from minority white regions to experience better health than those from mixed or majority white regions, reflecting less exposure to racism over the life course. Further, this literature identifies a possible new mechanism for the deteriorating health of immigrants with longer duration of U.S. residency: the longer black immigrants are in the United States, the greater their cumulative exposure to stressful life events associated with minority status (i.e., not just poor diet and lack of exercise).

*H3: Compared to U.S.-born blacks, black immigrants from minority white (Africa, South America) and racially mixed (West Indies) regions will have superior health, while those from majority white (Europe) regions will have health that is equal to or no better than U.S.-born blacks.*

*H4: Among black immigrants, those from minority white (Africa, South America) regions will have better health than those from racially mixed (West Indies) regions, who will in turn have better health than those from majority white (Europe) regions.*

### **Data and Methods**

As a preliminary test of these hypotheses, we draw on merged data from the 2000-2002 National Health Interview Survey (NHIS), an annual multi-purpose health survey conducted by the National Center for Health Statistics and Centers for Disease Control and Prevention, and administered by the U.S. Census Bureau. NHIS uses a multi-stage, stratified, cluster design to oversample the black and Hispanic populations and to obtain a nationally representative sample of the non-institutionalized civilian population. The U.S. Census Bureau conducts face-to-face interviews in a nationally representative sample of households, collecting information about the health and other characteristics of each member of the household. The combined sample for 2000-02 consists of 113,486 households, which yielded 293,527 persons in 115,470 families.

The 2000 questionnaire was the first to include a question on region of origin, which categorizes all respondents into one of 12 categories depending on their country of birth.<sup>3</sup> The analyses are based on U.S.-born ( $n = 24,540$ ) and foreign-born ( $n = 2,931$ ) non-Hispanic black respondents ages 18 and older. Of the foreign-born blacks, 61.6 percent ( $n = 1,806$ ) were born in the West Indies; 21.4 percent ( $n = 626$ ) were born in Africa; 5.3 percent ( $n = 155$ ) were born in South America; 3 percent ( $n = 88$ ) were born in Europe; and 8.7 percent ( $n = 256$ ) have birthplaces that were listed as Asia, elsewhere or unknown.<sup>4</sup> We include this latter category in the analyses but do not attempt to interpret the findings, since it includes a combination of groups.

Our dependent variables include three measures of health status: self-rated health, activity limitation and limitation due to hypertension. Self-rated health is assessed with a single item that asks, "Would you rate your health as excellent, very good, good, fair, or poor?" This item captures several dimensions of health status, has been shown to have high validity and reliability, and is highly predictive of mortality (e.g., Kington and Nickens 2001; Idler and Benyamini 1997). Because subjective assessments of health may vary across ethnic groups, we also include more objective measures of activity limitation and limitation due to hypertension. Hypertension is also useful to include because it represents an anomaly among black immigrants, with foreign-born blacks experiencing higher risks of hypertension than U.S.-born whites (Singh and Siahpush 2002). We were unable to include other measures of health status due to limitations of the NHIS file structure.

The main explanatory variable is region of origin, measured with four dummy variables for black immigrants from Africa, South America, the West Indies and Europe (U.S.-born blacks are the reference). Our independent variables include several social, demographic and immigrant characteristics typically thought to influence health. Socioeconomic status is strongly associated with health status for all groups (Lynch and Kaplan 2000); and we include four items to gauge these relationships: educational attainment, family poverty status, insurance coverage and employment status. Given the prior work on varying returns to education among foreign-born blacks (e.g., Doodoo 1997), we categorized educational attainment in several ways, including a continuous measure of number of years of schooling completed and a categorical measure of highest degree attained. Ancillary analyses revealed no significant difference in the effects of these measures on health, thus we used the categorical measure to be consistent with prior theoretical and empirical research on health disparities (e.g., Lynch and Kaplan 2000).



Health status also varies by a number of individual and family characteristics – persons who are younger, male, married and living in urban areas tend to rate their health better than those who are older, female, not married and living in non-metropolitan areas (e.g., Eberhardt, Ingram and Makuc 2001; Lillard and Waite 1995; Ross and Bird 1994), so we include measures of these. Finally, research finds mixed effects of assimilation on immigrant health, with the standard hypothesis suggesting that cultural and behavioral characteristics operate as protective mechanisms for immigrants, and with increased duration in the United States, their health advantage decreases (e.g., Cho et al. 2004; Singh and Siahpush 2002). To examine this possibility, we include duration of U.S. residency and U.S. citizenship status as proxy measures for assimilation and exposure to racism.

NHIS data are not without limitations. The data restrict analysis to region of birth rather than nation of birth. Further, the NHIS file structure requires that we use the person file to obtain a large enough sample for analysis; the person file does not contain measures of health behaviors (e.g., smoking, drinking) or risk factors (e.g., obesity) and only has a limited number of health outcomes (e.g., self-rated health and activity limitations). Since the analysis focuses on differences among blacks (rather than compared to U.S.-born whites), the exclusion of obesity is less of a concern; prior research shows minimal differences in obesity rates between U.S.-born and foreign-born blacks (mean BMI of 27.14 and 25.58, respectively) (Singh and Siahpush 2002). More detailed health behaviors and measures are contained in the sample adult file, which contains too few cases for analysis even when multiple years of data are combined. For example, the 2000 sample adult file only contains 12 African blacks and the 2001 file only contains 11.

The analysis consists of a series of ordinary least squares and logistic regression models that assess the net effects of the independent variables on self-rated health, activity limitation and limitation due to hypertension, respectively.<sup>5</sup> Model 1 examines only the effects of region of birth and Model 2 adds standard demographic, socioeconomic and immigrant characteristics. Region of birth is included in Model 1 as a baseline measure, and changes in the coefficients from Model 1 to Model 2 will help explain differences in health.

## **Results**

Table 1 highlights key comparisons among U.S.- and foreign-born blacks separately by their region of origin. We also include a column that combines all foreign-born blacks into one category (i.e., the standard categorization in research on black immigrants) to illustrate the utility of disaggregating this population. As seen in Table 1, U.S.-born blacks have the lowest self-assessed health (3.51), followed by blacks born in the West Indies (3.84) and Europe (3.85). South American (4.00) and African immigrants (4.22) have the best self-rated health of any group. A similar gradient exists for activity limitation, with African immigrants being least likely to report activity limitation (3 percent) or limitations due to hypertension (1 percent), followed by South Americans (6 percent and 1 percent), with Europeans and West Indian immigrants faring slightly worse. The “foreign-born” category obscures this diversity. Again, U.S.-born blacks have the worst health, with 18 percent reporting limitation in activity and 4 percent reporting limitations due to hypertension.

African immigrants’ superior health may be related to the fact that they are younger, more highly educated, and more likely to be employed than U.S.-born blacks and whites. However, their educational achievements do not necessarily translate into superior earnings (Dodoo 1997) the percentage of African immigrants who live in poverty (24.9) is second only to that of U.S.-born blacks (29.1). According to the assimilation perspective (e.g., Singh and Siahpush 2002), differences in years of U.S. residency may also contribute to differences in health

**Table 1: Characteristics of U.S.- and Foreign-born Black Respondents (n = 27,471)**

	By Nativity		By Region of Origin			
	U.S.-born	Foreign-born	Africa	S. America	West Indies	Europe
<u>Mean scores</u>						
Self-rated health (1=poor, 5=excellent)	3.51	3.91	4.22	4.00	3.84	3.85
Activity limitation (1=limited; 0=not limited)	.18	.07	.03	.06	.08	.09
Hypertension (1=limited; 0=not limited)	.04	.01	.01	.01	.01	.02
Education in years	12.32	12.8	13.73	12.90	12.4	13.61
Years in the U.S.	—	12.09	9.34	12.68	12.77	14.63
Age in years	43.42	40.97	36.67	41.61	42.76	34.30
<u>Percentages</u>						
Female	58.3	54.0	45.2	52.9	56.8	61.4
Marital status						
Never married	30.7	27.4	29.9	20.6	27.6	42.0
Div/Sep/Wid	23.8	15.9	12.3	11.0	18.2	17.0
Married	37.1	47.6	52.4	64.5	46.5	30.7
U.S. citizen	—	55.3	35.1	62.6	55.1	79.5
Employed	61.8	70.6	73.6	74.2	72.3	83.0
Family income < \$20,000	29.1	19.5	24.9	16.1	19.3	14.8
Not insured	17.5	26.2	27.2	26.5	28.7	14.8
Residing in MSA	90.5	98.9	98.1	99.4	99.3	95.5
U.S. region						
Northeast	14.0	48.4	29.1	85.2	55.1	27.3
Midwest	20.1	7.6	19.0	1.9	1.9	9.1
West	9.7	7.3	12.3	2.6	3.4	21.6
South	56.2	36.7	39.6	10.3	39.5	42.0
n =	(24,540)	(2,931)	(626)	(155)	(1,806)	(88)

Source: National Health Interview Survey, 2000-2002.

**Table 2: Ordinary Least Squares and Logistic Regression Coefficients for the Effects of Region of Origin on the Health Status of U.S. Blacks (n = 27,471)**

	Self-rated health		Limitation		Hypertension	
	M1	M2	M1	M2	M1	M2
Group origin (U.S.-born blacks) <sup>a</sup>						
Africa	.71**	.54**	.16**	.35**	.17**	.08*
South America	.49**	.49**	.28**	.53**	.17†	.06*
West Indies	.32**	.39**	.39**	.57*	.37**	.08*
Europe	.34**	.14	.46*	1.02	.62	.43
Education (less than high school) <sup>a</sup>						
High school graduate		.16**		.77**		.76**
Some college		.23**		.79**		.83†
Bachelor's degree or higher		.44**		.56**		.47**
Employed		.38**		.14**		.13**
Family income < \$20,000/year		-.23**		1.72**		1.71**
Not insured		-.01		.55**		.67**
Duration of U.S. residency (less 5 yrs) <sup>a</sup>						
Resident 5 to 14 yrs		-.15**		1.00		6.32†
Resident 15 yrs or more		-.18**		1.34		8.79*
Non-U.S. citizen		-.03		.83		1.83
Background factors:						
Female		-.08**		.85**		1.16*
Marital status (married) <sup>a</sup>						
Never married		-.01		1.24*		.62**
Divorced/widowed/separated		-.03		1.60**		1.14†
Living with partner/other		-.03		1.05		1.12
Number of persons in household		-.01**		.96**		.98
Non-metropolitan residence		-.12**		1.17*		1.30*
Region (South) <sup>a</sup>						
Northeast		-.01		.89*		.69**
Midwest		-.06**		1.31**		.99
West		-.01		1.24**		.92
Age in years		-.02**		1.03**		1.03**
Constant	3.51**	4.20**	.22**	.14**	.04**	.02**
Adjusted R <sup>2</sup>	.01	.23	—	—	—	—
Nagelkerke R <sup>2</sup>	—	—	.02	.37	.01	.25

Note: Self-rated health estimated with OLS regression; functional limitations and hypertension with logistic regression (shown as odds ratios).

<sup>a</sup> Reference category.

†p = < .10    \*p = < .05    \*\*p = < .01

status; on average, African immigrants have resided in the United States for fewer years than other black immigrant groups, and thus, have had less exposure to U.S. risk factors. The multivariate analysis will facilitate untangling these relative influences on health.

Tables 2 and 3 test our hypotheses about the significance of selectivity and racial context in the region of origin by comparing the health status of black immigrants to that of U.S.-born blacks (Table 2) and of black immigrants from South America, the West Indies, and Europe to that of African immigrants (Table 3). Table 2 finds that blacks born in minority white (Africa, South America) and racially mixed (West Indies) regions have better self-rated health and fewer activity limitations and limitations due to hypertension than U.S.-born blacks, all of which provides support for both hypothesis 1 (selectivity) and hypothesis 3 (racial context of origin). However, black immigrants from majority white (Europe) regions do not significantly differ from U.S.-born blacks on any of the health status measures, a finding that corresponds to hypothesis 3 but not hypothesis 1 (i.e., we expected European blacks to have better health, given the selective characteristics of immigrants). It is telling that the African/South American/West Indian advantage remains net of their socio-demographic and immigrant characteristics, all of which operate in the expected direction. Accounting for differences in human capital, duration of U.S. residency, marital status, gender, region and age do not appear to explain the observed differences in black health status.

Also noteworthy in Table 2 are the effects of duration of U.S. residency on health, a measure that serves as a proxy for acculturation and exposure to racism. Length of time in the United States has a significant negative effect on self-rated health, and to a lesser extent, on limitation due to hypertension. Compared to the newest immigrant arrivals (those with less than five years of U.S. residency), black immigrants who have lived in the United States for more than five years report worse self-assessed health and more limitations due to hypertension. Overall, the results in Table 2 provide moderate support for our central thesis regarding racial context in point of origin (hypothesis 3) – the black immigrant “advantage” appears isolated to those whose reference location is one in which whites are not the racial majority (Africa, South America, West Indies). Selectivity (hypothesis 1) would predict these outcomes; however, selectivity would also predict European blacks to be healthier than U.S.-born blacks, which is not the case for any of the three health measures.

When we change the comparison group to focus on differences among black immigrants, we find a more complicated picture, but again one that is somewhat more consistent with the racial context of origin thesis (hypothesis 4) than the selectivity argument (hypothesis 2). Compared to the healthiest group (African blacks), South American blacks do not differ significantly on any of the three health measures, despite considerable differences in their migration opportunities and educational achievements (i.e., selectivity). The selectivity argument would predict South American blacks to be less healthy than African blacks and more similar to European blacks; instead we find that South Americans do not differ from African immigrants and are healthier than both European and West Indian immigrants (analysis with alternate reference categories not shown). Based on selectivity, we also expected the more highly educated Europeans to be healthier than West Indian blacks. The results, however, find Europeans to be the least healthy of all the black immigrant groups. Again, these results support the idea that racial context of origin plays a role in determining variation in black immigrant health status: Those from minority white racial contexts (Africa and South America) experience better health than those from racially mixed contexts (West Indies), who in turn enjoy superior health to those from majority white racial contexts (Europe).

Figures 1-3 summarize our findings and underscore the utility of separating black immigrants by their regions of origin. Specifically, we disaggregate blacks by nativity (first section of each figure) and by region of birth (second section of each figure) and compare their health statuses to that of U.S.-born whites, the standard reference category in studies of

**Table 3: Ordinary Least Squares and Logistic Regression Coefficients for the Effects of Region of Origin on the Health Status of Foreign-born Blacks (n = 2,931)**

	Self-rated health		Limitation		Hypertension	
	M1	M2	M1	M2	M1	M2
Group origin (African-born blacks) <sup>a</sup>						
South America	-.22**	-.02	1.776	1.484	1.010	1.252
West Indies	-.39**	-.15**	2.421**	1.775*	2.177	1.236
Europe	-.37**	-.39**	2.881**	3.957**	3.606	6.85†
Education (less than high school) <sup>a</sup>						
High school graduate		.18**		.628*		.49
Some college		.17**		.67†		.71
Bachelor's degree or higher		.33**		.514*		1.29
Employed		.24**		.151**		.054**
Family income < \$20,000/year		-.28**		1.391		1.53
Not insured		.03		.443**		.76
Duration of U.S. residency (less 5 yrs) <sup>a</sup>						
Resident 5 to 14 yrs		-.11*		.894		9.12*
Resident 15 yrs or more		-.12*		1.17		8.22*
Non-U.S. citizen		-.05		.910		2.67*
Background factors:						
Female		-.13**		1.19		1.54
Marital status (married) <sup>a</sup>						
Never married		-.13**		1.04		.59
Divorced/widowed/separated		-.01		1.34		2.39†
Living with partner/other		-.19**		.76		1.49
Number of persons in household		-.02†		.97		1.10
Non-metropolitan residence		-.09		.01		.01
Region (South) <sup>a</sup>						
Northeast		-.17**		1.10		.68
Midwest		-.04		1.98*		2.87
West		-.21**		1.20		.356
Age in years		-.02**		1.03**		1.05**
Constant	4.22**	5.12**	.04**	.04**	.01**	.139**
Adjusted R <sup>2</sup>	.03	.19	—	—	—	—
Nagelkerke R <sup>2</sup>	—	—	.02	.30	.01	.37

Note: Self-rated health estimated with OLS regression; functional limitations and hypertension with logistic regression (shown as odds ratios).

<sup>a</sup> Reference category.

†p < .10 \*p < .05 \*\*p < .01

Figure 1. Odds of Black Americans Reporting “Fair or Poor” Health Compared to U.S.-born White Americans, NHIS 2000-2002 <sup>a</sup>

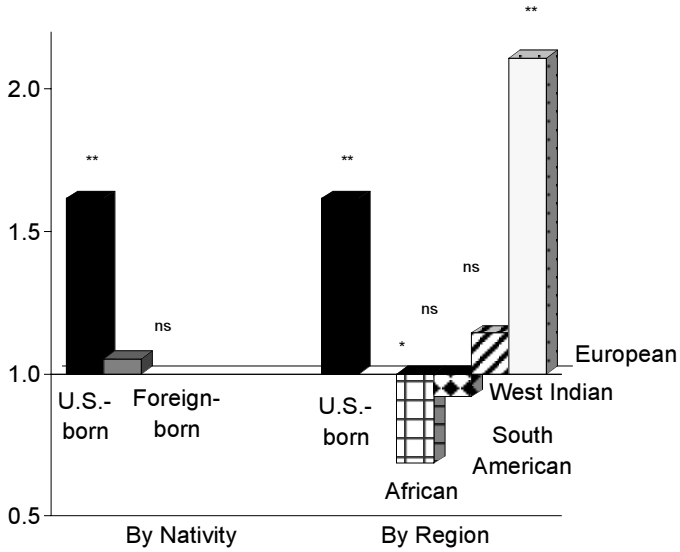
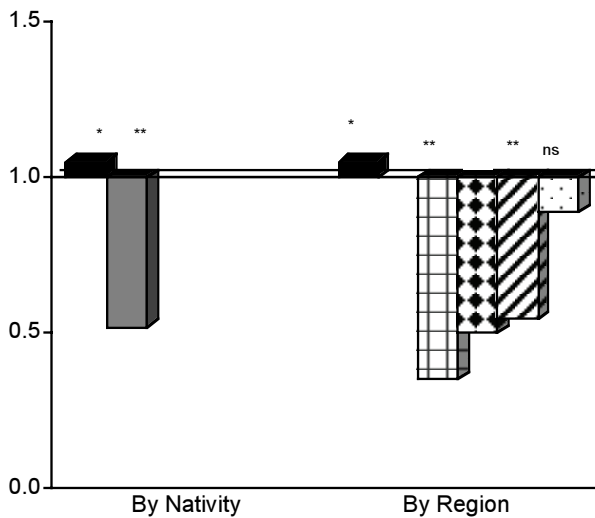


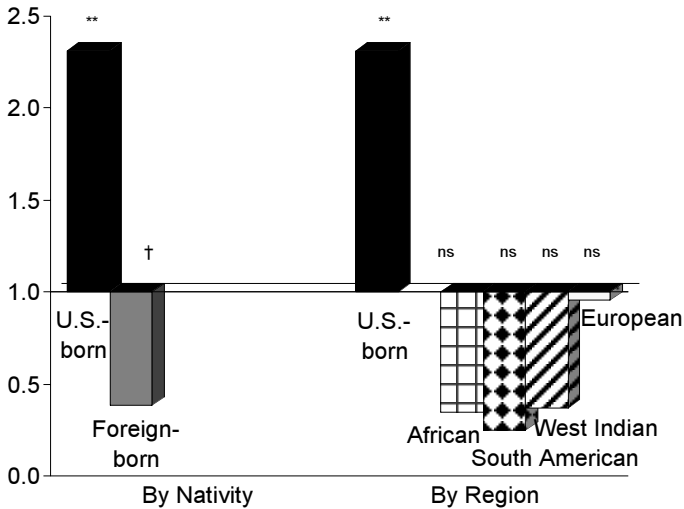
Figure 2. Odds of Black Americans Reporting “Activity Limitation” Compared to U.S.-born White Americans, NHIS 2000-2002 <sup>a</sup>



<sup>a</sup> Adjusted for age, sex, socioeconomic status, family characteristics, U.S. region, metropolitan residence, duration of U.S. residency, and citizenship status.

† p < .10 \* p < .05 \*\* p < .01

**Figure 3: Odds of Black Americans Reporting “Limitation due to Hypertension” Compared to U.S.-born White Americans, NHIS 2000-2002<sup>a</sup>**



<sup>a</sup> Adjusted for age, sex, socioeconomic status, family characteristics, U.S. region, metropolitan residence, duration of U.S. residency, and citizenship status.

†p < .10 \*p < .05 \*\*p < .01

immigrant health (e.g., Singh and Shiapush 2002). Two patterns are immediately apparent: 1) the health of U.S.-born blacks is far below that of U.S.-born whites across health measures; and 2) the “foreign-born” category obscures considerable heterogeneity in black immigrant health. Looking at self-rated health, for example, U.S.-born blacks are 62 percent more likely to rate their health as “fair or poor” compared to U.S.-born whites, while foreign-born blacks do not appear to differ significantly from the majority white population. However, when broken down by region of birth, we see that African immigrants are healthier than U.S.-born whites; South American and West immigrants do not significantly differ from them; and European immigrants are much less healthy.

## Discussion

Prior research has highlighted the importance of context of reception for immigrant incorporation (Portes and Rumbaut 1996) and of racial context for the health of black Americans (Williams 2001). We add *racial context of origin* as a conceptual tool for understanding variations in black immigrant health. Our central claim is that racial context of origin in combination with immigrant selectivity is an important mechanism by which race affects the health status of foreign- and native-born black Americans. As an initial test of this thesis, we derived four hypotheses that led us to analyze separately the health profiles of black immigrants by region of origin and to expand the comparison groups for black immigrant to include not only their U.S.-born counterparts but also each other. Together, these advances yield several tentative but notable findings that have implications for understanding racial and ethnic inequalities in U.S. health.

First, the results suggest that grouping together foreign-born blacks conceals important differences among this population. Rather than being uniform, the black immigrant “advantage” in health varies by region of birth and reference category. While theories of immigrant selectivity would predict some of the outcomes from our analysis, selectivity alone does not seem to account wholly for the patterns. For example, the superior health of South American blacks compared to West Indian blacks was not expected, nor was the poorer health of European blacks compared to all other black immigrants.

We propose that adding racial context of origin to existing theories provides a fuller explanation of observed patterns. Specifically, the experience of being a racial minority in one’s region of origin may have long-term implications for health disparities. Though awaiting further corroborating evidence, we theorize that the story of the superior health of black immigrants is two-fold: the health advantage holds only for those immigrants coming from minority white regions, and (2) given the work on second generation immigrants this advantage will be difficult to pass on to their children (e.g., Kasinitz et al. 2001; Portes and Rumbaut 1996; Waters 1999). If our thesis is correct, the health advantage cannot survive across generations in the United States because black immigrants and their children from all origins will eventually resemble U.S.-born blacks, as their racial contexts shift from abroad to the United States. Irrespective of selective migration, the health of black immigrants will likely erode as they are exposed to the harmful effects of discrimination and racism. In turn, this will expand the already large U.S. black/white health gap.

Racial context of origin is also useful because it highlights a new mechanism through which “Americanization” (Landale et al. 1999) may hurt immigrant health – the longer black immigrants are in the United States, the greater their cumulative exposure to stressful life events associated with minority status (i.e., not just poor diet and lack of exercise). To more fully examine this possibility, we need longitudinal datasets that not only contain information on region of birth and health status, but also on racial identity, discrimination, and generational status. One limitation of the current study is that we cannot compare black immigrants to their second-generation peers (e.g., first- and second-generation Africans). This information would allow us to see if black immigrants eventually look like U.S.-born blacks, or if they follow different trajectories depending on their region of birth.

We must also consider the plausibility of alternative explanations for our findings. The question is: given the data we have, do alternative explanations offer a more useful or equally useful explanation than the one we have offered? One possible explanation may be that differential acculturation to U.S. society, rather than racial context of origin, accounts for black immigrant health differences. However, if acculturation is measured as either years of U.S. residency (a standard measure in health studies) or citizenship or both, it does not remove the region of origin effects. These proxies for acculturation matter for health, but important variation remains, and the racial context of origin thesis remains useful.

Perhaps context of origin does matter, but its significance is something other than racial, such as the political structures, cultures or health systems of the home regions. If context is something other than race, then black and white Europeans should be similar to each other in health, as they are exposed to the same context. In analysis not included here, we find that black immigrants from Europe look much more like U.S.-born blacks than they do white immigrants from Europe, and white immigrants from Europe look much more like U.S.-born whites than they do their black compatriots. What is more, European countries have a much higher standard of living than either African or West Indian countries – their incomes and employment rates are higher, better extended vacation time, and better health care. So, on average, European black immigrants should have better health than other black immigrants. We find the opposite.

Finally, we must consider that there may be cultural bias in answering the health questions. Africans, South Americans, and to a lesser extent West Indian immigrants, may



give a more positive interpretation to their health than European black immigrants or U.S.-born blacks. We use three different measures of health – each with a different level of objectivity – and find the same patterns. Moreover, studies to date find little variation across cultures in responding to these questions. Cultural bias as an alternative explanation, then, seems less consistent with the data and other research than the racial context of origin explanation.

We do not dismiss these alternative explanations, nor do we view them as zero-sum explanations, where one must be true and all others false. We do put forth the claim – and invite further testing – that racial context of origin matters for the health of black Americans. And this, in turn, has important implications for understanding the unyielding grip of racial health disparities in the United States. Ironically, our study suggests that the value of studying black immigrants may be to direct us to study why U.S.-born blacks are unhealthy compared to whites rather than why some black immigrants are healthy. The need for new theory and new methods of collecting data are the central implications for social scientists. For public policy, the implications include the deteriorating health of the black population, increased black/white health disparities, and a greater strain on the U.S. health care system.

## Notes

1. Most studies on the role of racism do not measure racism, a difficult concept to measure. Rather, they posit that racial disparities that persist after controlling for alternative explanations are due to the effects of racism.
2. Mexico represents the largest foreign-born group at 28.4 percent, and Asia is second at 26.2 percent.
3. The categories are the United States; Mexico/Central America/Caribbean Islands; South America; Europe; Russia (USSR); Africa; Middle East; Indian subcontinent; Asia; SE Asia; Elsewhere (including Canada); and Unknown (includes refused, don't know, foreign-born but country not provided, and stopped answering).
4. Internal analyses from NHIS staff reveals that the "unknown" category includes responses of "don't know," "refused," "stopped responding," and "not born in the U.S., country not provided."
5. Substantive findings for the Ordinary Least Squares regression models were identical using Cumulative Logit modeling, a technique appropriate for ordinal dependent variables.

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