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RESEARCH REVIEW

Achieving a Cohesive Culture for Health Equity in Latino and All Communities

Abstract

Health inequities are persistent in the United States.

A widening socioeconomic gap, extensive poverty, and multi-level racism, discrimination, and segregation contribute to inequitable distribution of healthcare, resources, and a significant disparity in mental and physical health outcomes among Latino and other population groups.

In a society characterized by income segregation and information "bubbles," it is easy for those who are more fortunate and/or whose hard work has been amply rewarded to fail to perceive the degree of suffering that is experienced by those who do not share their affluence. There is growing evidence that the consequences of poverty and racial/ethnic disparities in access to health care have very profound effects, especially on children, who are blamelessly born into impoverished or negatively discriminated populations.

A cohesive culture with health equity is one in which everyone works both individually and as a group to ensure that each individual has a fair and just opportunity for health and wealth, as well as equitable access to basic services and resources required for these goals. To achieve a more cohesive culture, it will be necessary to overcome implicit bias, system justification, moral disengagement, and negative attitudes toward those living in poverty, including Latino and other minority groups. More effective communication about the lifelong and inter-generational impacts of poverty may increase compassion between outgroups and push back against moral disengagement. We must promote social cohesion and avoid bias toward the socioeconomic status quo and preference for sociocultural homogeneity.

Intergroup contact, peer modeling, awareness-provoking interventions, and use of targeted social media programs are emerging methods that may improve tolerance and compassion toward minority and impoverished out-groups to counteract the stereotypes that contribute to

system justification. It is our hope that these interventions may stimulate rational and unemotional dialogue to spur a movement toward social justice and to reduce health disparities and inequities. Improving social cohesion and increasing access to resources may also buffer the negative effects of poor living conditions and thus increase overall well-being in all communities across the United States.

This research review summarizes current literature on the social and health impact of poverty, the impact of racism and bias on minorities and those living in poverty, and emerging interventions, policies, and practices that can be implemented to alleviate poverty, improve social cohesion, reduce bias, and increase compassion toward all groups to contribute to a cohesive culture with health equity.

Introduction

There is an undeniable link between education, socioeconomic status, and quality of life. Those with more education live longer and are healthier than those with less education, and their children have a better quality of life and more opportunities than those with less education. Unemployment and underemployment negatively affect health and overall quality of life, and employment opportunities are influenced by both the economic condition of a community and the individual's level of academic attainment.

Socioeconomic status (SES) is a measure of an individual's (or family's) economic or social position compared to others and is a composite based on several factors including income, financial security, educational attainment, subjective perceptions about social class and status, and the commensurate quality of life and privilege afforded by that status. SES is a reliable predictor of lifelong physical and mental health outcomes. Low SES correlates to poverty, low educational attainment, and poor health.[1]

The socioeconomic gap, the differences between lower and higher SES groups, is widening in the United States, leading to inequitable distribution of healthcare and resources and a significant disparity in quality of life. Low SES in childhood is correlated with low income and poor health in adulthood due to poor cognitive development and poor language and memory processing due to chronic deprivation. Almost half of the 72 million children in the United States are growing up in low-income families.[1–3]

Communities are often segregated by SES, race, and ethnicity, and race and ethnicity often determine a person's SES. Low SES communities often have low economic development, poor health conditions, and low educational attainment, and the schools in these areas tend to be

under-resourced. Low SES is perpetuated by inadequate education and higher school dropout rates in lower SES areas.[2–4] Nearly one quarter, 24.8%, of people living in poverty do not have a high school diploma or equivalent, and 13.3% have a high school diploma but no college education.[5] This is significantly lower than the national average: in 2015, 88% of U.S. adults had a high school diploma or equivalent, and 33% had at least a bachelor's degree. Low SES Americans are also less likely than high SES Americans to have health insurance, more likely to avoid seeking medical care due to high costs, more likely to be treated in hospital emergency departments, and have twice as many avoidable hospitalizations. The United States has the greatest disparities in health care access of any wealthy country in the world.[6]

Structural racism plays a significant role in healthcare inequality, and inequality in general, by reinforcing and perpetuating dynamics that are advantageous to whites while creating a myriad of adverse outcomes for minority groups and people of color. Public policies and institutional practices contribute to a system that reinforces racism and is responsible for inequities in insurance rates, payment structures, treatment, and health outcomes.[6]

In 2018, there were 38.1 million people living in poverty in the United States, representing 11.8% of the population; while children represented 22.6% of the total population in 2018, they constituted 31.1% of people living in poverty.[5] Moreover, 33% of Latino children and adolescents are living in poverty, compared to 14% of white children. Minority groups are more likely than whites to experience multidimensional poverty, suffering from poor health, poor living standards, and disempowerment, and African American and Latino children are more likely to attend high-poverty schools. Latino students have the highest rates of high school dropout in the country.[4]

According to data from the 2019 Current Population Survey Annual Social and Economic Supplement, the median Latino income was $51,450, compared to $70,642 for whites; 17.6% of Latinos in the United States live in poverty.[5] The lowest median income reported was in rural areas at $45,830, where, according to the 2010 census, almost 60 million people (19.3%) in the United States reside.[7] In addition to having a lower median household income, people living in rural areas are less likely to have a bachelor's degree or higher.[7]

Complicating, and contributing to, the high levels of poverty among minority populations in the United States, including the Latino population, is the issue of discrimination, both economic and racial. Almost 60% of Latinos and African Americans believe that race relations in the United States are generally bad, and 58% of Latinos have been treated unfairly based on race or ethnicity or have been discriminated against.[8] Latinos with darker skin colors (64%) report they have experienced discrimination or been treated unfairly regularly or from time to time, compared with Latinos with a lighter skin tone (50%).[8] Younger Latinos also are more likely to have an experience with discrimination, with 65% reporting an encounter.[9]

Only through understanding and alleviating conditions of poverty – and recognizing and reducing racism and biases while increasing compassion through intergroup contact and peer modeling – can public health policies, community leaders, and policymakers begin to address

health inequities and start to build a cohesive culture of health for Latinos and all people. Communication has the potential to influence cognitions, attitudes, and emotions to increase people's support for changes that can reduce health disparities and inequities.

Methodology

This research review summarizes available peer-reviewed scientific literature regarding discrimination and bias toward children and adults living in poverty as well as toward Latino and immigrant communities; common misconceptions regarding immigrant populations and people living in poverty and how these misconceptions and biases are destructive; efforts developed to correct misconceptions and alleviate conditions of poverty; and the efficacy of those efforts.

Keyword searches were conducted in PubMed and Google Scholar. Databases were searched with key terms such as: "poverty AND Latino children," "poverty AND Hispanic children," "poverty AND immigrants," "poverty AND immigrants AND Latino," "poverty AND immigrants AND Hispanic," "poverty AND rural," "poverty AND Latino AND child health," "poverty AND mental health," "rural AND mental health," "poverty AND bias," "poverty AND bias AND Latino," "poverty AND bias AND Hispanic," "poverty AND discrimination," "poverty AND discrimination AND Latino," "poverty AND discrimination AND Hispanic," "implicit AND bias," "implicit AND bias AND Latino," "implicit AND bias AND Hispanic," "social cohesion AND Latino," "social cohesion AND poverty," "system AND justification AND discrimination," "system AND justification AND bias," "discrimination AND education AND Latino," "discrimination AND education AND Hispanic," "bias AND healthcare AND poverty," "bias AND healthcare AND Latino," and "bias AND healthcare AND Hispanic."

Article titles and abstracts were examined; relevant articles were retrieved and reviewed, regardless of the study's conclusions regarding discrimination and bias toward immigrants and those living in poverty. Additional articles were identified through searches of the references of the initial set of articles found through keyword searches. Search limits were confined to the English language.

Key Research Results:

<u>Poverty Contributes to Health Inequity among Latinos and Other People of Color</u>

- Latino families are more likely to live in poverty than white families.
- Ethnic minorities, including Latinos, and people living in rural areas face unique issues, including less access to health care and emergency services, a lack of internet access, and higher suicide rates.
- The Affordable Care Act resulted in increased access to care in states that voted to expand Medicaid, though many who stand to benefit from ACA provisions live in non-expansion states, and gaps remain in expansion states.

Social Division, Moral Disengagement, Racism and Biases, and Systems Reinforce Poverty & Health Inequity among Latinos and Other People of Color

- Latinos have fewer and poorer quality academic opportunities compared to whites, and this is influenced by racial and ethnic discrimination and bias.
- Implicit bias influences behavior, resulting in the unintentional perpetuation of inequity in many areas, including health care.
- Systems justification results in negative attitudes toward those living in poverty, both from those of higher socioeconomic status, and those who themselves live in poverty.
- Increased racial/ethnic diversity and rising income inequality in the U.S. has resulted in moral disengagement and decreased tolerance of other groups; increased distraction contributes to indifferences toward those who are suffering.

Emerging Solutions for Health Equity & Social Cohesion

- Intergroup contact, peer modeling, and awareness-provoking interventions may improve tolerance and compassion toward Latinos and other out-groups and counteract stereotypes that contribute to system justification.
- Social cohesion has decreased in the U.S., but improving social cohesion and increasing access to affordable housing and health care may buffer the negative effects of poor living conditions and increase overall well-being.
- Social media can be used to affect social change and alter negative perceptions about racial/ethnic groups and those living in poverty.

STUDIES SUPPORTING KEY RESEARCH RESULTS:

Poverty Contributes to Health Inequity among Latinos and Other People of Color

Latino families are more likely to live in poverty than white families.

Child poverty rates are more than twice as high for black children than white children (38% vs 14%, 2019 data)[10] and Latino children than white children (23.7% vs 8.9%, 2018 data) across the United States,[5] according to data published in the 2019 County Health Rankings and Roadmaps Report[10] and the 2018 U.S. Census Bureau Current Population Report.[5]

The Institute for Policy Studies found that between 1983 and 2013 there was a 51% decline in the wealth of the median Latino household (from $4,100 to $2,000); during this same period, wealth of the median white household increased by 14% from $105,300 to $120,300). It was projected that by the year 2020, there would be a further 12% decline in Latino wealth. With these projections, the median white household would own 68 times more wealth than the median Latino household. If these numbers aren't enough cause for concern, the 2024 projection is staggering: median white households will hold 75 times more wealth than their Latino counterparts. Job market statistics show similar trends: a recent meta-analysis of 24 studies of labor market discrimination found that whites received an average of 24% more job callbacks than Latinos.[11] In 2016, the wealth of a median Latino household was $6,300,

compared to $140,500 for a white household.[12] The "lack of savings and assets that underpin household wealth has left these [Latino] communities in a difficult position as they work to achieve long-term economic stability," and their net worth could hit zero by 2073.[12]

Current laws contribute to these trends. Without significant changes to federal policy, current trends estimate that it will take 2,000 years for the median Latino family to match the current wealth of the median white family. Unfortunately, passage of the 1.9 trillion-dollar Tax Cuts and Jobs Act passed in December 2017 gave 72% of tax cuts to the richest 20% of households in the U.S. Because white taxpayers are more likely to be in the upper income brackets, they are more likely to benefit from the new tax law.

Research shows that white taxpayers received 79.5% of the tax cuts, while Latinos and blacks received 6.7% and 5.0%, respectively, effectively excluding Latino and black households from the benefits of the Tax Cuts and Jobs Act, thus perpetuating the racial economic divide in the U.S.[13]

Ethnic minorities, including Latinos, and people living in rural areas face unique issues, including poverty, less access to health care and emergency services, a lack of internet access, and higher suicide rates.

Disparities in poverty rates also exist across geography: child poverty rates are highest in rural counties, at 23.2%, compared to large urban metro areas (21.2%), smaller metro areas (20.5%), and suburban counties (14.5%). Race/ethnicity and geography intersect as well. The poverty rate among black and Latino children in suburban counties is higher than it is for white children in rural counties.[10]

Most of the U.S. Latino population was concentrated in the Southwest until the 1990s, when Latino immigrants began to migrate to rural areas in the South and Midwestern United States for low-wage jobs in manufacturing and meat processing. Crowley et al.[14] wanted to know: are Latinos actually faring better in these rural communities? Using county-level data, the authors divided non-metropolitan counties into three types: new Latino destination counties, established gateway counties (those with a Latino population of at least 10% in 1990), and all other counties. The authors then investigated the impact of Latino migration on the economic circumstances of blacks living in those communities, who felt an increased competition for jobs due to the influx of immigrants.[14]

In 2000, poverty rates among Latinos were similar in both new and established Latino communities, while in 2010, new Latino destinations saw more poverty and lower income and employment rates compared to traditional Latino communities. The individual poverty rate was

21% higher in new Latino destinations, with a slight decline in median household income. In counties with high Latino growth and established African American populations, unemployment rates were 44% higher among African Americans in 2000, though this did not translate to higher income, lower poverty rates, or greater wealth for Latinos compared to African Americans. Over the course of the next decade, however, poverty rates among Latinos increased significantly, at 11% overall and 23% among children, compared to African Americans.[14]

Access to a primary care physician may also prove difficult for those living in rural areas. In the United States, rural areas represent approximately 19% of the total population, but are served by only 9% of practicing physicians.[15] In a population-based study of physicians aged 50 or older in British Columbia, Canada, Hedden et al.[16] found that compared to physicians who practiced in metropolitan areas, those who practiced in rural areas had higher age-specific odds of retirement.[16] In addition to the lack of physicians in rural areas, 89 rural health centers across the United States have closed since 2010.[17]

While cancer incidence rates are often lower in rural residents than urban residents, rural residents are more likely to die from their cancer.[15] Rates of lung, prostate, cervical, and colorectal cancer deaths are higher among rural populations, and this can be attributed in part to longer travel distances for care and lack of access to transportation, medical facilities, and physicians. The disparities that exist between rural and urban dwellers in cancer incidence and mortality extend across the continuum of cancer care, from prevention and screening to diagnosis and treatment.[15]

In addition, in the fifteen years between 1990 and 2005, 339 trauma centers in the United States closed their doors, largely due to the cost of trauma care. The closing of these emergency room trauma centers increases travel time for patients, some of whom must travel significant distances to reach a trauma center. In emergency situations such as a stroke, time is of the essence, and increased travel time has a negative impact on patient outcomes.[18]

Hsia and Shen[18] identified all trauma centers existing in the United States between 2001 and 2007 and calculated the community characteristics surrounding each center. The authors then calculated the distance community residents had to travel to the closest trauma center. The study included 283 million people and found that approximately 75% of the U.S. population lives within 10 miles of a trauma center, while 14% live more than 30 miles from a trauma center.[18]

In rural areas, however, only 24% of people live within 10 miles of a trauma center, and 29% do not have a trauma center within 30 miles. In addition, high-poverty communities were at a higher risk of facing a 30 minute or greater increased drive time due to trauma center closures in both urban and rural areas, and rural communities, which already have higher baseline drive times, had the highest risk of experiencing a significant increase in drive time compared to urban communities.[18]

Vulnerable populations include those with a lack of access to primary care services as well as high unemployment rates, high rates of uninsured and underinsured, challenging cultural differences that present barriers to care, and low education. These populations are present in both rural and urban communities, though rural communities tend to also suffer from a declining or aging population, business closures that significantly impact the local economy, and a lack of transportation.[18,19] The closing of community hospitals creates a dire situation for these populations, depriving them of essential health services, including primary care, prenatal care, emergency services, psychiatric and substance abuse treatment, diagnostic services, and a strong referral structure.[19]

In 2015, the American Hospital Association created the Task Force on Ensuring Access in Vulnerable Communities. The task force was created with the goal of providing vulnerable communities and their hospitals with the tools to determine their essential health care needs and services and how to best provide those services. Nine strategies for health care delivery and payment reform were identified by the task force; the first strategy is addressing the social determinants of health, which include economic stability, neighborhood and built environment, education, community context, health and health care, biology, and health behavior. An inpatient/outpatient transformation strategy was also identified, wherein the hospital reduces its inpatient capacity to the necessary level while enhancing its outpatient and primary care services while continuing to provide emergency services.[19]

Other strategies identified by the task force include the use of urgent care and more innovative method of health care, such as telemedicine. Of course, barriers to implementation exist for these strategies, including limited federal funding, restrictive regulations, and lack of collaboration with public health departments, government agencies, and other health care organizations.[19]

Telemedicine in particular may be difficult to implement in rural areas. Almost a quarter, 23.8%, of people living in rural areas do not have regular internet access, compared to 17.3% in urban areas.[7] The principal barriers to internet access, whether in rural or urban areas, are affordability and quality of the internet.[20] A 2018 report published by the Maryland Health Care Commission found that the adoption of telemedicine was highest in urban areas, noting that the more rural areas of the state, such as the Eastern Shore, may have insufficient internet access to support telemedicine initiatives.[21] However, improvements to Internet access may be implemented more quickly that improved transportation and increased access to the remaining low number of primary and specialty physicians, making telemedicine an attractive alternative

in these communities. Furthermore, Internet is required for education and work responsibilities, which play important roles in health equity.

Katz et al.[3] interviewed 336 low-income Latino parents and children in Arizona, California, and Colorado about their internet usage and accessibility; these interviews led to a nationally representative phone survey of 1,191 parents of school-aged children from all backgrounds with annual household incomes less than the median. Results showed that 94% had some kind of internet connection, including 90% of those below the poverty line, but 52% reported that their internet connection was too slow to do many of the things they needed to do online. In addition, 26% reported sharing a computer or device, which resulted in not having enough time to use the device, and 20% had their internet cut off in the past year due to nonpayment. Of the respondents, 23% had mobile-only access; these people were much less likely to apply for jobs or services online, and the groups who are most likely to have mobile-only internet access — Latinos, African Americans, the uneducated, and the low-income — are the same groups that suffer from disparities in health and healthcare.[3]

Leadville, Colorado, is one community with residents facing the challenges common to low-income individuals in rural areas, and Latinos in particular. Leadville has seen a 99% increase in its Latino population since 1990; currently, almost 40% of the town's population is Latino. Compared to state averages, Leadville has higher rates of poverty, child poverty, domestic violence, and suicide, and according to the county health rankings report from 2014, Lake County, where Leadville is located, ranked 48th out of Colorado's 59 counties in low quality of life scores, low birth weights, poor physical and emotional health, and poor clinician care.[22]

In 2012, Lake County published a report assessing the health disparities and social determinants of health that complicate health care delivery in the county. The report found that most health care services and clinics were prohibitively expensive and unwelcoming to immigrants, most of whom sought care from a sliding-scale cost-base community health clinic in Frisco, a 45-minute bus ride over the mountain from Leadville. The only hospital in Leadville, St. Vincent Hospital, operates under very limited capacity, having been temporarily saved from closure. The next closest hospital is in Frisco.[22]

Latinos living in rural communities may feel socially isolated and have a lack of community support services, and perceived discrimination is a reported barrier to health care access for minorities in these communities.[23] Lack of legal status is associated with feelings of stress and anxiety as well as a reluctance to engage in community meetings and a reluctance to seek health care for fear of being reported. In Leadville, the majority of the Latino community is

concentrated in three mobile home parks on the outskirts of the town center, as they cannot afford housing in town or near the ski resorts where many of them are employed.[22]

In a study of mortality data from the National Vital Statistics System from 2001 to 2015, the Centers for Disease Control and Prevention (CDC) found that deaths by suicide increased across all urbanization levels (large metropolitan, medium/small metropolitan, and rural), with consistently higher rates in rural areas among all demographic groups. Among Latinos, the suicide rate in rural areas increased from 8.85% in the 2007 to 2009 period to 10.21% in the 2013 to 2015 period.[24]

The Affordable Care Act resulted in increased access to care in states that voted to expand Medicaid, though many who stand to benefit from ACA provisions live in non-expansion states, and gaps remain in all states.

The Patient Accountability and Affordable Care Act, generally referred to as the Affordable Care Act, or ACA, was signed into law in March 2010. The ACA was designed to expand insurance coverage, improving access to health care. Key provisions were included to benefit those of lower SES, including Medicaid expansion and federal health subsidies for those living at 138% of the federal poverty level, and large subsidies for those at 100% to 400% of the federal poverty level who purchased insurance plans through ACA exchanges. In January 2014, the most impactful ACA provisions took effect, including the expansion of Medicaid in 24 states and the District of Columbia.[6]

Data from the 2011 to 2015 Behavioral Risk Factor Surveillance System (BRFSS) found that, from 2013 to 2015, there was a 15% increase in health insurance coverage among poor populations in states that voted to expand Medicaid under the ACA. In addition to the significant increase in rates of the insured, there was also a 7.7% increase in those who reported access to a primary care physician, and a 7.5% reduction in reports of avoiding care due to prohibitive cost; these changes were also mostly limited to poor populations, but also extended to specific vulnerable populations, including immigrants.[6,25] Expansion states also saw increased coverage and lower uninsured rates in rural areas; in fact, growth in Medicaid and decline in the uninsured rates in rural areas exceeded those in metropolitan areas.[25]

In an analysis of data from the Consumer Expenditure Survey from 2010 to 2015, Glied et al.[6] found that low-income families in Medicaid expansion states saved an average of $382 annually in health care-associated costs and were less likely to report out-of-pocket spending on insurance premiums and medical care compared to families in non-expansion states.[26] Americans who benefitted most from ACA provisions were the unemployed, those without a college degree, and those earning a low income; in other words, those who were most likely to be excluded from an employer-based health insurance program.[6]

The proportion of nonelderly adults lacking health insurance fell from 20.5% in 2013 to 12.3% in 2017, a decline of 40%, while all U.S. racial and ethnic groups saw comparable, proportionate declines in uninsured rates, according to a 2019 analysis of data from the American Community

Survey by Chaudry et al.[27] However, because uninsured rates started off much higher among Latino and black non-Latino adults than among white non-Latino adults, the coverage gap between blacks and whites declined from 11.0 percentage points in 2013 to 5.3 percentage points in 2017. Likewise, the coverage gap between Latinos and non-Latino whites declined dropped from 25.4 points to 16.6 points. The percentage of uninsured adults ages 19-64 was 25.1% among Latinos, 13.8% among blacks, and 8.5% among whites. Latino noncitizens (such as green card holders) also made gains in their insurance coverage, although this group did not qualify for Medicaid or for subsidies.

Latinos also saw greater healthcare coverage improvements in states that expanded Medicaid than in those that did not, with a 14-percentage point decline in expansion states (from 36% uninsured to 22% uninsured) compared to only 11 percentage points in non-expansion states (from 47% to 36%), according to an analysis of American Community Survey data between 2013 and 2015. It is important to note that many non-expansion states, including Florida, Georgia, North Carolina, and Texas, have large black and Latino populations. Also noteworthy is that the rate of uninsured was lower in Medicaid expansion states even before expansion took effect and this was true for all groups.[28]

Well before the ACA, Latinos and blacks were significantly more likely than whites to face barriers in access to health care. After the ACA was implemented, researchers found a 5% reduction, from 27% to 22%, in the number of Latinos who avoided seeking medical care due to prohibitive cost. While this is a trend in the right direction, it narrows the gap only somewhat, as only 10% of whites report avoiding care due to high cost. There was also a 4% reduction in Latinos who did not have access to a primary care physician.[28]

Compared to the pre-ACA era, there were significant increases in health insurance coverage and well-child visits in the post-ACA era, according to a cross-sectional review of data from the National Health Interview Survey, Ortega et al.[29] The largest gains in insurance coverage were seen in Latino youth, though the rates of uninsured Latino youth remain the highest in the country. Additionally, disparities in health care utilization between black and Latino youth compared to white youth did not improve.[29]

Despite the gains seen in health insurance coverage and access to care following passage of the ACA, there is still much room for improvement. Shartzer et al.[30] found that while more low- and moderate-income adults reported having a primary care physician in March 2015 compared to September 2013, 25.7% of adults still do not have a regular source of care, and these adults were more likely to be younger, low-income, and Latino.[30]

Yue et al.[31] reviewed data from 2013 (pre-ACA) and 2015 (post-ACA) to determine whether there were any significant changes in health outcome measures among low-income adults. Results showed that among low-income adults, Medicaid expansion was associated with significant gains in health insurance coverage, having a primary care physician, and reported health care affordability. Despite these gains, Latinos saw the fewest benefits.[31]

Social Division, Moral Disengagement, Racism and Biases, and Systems Reinforce Poverty & Health Inequity among Latinos and Other People of Color

Latinos have fewer and poorer quality academic opportunities compared to whites, and this is influenced by racial/ethnic discrimination and bias.

Many Latino children are at risk of not getting the proper care, services, and environment they need for healthy formative development. Adverse childhood experiences (ACEs; including racism, discrimination, and violence), poor nutrition, physical inactivity, and low participation in preschool programs can impair Latino children's social and emotional development, health and wellbeing, and academic achievement.[32] Even when minority children live in wealthier areas, research shows that they are often treated differently by teachers. "They are more likely to be harshly punished for minor infractions, less likely to be identified as needing special education, and teachers may underestimate their abilities," according to one researcher.[33] Also, U.S. Latino children are likely to enter elementary schools with fewer white peers than a generation ago. In 1998, Latino children attended elementary schools in which nearly 40% of their classmates were white; that percentage fell to just 30% in 2010. This worsening segregation grows into severe isolation in large urban school districts. In the nation's 10 poorest districts, Latino elementary students attended, on average, schools that were just 5% white—down from 7% white in 1998.[34]

Educational attainment is an important factor for future health and wellbeing. Yet the high school dropout rate among Latino students is 17.6%, a rate that is much higher than African American students (9.3%), white students (5.2%), and Asian American students (3.4%). In addition, only 76.8% of Latinos aged 18 to 24 years have earned a high school diploma or general equivalency diploma (GED).[35] Lower educational attainment among black and Latino students is associated with an increased risk of institutionalization, poorer physical and mental health, increased risk of dependence on social services, and reduced lifetime earning potential.[35]

Racial discrimination is a risk factor for poor academic performance for Latino students, whether that discrimination is perpetrated by teachers, peers, police, or business owners. It

may also negatively impact Latino students' perception of the economic value of education. Mroczkowski et al.[35] surveyed low-income Latino students from a large city in the Midwestern United States (city not named in study). Results showed that greater perceived discrimination was associated with greater perceived economic limitations of education.[35]

Sanchez et al.[36] recruited 9th grade Latino students from two public high schools in a large midwestern city to determine whether mentoring had any influence on the effects of discrimination on Latino students.[36] Results demonstrated that perceived racial discrimination in 9th grade significantly negatively predicted coping efficacy in 10th grade; however, instrumental mentoring quality in 9th grade was a significant positive predictor of coping in 10th grade. Greater racial discrimination was significantly associated with lower instrumental mentoring quality, which predicted lower coping efficacy with discrimination. The quality of the mentoring relationship did not weaken the negative association between discrimination and coping efficacy.[36]

In a cross-examination of data from three waves of the Add Health survey, Thompson et al.[37] aimed to determine whether and to what extent self-identified race category and perceived skin tone influence educational performance, and whether race and skin tone may predict school outcomes.[37] Darker skin tone was associated with lower GPA on average compared to lighter skin tone, with a 0.4-point GPA differential, and African American, Latino, Native American, and multiracial students were found to earn significantly lower grades than white students.[37]

Experiencing discrimination impacts a child's health and development, according to a meta-analysis of 214 child-focused studies by Benner et al.[38] The researchers found that experiencing discrimination is consistently linked to poorer mental health, lower academic achievement and more engagement in risky or negative behavior, which sets the stage for future health disparities. Children with Latino or Asian backgrounds were at greater risk for the negative effects of discrimination on depression and other mental health issues than African Americans. The researchers also found that discrimination was more detrimental to Latino males' academics, compared with Latinas and African Americans. Benner et al. also theorized that Latinos experience a type of discrimination in which they are viewed as "perpetual foreigners."[38]

The 2019 County Health Rankings Key Findings Report noted that high school graduation rates are lower and unemployment rates higher in the Southeast, Southwest, Mississippi Delta, and Appalachian regions of the United States, areas with high Latino populations. In addition, blacks, Latinos, and American Indians have fewer economic and academic opportunities, as one in four do not graduate from high school in four years.[10]

These collective findings on the impacts of discrimination on education, opportunity, and health are critical for people of color. Overall, more Americans say that being Latino hurts people's ability to get ahead in this country (51%) than say it helps (18%) or that it neither helps nor hurts (30%), according to 2019 and 2020 Pew Research Center surveys.[39,40] Among Latinos

themselves, about 23% say being Latino has hurt their ability to get ahead at least a little. More Latinos than Whites also say they have been treated unfairly in hiring, pay, or promotion (26% to 19%), or have been unfairly stopped by police (19% to 9%), although nearly half of blacks said the same.[39] Latinos with darker skin, compared to Latinos with lighter skin, are more likely to fear for their personal safety (35% to 23%), say people acted as if they weren't smart (55% to 36%), been treated in hiring, pay, or promotion (30% to 19%), and been unfairly stopped by police (24% to 11%).[40]

These experiences of discrimination continue amid the novel coronavirus outbreak of 2020, as Latinos are more likely than their White peers to report negative experience s because of their race/ethnicity since the COVID-19 outbreak, according to a 2020 Pew Research Center survey.[41] Since the coronavirus outbreak, 27% of Latinos reported that people acted as if they were uncomfortable around them (compared to 13% of Whites), 15% of Latinos reported being subject to racial slurs (compared to 8% of Whites), and 10% of Latinos feared someone might physically threaten or attack them (compared to 9% of Whites). Also, 23% of Latinos say they worry a great deal or a fair amount that other people might be suspicious of them because of their race or ethnicity if they wear a mask or face covering when in stores or other businesses (compared to just 5% of Whites).[41]

Most people of color say they have experienced discrimination or have been treated unfairly because of their race or ethnicity from time to time or regularly, including 76% of Blacks and Asians and 58% of Latinos, compared to 33% of Whites. Most Americans (57%) say the country's bigger problem is people not seeing discrimination where it really exists, rather than people seeing racial discrimination where it really does not exist. Latinos are more likely than the overall population to believe this (67%).[39]

Implicit bias influences behavior, resulting in the unintentional perpetuation of inequity in many areas, including health care.

Bias is the tendency to favor one group over another. Most people think they harbor no bias toward other people, or they believe they know their biases and don't act on them.

The first type of bias is explicit bias, or overt bias. Explicit bias is a consciously held set of beliefs about a social group. Acting on race or ethnicity-based bias would be conscious, or explicit, racism, which many Americans openly reject, although which still exists in American society.

The second type of bias is implicit bias, or unconscious bias. Implicit bias is preconceived notions, or stereotypes, which affect our understanding, actions, and decisions about others—and which operate beyond our control. These perceptions play an integral role in our brain processes. Perceptions about people based on socioeconomic status, race, ethnicity, level of education, political leaning, style of dress, etc., lead us to behave a certain way toward that person or group of people, involuntarily.[42] Marcelin et al. note that implicit bias influences all human interactions, as our brains use "innate tendencies to categorize everything we encounter" as a shortcut.[43]

Importantly, implicit biases do not necessarily align with one's stated beliefs or reflect stances we would explicitly endorse—making us do things we might not consciously support. We generally tend to hold implicit biases that favor our ingroup, though this is not always the case. Significant research has documented that implicit bias has a real-world effect on behavior, with data from various domains including employment, education, and criminal justice, among others.[44] However, research has also demonstrated that implicit biases are malleable, meaning these unconscious associations can be "unlearned" and replaced with new mental associations.[44] Thus, intervention programs aimed at "rewiring" implicit biases in the direction of more compassion and understanding for the impoverished, minorities, and people of color may lead to more equitable distribution of resources and access to health and wealth opportunity.

Many white Americans outwardly oppose explicit racism, though many of those same white Americans harbor implicit prejudices against minorities, perhaps unknowingly or unintentionally perpetuating harmful racist behavior. In fact, most white Americans continue to reside in majority white neighborhoods, sending their children to majority white schools, and, in general, have limited contact with nonwhites. The choice to remain largely segregated from and limit interactions with other racial and ethnic groups serves to bolster racist beliefs and behaviors, whether knowingly or not.[12]

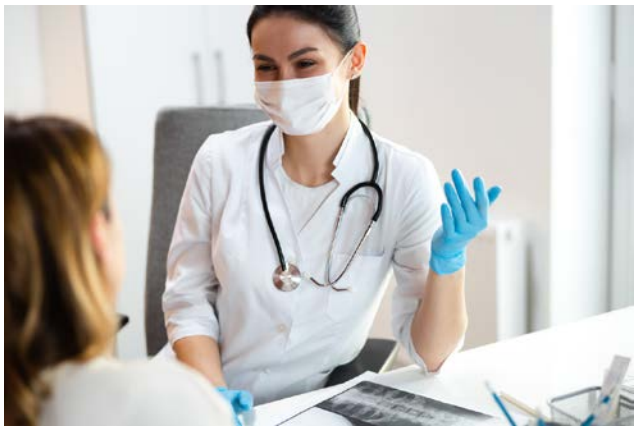
In 2003, the Institute of Medicine published a report stating that "bias, stereotyping, and clinical uncertainty on the part of healthcare providers" contribute to the significant health disparities that exist in the United States across a range of illnesses. The report found that racial/ethnic disparities existed even after adjusting for co-morbidities, socioeconomic differences, and factors affecting access to care, such that they were due in part to bias against minorities, stereotypes about the behavior of minorities, and increased clinical uncertainty when treating minority patients.[45] Though explicit racial bias has declined over the past half-century and is considered unacceptable by many, implicit bias persists.[46,47]

Implicit bias is difficult to overcome, as many health care providers may not believe that they harbor stereotypes that affect how they treat their patients. These implicit stereotypes are generally systematically biased, as a noticeable physical attribute, such as skin color, is used to draw conclusions about other attributes that cannot be seen, such as intelligence, honesty, or compliance. This type of bias cannot be accurately measured via self-report and is instead measured using tools such as the implicit-association test (IAT). The IAT measures the strength

with which concepts (in this case, race or ethnicity) are associated with attributes such as good or bad.[46,47]

Blair et al.[46] aimed to measure both implicit and explicit ethnic/racial biases of primary care physicians in the Denver area between May 2009 and May 2010. Explicit bias toward African Americans and Latinos was measured using a feeling thermometer (cool to warm on a scale of 0 to 100) and trait-rating scales (hardworking-lazy, cooperative-hostile, and so on); implicit bias was measured using the IAT.[46]

Results of the study showed that, in comparing the group of primary care physicians to the group of community members, the physicians were more likely to be white, fluent in Spanish, and of higher SES. There was weak to non-existent explicit bias expressed toward African Americans or Latinos by either group, but strong implicit bias against Latinos was reported for both physicians and community members, and two thirds of the physicians showed implicit bias that favored whites.[46]



In a second analysis by Blair et al.,[46] the authors contacted by phone 2,908 patients of 134 of the 210 physician participants from the prior study to have these patients rate their interactions with the physicians using four subscales of the Primary Care Assessment Survey (PCAS) that assessed perceived bias via interpersonal treatment, communication, trust, and contextual knowledge. The majority of the physicians had implicit bias against African Americans and Latinos. Latino patients have comparatively lower ratings of patient centeredness compared to white patients *(P* < 0.0001), though these low ratings had no association with the clinicians' racial bias toward Latinos.[46]

Blendon et al.[48] surveyed 4334 U.S. adults in 2007 to study patients' perceptions of the quality of their care, comparing the perceptions of patients in 14 racial/ethnic groups to the perceptions reported by white patients. Participants were asked questions regarding wait times and quality of patient-provider interactions. Ten out of the 14 racial/ethnic groups, including Mexican-Americans, were significantly less likely to report good or excellent care compared to white patients *(P* < 0.05).[48]

López-Cevallos and Harvey[23] conducted interviews with Latino young adults living in rural Oregon to assess health care discrimination against the Latino population. The participants were recruited from farms, health clinics, health fairs, and other community locations. In-person computer assisted interviews of approximately one hour were administered by staff members of the *Proyecto de Salud Para Latinos* program.[23] Health care discrimination was measured using a one-item question about personal experiences with discrimination while

seeking medical care. In addition, immigration status was determined by asking participants where they were born. The study revealed that foreign-born Latinos were more likely to experience health care discrimination, as were those currently attending school and those with middle and lower incomes. Overall, 39.5% of participants reported healthcare discrimination, compared to 30% of Latinos overall, suggesting that Latinos in rural areas are more likely to experience health care discrimination.[23]

In a 2015 systematic review of 15 studies that sampled existing health care providers and providers-in-training, all but one study found low to moderate levels of implicit bias among health care professionals, with similar levels of bias toward blacks, Latinos, and "dark-skinned people."[49] Most of these were cross-sectional studies with U.S. participants and assessed implicit bias using the IAT. Implicit bias was found to be significantly related to patient-provider interactions and patient health outcomes, and, to a slightly lesser but still significant degree, treatment decisions. The review found that most providers have implicit bias: that is, positive attitudes toward white patients, and negative attitudes toward patients of color.[49]

Implicit bias held by health care providers in the United States against Latino and black patients has resulted in significant differences in treatment decisions, as evidenced by several recent studies.[50,51] A 2019 meta-analysis of studies published between 1990 and 2018 demonstrated that black patients were 40% less likely and Latino patients 25% less likely to be given analgesia for acute pain relative to non-Latino white patients in United States emergency rooms.[50] Similarly, black and Latino patients were less likely to receive mechanical thrombectomy for treatment of acute ischemic stroke relative to white patients (7.0% vs. 9.8%; $P < 0.001$); this procedure is proven to reduce fatalities and improve patients' quality of life following a stroke.[51] Furthermore, new data show that as resident physicians face burnout, their implicit biases play a larger role in their treatment decisions, placing Latinos and black patients at higher risk for lower-quality health care.[52] Combined, these data suggest that any intervention that can reduce implicit bias in the healthcare setting would benefit these populations.

Interventions to decrease implicit bias in the healthcare setting are becoming more readily available, as the problem of implicit bias is more widely recognized. Jabraan Pasha, M.D.,[42] and Kelly Capatosto,[53] of the Kirwan Institute for Race and Ethnicity at Ohio State University have each developed implicit bias training programs targeting the health care environment. Both highlight how such programs need to approach the issue of implicit bias without blame or shame, and need to incorporate personal anecdotes that the audience can identify with to make the training relevant.[53,54]

Pasha's workshop, "Unlocking Implicit Bias," is an engaging practical learning experience that is straightforward, compassionate, and empathetic. It incorporates poignant storytelling, events and trends from national headlines, and Pasha's personal anecdotes featuring his own experience as both the perpetrator *and* the victim of implicit bias—removing feelings of shame and guilt that many people associate with implicit bias. Importantly, participants then work together to formulate a personalized list of methods to combat implicit bias.[54]

System justification results in negative attitudes toward those living in poverty, both from those of higher socioeconomic status, and those who themselves live in poverty.

System justification is the label for a social psychology theory asserting that people will rationalize the status quo, as they believe that the social, economic, and political systems must be fair and advantageous, otherwise they would not be in place.[55] In other words, the theory states that there is a general subjective motive justifying the existing socioeconomic order; that motive is partially responsible for creating and maintaining the inferiority of racial/ethnic and other minority groups and is largely implicit; and the motive may be strongest among those who are most harmed by it.[56] The majority of Americans accept the current system as fair and legitimate, even those in the lowest SES group.[57] System justification is a "potentially strong motivator of human behavior because it addresses fundamental human needs to reduce uncertainty, threat, and social discord,"[58] and can make people feel better, happier and more satisfied with the status quo on an emotional level,[59]; but it also can also interfere with and hinder efforts to promote social justice, such as the rich-poor gap or racial/ethnic disparities and inequities.[60]

Hennes et al.[61] conducted a study of American-born research participants; 84% of the participants identified as white or European American, and the sample was on average slightly liberal: 42% were Democrats, 34% were Independent, and 14% were Republicans, while 10% selected an affiliation of "other" or "none." The authors wanted to determine how epistemic, existential, and relational needs affected system justifying behavior.[61]

Participants answered a questionnaire that assessed these measures; epistemic needs were assessed via statements such as "I only think as hard I have to" and "I really enjoy a task that involves coming up with new solutions to problems," existential needs were assessed via the rating of statements related to death anxiety, including "it annoys me to hear about death" and "I get upset when I am in a cemetery," and relational needs were assessed using a scale that measured participants' need to share their worldview with others. System justification was measured via agreement or disagreement with statements such as "most people who don't get ahead in our society should not blame the system; they have only themselves to blame." Finally, the participants were asked their feelings about several sociopolitical issues, such as the Tea Party movement, the Occupy Wall Street movement, and the Ground Zero mosque.[61]

Results of the study showed that all three of the needs measures — epistemic, existential, and relational — were significantly associated with higher system justification scores (all $P < 0.050$). Regarding sociopolitical movements, economic system justification was positively associated with support for the Tea Party movement and negatively associated with support for the

Occupy Wall Street movement (both $P < 0.001$). These results support the hypotheses that greater epistemic, existential, and relational needs are associated with support for system-justifying ideologies; in other words, those who exhibited greater system-justifying beliefs had a lower need for cognition, greater death anxiety, and a stronger desire to share their reality and worldview with others. Those who supported system justification ideologies were more likely to support the pro-business, pro-traditional American values Tea Party movement, and were less likely to support Occupy Wall Street, a movement with the goal of restoring social and economic justice and democracy.[61]

In a 2016 study, Godfrey and Wolf[55] structured in-depth interviews with 19 low-income Dominican, Mexican, and African-American mothers of infants. Bilingual field workers visited the women in their homes every eight to ten weeks and conducted semi-structured interviews. The third interview occurred when the children were about one year old and dealt with the economic circumstances of the family, including economic hardship experiences, survival strategies, attitudes toward the government and community services, and beliefs about economic opportunity, inequality, and mobility in the United States.[55]

The women's explanations for poverty, wealth, and economic mobility represented two categories: individual attributions and structural attributions. Individual attributions were most commonly cited; 11 of the 19 women believed that economic outcomes were determined by character flaws, and that hard work and meritocracy were largely determined by an individual's ability to make money. Even when structural attributions were offered, these were usually tempered with an individual attribution.[55]

System-justifying behavior is evident not only in adults but in children and adolescents. In a longitudinal study of sixth-grade students, Godfrey et al.[55] examined whether there are associations between system-justifying behavior and mental health, and whether the association changes over time. Data from the study was collected in three waves from students at an urban middle school in the Southwestern United States. The school staff was largely white with an ethnically-diverse student body; 53.2% of the students were Latino, and 81% were economically disadvantaged.[55]

The three waves of data collection were spaced approximately eight months apart. All participants were in sixth grade during wave one, and all were from low SES families. There were 257 total participants, 55 of whom were Latino. The participants completed a questionnaire at each wave; the questionnaire measured system justification, self-esteem, mental health symptoms, deviant behavior, classroom behavior, and perceived discrimination.[55]

Results of the study showed that system justification was highly correlated with high self-esteem at wave one but was correlated with declining self-esteem over time; similar results were seen with the association between system justification and classroom behavior. There was no significant association, either initial or over time, between system justification and symptoms of anxiety or depression. System justification was significantly negatively associated

with deviant behavior in sixth grade *(P* = 0.05) but was significantly positively associated with increases in deviant behavior through early adolescence. Youth who perceived high levels of discrimination in early adolescence were also significantly more likely to have increased deviant behavior by eighth grade *(P* < 0.001). The authors surmised that believing in the fairness of the system may influence younger adolescents to behave well in school due to feeling that success depends on their individual effort in school, but this may wane over time as children are able to recognize how they are treated by the sociopolitical and economic systems.[55]

Godfrey also conducted a study in 2013 that focused on the effects of system justification on mental health and behavior among low-income immigrant Dominican, Mexican, and African American mothers and their children. The study aimed to determine how maternal system justification changed over time and how maternal system justification affected mothers' psychological distress and their children's externalizing behaviors. Data were collected via in-home interviews when the children were 14, 24, and 36 months old.[62]

The average family income was $28,298 in the year prior to the child's birth; the mean age of the mothers was 27 years at the 14-month data collection wave. System justification, psychological distress, and child externalizing behavior scales were administered to participants. System justification and maternal mental health data were collected at each of the three waves, and child externalizing symptom data were collected only at wave three.[62]

Results of the study showed that participants reported an overall downward trajectory of system justification from wave one to wave three *(P* = 0.002). Dominican and Mexican mothers reported significantly higher levels of system justification compared to African American women. Psychological distress scores did not vary significantly across the three racial/ethnic groups. Psychological distress at 14 months was significantly positively related to system justification at 24 months, and psychological distress at 24 months was significantly positively related to system justification at 36 months, suggesting that mothers may engage in system justification to cope with psychological distress.[62]

System justification at 14 months was significantly negatively related to psychological distress at 24 months, and. there was a significant positive association between psychological distress at an earlier wave and child externalizing behavior at a later wave. Overall, the results of this study suggest that members of disadvantaged groups do not receive any mental health benefits from engaging in system justifying behavior, as has been seen in advantaged groups, where opposition to equality has been positively associated with self-esteem, and negatively associated with depression and neuroticism. In addition, the results show that immigrants may

be more motivated to justify the U.S. system than those who are native born, as the immigrant women in this study reported significantly higher system-justifying behavior than the native-born African American participants; this data is consistent with system justification theory.[62]

People living in poverty are also victims of the so-called "poverty mindset;" this mindset occurs as income instability fosters an environment of scarcity and chaos, requiring sufferers to manage their resources more carefully than those who do not live paycheck to paycheck; the all-consuming thoughts about money and money management create a mental challenge in addition to the financial challenge. While those with ample or sufficient financial resources may not spend time worrying about what will happen if they have a flat tire or if their car breaks down, these events are significant hardships to someone who lives in poverty. These unforeseen or unanticipated situations lead poor people to borrow money to make ends meet; while others tend to view this as poor money management, for the person living in poverty, the immediate need often usurps the cost down the road, as they must often borrow at extremely high interest rates.[63]

People living in poverty are preoccupied with money and budgeting as a necessity for survival; this preoccupation affects cognitive processes, leaving less cognitive capacity for other tasks. Instead of earning poor people respect for the constant challenges they face, their struggles leave them open to disdain and ridicule by those who are more fortunate; poor people are seen as incompetent, lazy, and unmotivated. The judgment leveled at those living in poverty has a negative impact on their self-worth and makes some less likely to participate in government programs out of embarrassment.[63] Still, there is some poll-based evidence that Americans are at least increasingly acknowledging the plight of those in poverty. A growing share of Americans (65%) say the main reason a person is rich is because they possess more advantages than other people (rather than worked harder); and most (71%) say the main reasons a person is poor because they have faced more obstacles in life (rather than because they have not worked as hard), according to Pew Research Center surveys between 2014 and 2020.[64]

Increased racial/ethnic diversity and rising income inequality in the U.S. has resulted in moral disengagement and decreased tolerance of other groups; increased distraction contributes to indifference toward those who are suffering.

Moral disengagement is the cognitive process of decoupling one's internal moral standards from one's actions, thus allowing oneself to conduct unethical behavior without feelings of guilt or distress.[65] In simpler terms, it is the psychological process of rationalizing bad decisions, by convincing oneself that ethical standards do not apply within a particular context or situation. Moral disengagement has been studied in relation to cruelty to animals, support for the death penalty, or in cases where victims are said to have "brought the harm onto themselves."[66]

Moral disengagement can be broken down into four categories by which the perpetrator justifies his or her actions: 1) moral justification; reconstructs the immoral action as serving the greater good, 2) diffusing responsibility; attributes the immoral action to an order from an authority figure, 3) mis-presenting injurious consequences; the perpetrator tells him/herself

that the outcome of the action will not be a "big deal," and 4) dehumanizing the victim; the perpetrator reduces his/her identification with the victim, saying the victim did something to make themselves a target for the action.[66]

Unfortunately, Latinos and other out-groups suffer the consequences of implicit biases that result in negative interactions with those acting with moral disengagement, often at the doctor's office, with law enforcement officials, during the hiring process, or at the work place.[66] According to a recent Pew Research Center poll, 70% of Latino immigrants in the United States believe that discrimination is a major hindrance to their success in this country. The associations between perceived discrimination and depression, anxiety, self-esteem, poor academic performance, and poor social skills make this difficult to refute.[67]

Discrimination isn't reserved for only immigrants and minority groups. Social dominance, or group-based social hierarchy where superior groups dominate over inferior groups, influences how we view those living in poverty. Beliefs about causes of poverty can be classified into three types: individualistic, where poor people themselves are believed responsible due to immorality, poor money management, or laziness; structuralist, where the socioeconomic system itself fails to provide jobs, sufficient wages, and good schools; and fatalistic, where poverty is believed to be a result of illness, handicaps, or bad luck. In the United States, there is an overall negative view of the poor, with most attributions of the causes of poverty being individualistic. Myths legitimizing these beliefs, such as the bootstraps myth, work to enhance the social hierarchy. While exposure to the poor in an impersonal way, such as panhandling, usually negatively reinforces negative feelings and beliefs, interpersonal or intergroup contact may change a person's beliefs about out-group members in a positive way.[56]

In a 2014 study by Craig and Richeson,[68] ninety-two white participants were recruited to participate in a web-based survey that included reading about either the projected (2042) U.S. racial demographics as a "majority-minority" demographic makeup, or about the current (2010) U.S. racial demographics. Following the reading, the participants completed a self-report measure of racial bias. There were 86 participants in the final sample, 44 of which read about the future racial demographic shift, and 42 of which read about the current U.S. racial makeup. Racial bias was assessed using the Evaluative Bias Scale, a 6-item measure of individuals' preferences for interactions with their own racial group and relative discomfort with other racial groups. The items were ranked by participants using a scale from 1, or strongly disagree, to 7, or strongly agree. Example questions included "I would rather work alongside people of my same ethnic origin" and "it would bother me if my child married someone from a different

ethnic background." Participants who read about the future demographic shift revealed more racial bias than those who read about current demographics *(P* = 0.0250).[68]

A second analysis aimed to determine whether the future racial shift information would lead whites to express more racial bias toward specific racial groups; in other words, would knowing that the majority-minority shift is mostly due to an increase in the Latino population lead to greater expression of bias against Latinos? Data for the study came from 414 white participants in the Time-Sharing Experiments for the Social Sciences (TESS) online survey. Half of the participants were assigned to the majority-minority data group, and the other half comprised a control group that received information about geographic mobility projections. Regardless of the condition, participants felt more positively toward the in-group versus Asian Americans and African Americans and felt the least positivity toward Latinos (all $p<0.05$). The experimental group had greater negative attitudes overall than the control group.[68]

There are many factors that influence and foster anti-immigrant sentiment. The labor market competition theory, or the idea that anti-immigrant sentiment stems from the belief that an influx of unskilled immigrants will result in lower wages and higher rates of unemployment for non-immigrants, is a socioeconomic determinant that may be partially, but is certainly not fully, responsible for discrimination against immigrants. Socioculturally, people may be opposed due to the desire to preserve a national language. From a psychosocial standpoint, social identity theory likely has an impact on anti-immigrant feelings.[69]

Social identity theory refers to a person's feeling of belonging to a certain social group and his or her desire to maintain a positive social identity through membership to that group, as belonging creates positive feelings toward the group and its members. This can result in one group member or members acting on behalf or in defense of another member or members, even if there is no personal relationship. It also creates antipathy and negative attitudes toward out-group members. A perceived threat to the identity associated with the in-group, in the case of immigrants versus non-immigrants, can result in discrimination and prejudice toward immigrants.[69]

Bazo Vienrich and Creighton[69] used random-digit dialing to sample 1486 respondents for a questionnaire about opposition to a closed border. There were 733 respondents in the control group and 753 respondents in the treatment group; combined racial makeup was 78.7% white, 10% black, and 11.4%Latino. Control group participants were provided a direct question asking whether they supported or opposed cutting off all immigration to the United States; the purpose of this question was to measure overt opposition. The control group was then provided a list with the following three items: the federal government increasing assistance to the poor; professional athletes making millions of dollars per year; and large corporations polluting the environment. Respondents were asked how many of the three items they opposed but were not asked which items they were opposed to specifically. The treatment group was provided the same list but with one additional item about cutting off all immigration to the United States.[69]

Latino respondents showed the most overt opposition to a closed border, with 52% being opposed. Of the white respondents, 43% were overtly opposed, and 30% of black respondents were overtly opposed. There was no significant difference between overt and covert opposition among Latino respondents (52% versus 55%), demonstrating that Latinos are not reluctant to voice their opposition to a closed border. However, there were significant differences in overt and covert opposition among white and black respondents. Covertly, 28% of whites opposed a closed border, a 15-point difference, and just 13% of blacks opposed a closed border, a 17-point difference. These results show significant social desirability bias among white and black respondents, who are likely to underreport anti-immigrant sentiment to appear more tolerant.[69]

In a 2010 study, McAlister conducted a statewide telephone survey in Texas to determine whether moral disengagement was associated with tolerance for health care inequality. The author defined moral disengagement as the act of people pardoning themselves for inflicting suffering upon others via self-deceptive psychological maneuvers. These maneuvers include the minimization of perceived harmful consequences, dehumanization and blaming of harmed victims, and engaging in justifications that rationalize harmful actions.[70,71]

The survey asked participants about their age, gender, education, income, political affiliation, and political ideology, as well as questions measuring general support for government actions to reduce economic inequality and support for specific programs such as free health care. As a measure of moral disengagement, participants were asked whether they made moral justifications, whether they were willing to victim-blame those with social inequality, and whether they tended to minimize perceived suffering.[70]

Of the 1,063 participants who completed surveys, those who identified as conservative Republicans were more opposed to government programs to reduce inequality compared to other groups; 30% of conservative Republicans believed that the government should reduce gaps in social equality, compared to 60% of moderate or liberal Democrats. Most of the survey respondents supported action to increase access to government subsidized health insurance, though this was supported least by conservative Republicans at 55%, versus 87% of moderate or liberal Democrats. Those respondents who agreed with statements of moral disengagement were less likely to support government subsidized health insurance than those who disagreed, and 68% of those who believed that too much government reduces people's willingness to help themselves supported reducing health care disparities, while 82% of those who disagreed with that statement did.[70]

Crawford et al.[72] conducted a series of studies to investigate whether social ideologies — restrictions on personal freedom, for example — or economic ideologies, such as the role of government in regulating the economy, were more likely to predict prejudice against those with opposing views. The authors proposed several hypotheses. The dimension-specific hypothesis supposed that people would perceive conflict between their own social and economic views and those of others, fueling negative intergroup attitudes. Crawford et al. predicted that social conservatism, but not economic conservatism, would predict prejudice against socially liberal individuals; social, but not economic, liberalism would predict prejudice against socially conservative individuals; economic conservatism would predict prejudice against economically liberal individuals, and vice versa. The social primacy hypothesis presumed that both the social and economic ideological dimensions would predict ideological conflict, but the effects would be greater in the social dimension; the social-specific asymmetry hypothesis postulated that social conservatives would express prejudice, but social liberals would not, as need for closure and certainty is associated with social conservatism.[72]

The authors conducted five separate studies to test these hypotheses. The dimension-specific hypothesis received the most support, with social and economic conservatives tending to be more biased against social and economic liberals, and social and economic liberals tending to be more biased against social and economic conservatives, respectively. Two out of the five studies supported the social primacy hypothesis, while the social-specific asymmetry hypothesis did not receive any support, meaning that social conservatives were in fact not uniquely biased. Overall, the results showed that social issues are associated with more hostility than economic ones, and that, while worldview conflict fuels political prejudice, it is not necessarily a driver of discrimination.[72]

Paluck et al.[73] conducted a series of studies to test their hypothesis that ignoring news about human suffering could lead to lessened concern for issues related to that suffering. The first study included 232 university students who were recruited to participated in a study called "Global Attitudes and Mood." The students were randomly assigned to one of three conditions: an attention condition, a distraction condition, or a control group. Each participant was to arrive to a campus building lobby and directed to sit on a couch facing a television. In the control condition, the television was off; in the other two conditions, the television was on at low volume.[63]

Those in the control arm waited in the quiet room for the experimenter to return. Those in the attention condition were told they were free to watch television while they waited; those in the distraction condition were given illusion-of-choice instructions: they were free to watch television while they waited, but at some point, either while they waited or at the end of the study, they would need to complete a brief task on a laptop placed on the table in front of them. All but two of the participants chose to perform the task in front of the television rather than waiting until the end.[73]

In the attention condition and the distraction condition, real pre-recorded news footage of a famine in Niger was played on the television, with captions at the bottom of the screen. The

footage included a crying and emaciated baby and child. Prior to the end of the news program, the experimenter returned to the room, turned the television off, and removed the skin sensors. Participants then completed a survey that included rating the importance of certain political issues (hunger reduction, poverty reduction, the war in Afghanistan, and the abortion rights debate, among others), the allocation of a fictitious budget toward five issues (poverty and malnutrition, education and arts, foreign and crisis relief aid, defense and intelligence, and bio-diversity and the environment), and an assessment of mood.[73]

Participants who were distracted during the famine broadcast cared less about famine-related political issues compared to those who watched the broadcast without a distraction and compared to participants in the control condition. Political issues unrelated to famine were not rated any differently between groups. Those in the distraction condition also allocated less of the budget to poverty and malnutrition compared to the other groups, though this result was not statistically significant. In addition, participants in the attention condition reported significantly more negative mood compared to the other conditions.[73]

The second study aimed to replicate the first using online media instead of television news media. The participants were asked to watch videos as part of a test related to online visual processing and were to choose a single one-minute video from a list of three videos with short descriptions. Once the video had been selected, the participant pressed play, and a brief promotional video appeared, similar to the advertisements that appear before most online video content. The promotional video in the famine condition was the same as in the first study, and the video in the computers condition was a 30 second promotion about Dell computers. Half of the participants in each of these two conditions were randomly assigned to either the dismissal condition, where they could opt to skip the video after eight seconds, or the attention condition, with no option to dismiss. The survey was the same as in the first study, albeit with a shortened mood scale.[73]

Those in the dismissal-famine condition showed less concern for famine-related political issues than those in the attention-famine condition and the dismissal-computers condition, and those in the attention-famine condition reported more concern for famine-related political issues than those in the control condition, and significantly more compared to those in the attention-computers condition. Those in the attention-famine condition also reported significantly greater negative mood than the other conditions.[73]

In the third study, participants were randomly assigned to the distraction group or the control group. In the distraction group, participants were led to a waiting room and instructed to sit at a table. At one end of the room was another table containing gadgets and magazines; at the other end of the room was a television at low volume. In the control condition, the television was off. Participants in the distraction condition were told they were free to play with the gadgets or read magazines during the six-minute television programming (again, a pre-recorded news report of the famine in Niger). Participants in both groups were to complete the same survey as in the first study. Results showed that participants in the distraction condition rated famine-related issues as significantly less important and allocated significantly less of the

budget to poverty and malnutrition. The results of these studies support the authors' hypothesis that ignoring news about human suffering can lead to indifference toward suffering.[73]

Emerging Solutions for Health Equity & Social Cohesion

Intergroup contact, peer modeling, and awareness-provoking interventions may improve tolerance and compassion toward out-groups and counteract stereotypes that contribute to system justification, implicit bias, and moral disengagement.

Mitigating implicit bias and promoting inclusivity "is a long-term goal requiring constant attention and repetition and a combination of general strategies that can have a positive influence across all groups of people affected by bias," and can overlap between domains, according to Marcelin et al. and other researchers (see Figure 1).[43,74]

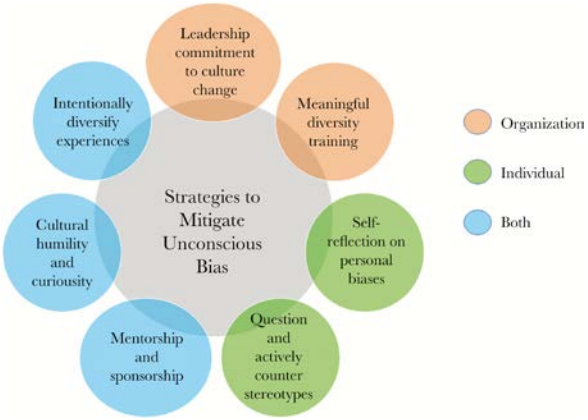


Figure 1: 7 Ways to Mitigate Unconscious Bias

A combination of both organizational and individual strategies can be used to mitigate unconscious bias. Figure from Marcelin et al. 2019.[40]

At the individual level, the contact hypothesis of social psychology, also called the intergroup contact theory, proposes that members of one group, having incomplete or inaccurate ideas about members of another group, can positively change their beliefs and attitudes toward that group via contact, whether face-to-face or through other interactive methods such as computer-mediated communication.[75]

Joyce and Harwood[75] recruited students from communications classes at a large university in Arizona to participate in an intergroup contact study. Of the 147 participants, 125 were white, 3 were black, 4 were Asian American, 8 were Latino, 2 were Native American, and 2 were unidentified. The participants were randomly assigned to view one of four videos. Three of the videos were taken from a documentary called 30 Days that chronicled a United States border patrolman sent to live with a family of illegal immigrants for 30 days. The three videos represented three different portrayals of intergroup contact: one was 80% positive, one was mixed, and one was 80% negative. The fourth video was a control and consisted of footage from a nature documentary. After viewing, the participants were instructed to fill out an online questionnaire.[75]

The positive condition resulted in more positive attitudes toward illegal immigrants. When there was higher identification with the border patrol officer, his negative interactions with the illegal immigrant had a stronger impact on decreasing positive attitudes toward illegal immigrants compared to when identification with the border patrol officer was lower, and greater identification with the illegal immigrant character was associated with positive attitudes

toward illegal immigrants. There was a mediating effect for groups related to illegal immigrants either socio-politically or as a minority; as an example, negative attitudes toward illegal immigrants were related to negative attitudes toward the poor. However, likeability of the out-group member was associated with positive attitudes toward the out-group, highlighting the importance of intergroup friendships.[75]

Intergroup contact theory supposes that the greater the interaction between in-group and out-group members, the less prejudice exhibited by the in-group; cross-group friendships in particular help to attenuate this prejudice. Kiehne and Ayon[67] conducted a study to determine how political orientation and friendships with immigrants affect negative attitudes toward immigrants, as, in the United States, anti-immigrant propaganda is typically perpetuated by conservative political groups and is often represented in the political platforms of Republican Candidates.[67]

The authors performed a cross-sectional analysis of data from the Transatlantic Trends Survey. Of the 1,000 U.S. participants included in this study, 13.3% were African American, 8.8% were Latino, and the remainder were white. Approximately two thirds of respondents had either a high school diploma or a college degree, and 84.4% had religious affiliation. Participants were asked about their political affiliations and how they felt toward immigrants[67].

Results of the analysis showed that lower levels of anti-immigrant sentiment were associated with African American ethnicity, Latino ethnicity, and higher levels of education (all $P < 0.001$). Religious affiliation was associated with higher levels of anti-immigrant sentiment ($P < 0.001$). In addition, both liberal political ideology ($P < 0.001$) and immigrant friends ($P < 0.001$) were significantly associated with lower levels of anti-immigrant sentiment. Interestingly, having immigrant friends did not have a significant moderation on the effects of political conservatism on anti-immigrant sentiment.[67]

Children show evidence of prejudice and stereotyping as early as 3 or 4 years old; children who are members of minority and/or low-status groups are often aware of prejudice and stereotyping earlier than non-minority or high-status children, likely because they have been the target of discrimination by other groups.[76]

Liebkind and McAlister[77] designed an intervention to determine whether moral engagement and tolerance of other groups could be improved through peer modeling based on the extended contact hypothesis, which supposes that positive intergroup attitudes can be

promoted via the knowledge that an in-group member has a close relationship with an out-group member. The in-group friendship partner becomes a positive peer model that demonstrates tolerance in interacting with the outgroup, while the outgroup friendship partner becomes a positive example that repudiates the negative beliefs or stereotypes about the outgroup.[77]

In the study, the authors used a "behavioral journalism" intervention as a way to strengthen the characteristics of both the in-group peer model and the out-group friend. The in-group peer model demonstrated a close friendship with this typical out-group member while also admitting to having a negative attitude toward the out-group prior to the friendship, an attitude that changed as a result of the friendship. The goal of this was to make the participants feel that the peer model may have once shared their beliefs, or, in other words, make the participants able to identify a closeness with the model. In addition, the intervention was designed to make a change to more tolerant intergroup attitudes feel attainable and desirable.[77]

The study was conducted in Finland and included 1,480 ethnic Finns with a mean age of 14.1 years. The participants were from three pairs of schools that were matched based on ethnic density, from high (16-19% immigrant students) to low (3-4% immigrant students). The schools were randomly assigned to an experimental condition or a control condition. The intervention included two types of peer models: same-age peers, and older university students. The same-age peers shared their own stories, in print, of changing attitudes toward outgroups, while the older students shared stories expressing support for increasing tolerance of foreigners. Group discussions designed to influence group perceptions of the social desirability of increased tolerance were also included in the intervention.[77]

Overall, the results of the study showed that learning from the experiences of peer models' interactions with out-group members significantly positively influenced intergroup attitudes among students who had fewer opportunities to form intergroup friendships due to attending schools with less diverse student populations.[77]

McAlister et al.[70] employed a similar behavioral journalism intervention in U.S. schools; this intervention emphasized peer modeling via authentic stories of changed behavior that came from the audience itself. The study participants were ninth grade students from two high schools in Houston: one was used as the program school, and one as the comparison school. In the program school there were 393 surveys returned at baseline and 363 at follow-up; students were 18.8-19.7% Mexican American, 25.8-23.3% other Latino, 37.0-36.3% African American, 9.9-10.3% white, and 8.9-10.6% Asian. At the comparison school, 617 surveys were returned, and students were 32.8% Mexican American, 33.8% other Latino, 15.4% African American, 13.2% white, and 5.7% Asian.[63] Surveys were conducted in December 1996 and May 1997 in the program school, and in June 1997 in the comparison school. The surveys concerned tolerance of and prejudice toward five groups: whites, Mexicans/Mexican-Americans, blacks, Asians, and Jews.[70]

From December 1996 to May 1997, a five-month communication campaign was presented in the program school; this communication promoted peaceful, positive intergroup interactions and included four behavioral journalism newsletters distributed and read aloud by a multicultural team from the University of Texas School of Public Health. The newsletters contained four to eight student stories, at least two of which featured Latino students' stories, about overcoming prejudice. The fourth newsletter included stories from students who rejected moral disengagement processes.[70]

There was a significant association between behavioral intentions for discrimination and hostility and attitudes toward segregation, intermarriage, lack of sympathy, moral disengagement and violence, and superiority (all $P = 0.001$ or less). There were significant differences for affiliation, intermarriage, value similarity, and perceived superiority between the follow-up group and both the baseline and comparison groups, without any significant ethnicity or experimental group interactions. Attitudes toward violence and hostility were lower in the follow-up group, and behavioral intentions were significantly lower compared to the baseline group but not to the comparison group. A significant reduction in verbal aggression was noted in the program school, with those reporting five or more experiences of verbal aggression decreasing from 16% at baseline to 7% at follow-up in the program school. There were no significant changes in instances of physical aggression, which had low rates at baseline.[70]

Beelmann and Heinemann[78] conducted a meta-analysis of studies that evaluated either psychological or educational intervention programs designed to improve intergroup attitudes and relations to reduce prejudice. The meta-analysis included 81 research reports with 122 intervention-control group comparisons. The majority of these comparisons (61.5%) explored intergroup attitudes toward other ethnicities, and 54.1% of the interventions were based on direct or indirect intergroup contact; over half of the interventions used a combination of intergroup contact, socialization and knowledge acquisition, and/or empathy training.[78]

Results of the meta-analysis showed that, in general, the interventions resulted in about a 15% improvement in intergroup attitudes, though it should be noted that most of the studies only reported the short-term outcomes of the interventions, when the ultimate goal of these interventions is, of course, a lasting effect. The results do show, however, that the promotion of positive intergroup attitudes and the prevention or correction of prejudice through training programs in children and adolescents is possible. Direct intergroup contact and empathy training were found to be the most promising intervention components, and direct contact, unsurprisingly, was more beneficial than indirect or vicarious contact. The authors note that,

while indirect contact is sometimes the only option, direct contact should be applied if at all possible.[78]

Implicit bias training programs, such as those designed by the Kirwan Institute of Race and Ethnicity at Ohio State University, also aim to improve intergroup attitudes and relations, by "rewiring" subconscious associations. The Kirwan Institute has made the first set of publicly available training modules available online, tailored specifically toward K-12 educators.[79] Each module focuses on key topics like what implicit bias is, historic inequities in the education system, and education policy, with the ultimate goal of addressing disparities in K-12 education outcomes. Key elements that make this approach promising are: 1) it is being made available free of charge, since many school districts have limited ability to equip teachers and staff with resources and training related to implicit bias due to cost, 2) each module is a maximum of 45 minutes, to show respect for participants' time, and 3) modules can be accessed and completed at the participants' own pace, making the program flexible enough to fit in the busy of lives of K-12 educators.[79] A combination of videos and activities, as well as access to additional resources, form each module. Whether such training programs will result in long-term change is yet to be determined. However, the study by Marcelin et al notes that these kinds of implicit bias sessions (and ones that use the IAT), can be useful tools within a comprehensive organizational training program directed toward understanding and addressing individual unconscious bias.[43]

Taylor et al.[80] used data from the 2010 Chicago Area Study to determine whether interpersonal contact with Latinos would have any effect on whites' immigration policy views. The Chicago Area Study was a survey of adults in Lake County, Illinois, an area that saw a four-fold increase in the Latino population (from 4.8% to 20%) between 1990 and 2010. The authors' study questions and analysis focused on non-Latino white respondents. The study included a resistance-to-immigration scale, with questions about increasing border security, work site raids, and deportation; an opposition-to-assistance-for-immigrants scale, with questions about the DREAM Act and programs to help immigrants start small businesses; and a five-level prefer-lower-immigration-rate item.[80]

The authors hypothesized that results would be moderated by acquaintance with an undocumented immigrant, and affirmation of substantial local anti-Latino discrimination. Results showed that more interpersonal contact with Latino immigrants had a significant inverse relationship with the respondents' desire for decreased legal immigration, and those who denied substantial local anti-Latino discrimination were more likely to prefer lower immigration rates, though this result only approached statistical significance. In addition, those who validated local anti-Latino discrimination were significantly more likely not to call for lower immigration rates, and interpersonal contact with Latino immigrants predicted fewer calls for increased border security and increased work place raids. These results suggest that the inverse relationship between interpersonal contact with Latinos and immigration resistance is strengthened among those who are aware of the problems faced by Latino immigrants.[80]

McCall et al.[81] conducted a series of studies to determine whether knowledge of rising inequality would impact Americans' beliefs about the factors leading to income inequality. Participants were assigned to either an inequality treatment condition or a comparable control condition. Those in the inequality condition read an article about rising income inequality in the United States; the article did not call attention to any particular social group, nor did it discuss the issue of opportunity. The control group participants read a similar length article about baseball.[81]

Participants then answered questions about the importance of structural or system factors, such as coming from a wealthy family or having well-educated parents, and individual factors, such as hard work and ambition, in getting ahead. Those in the inequality treatment group rated structural factors as more important than individual factors in getting ahead, as compared to the control group (both $P < 0.001$).[81]

In the second study, participants were randomly assigned to one of three conditions. In the inequality condition, participants read the same article as in the first study followed by an article related to cooking. In the American Dream condition, participants read the article from the first study followed by a rags-to-riches story about an individual's upward mobility. The control group participants read the baseball and cooking articles. Those in the inequality condition rated structural factors as more important in getting ahead compared to the control condition; however, there was no significant reduction in the beliefs about the importance of individual factors. Participants in the inequality condition did rate individual factors as less important than those in the American Dream condition. Interestingly, the American Dream article did not reduce participants' concerns about structural factors, and those in the American Dream condition considered structural factors more important than those in the control condition.[81]

Participants in the third study answered the same questions as in the first study, followed by two questions regarding policies to combat inequality and a third question forcing participants to choose which group (low-income individuals, charities, high-income individuals, the government, or major companies) held the most responsibility for reducing income inequality. The inequality group again rated structural factors are more important than individual factors and was also significantly more likely to hold both the government and major businesses as most responsible and less likely to hold low-income individuals responsible.[81]

The narratives that exist to explain racial/ethnic economic disparities are insidious, entrenched in the idea that these outcomes are due to individual choices such as spending habits and poor

academic attainment. These are internal explanations for the negative outcomes that affect outgroups, and it is common for people to blame outgroup members for their problems on the basis of factors perceived to be within their control; the popular "bootstraps" myth is an example of this type of narrative. External explanations, on the other hand, include forces that are deemed to be beyond the individual or group's control. These explanations are generally applied to explain away positive events rather than negative ones: an outgroup member succeeding as a result of receiving government assistance, for example, rather than being the victim of racist government policies that intentionally depress the wealth-building potential of minority households. But what if the outgroup member is perceived as not being in control of a negative outcome? Would this evoke more compassion?[13,82]

Gill et al.[82] conducted a series of correlational and experimental studies to test the hypothesis that people would indeed show more compassion for outgroup members if the outgroup members were seen as not being in control of the outcome, such as a situation where poor academic performance was due to cognitive deficit rather than laziness. The first study was correlational and examined the attitudes of whites toward African Americans. Results showed that white participants did favor external explanations in situations where outgroup members were perceived to have less control, and they also reported increased perceptions of suffering. Moreover, whites' perception of black suffering was associated with increased compassion, and whites' perception of black control was associated with reduced compassion. Interestingly, after moderating for control, results showed that external explanations can foster increased compassion, even if perceived control is high, suggesting that external explanations increase the perception of outgroup suffering.[82]

The second study was an experimental study of attitudes toward Chechen militants, a group that has committed controllable acts of violence. Manipulation of external explanations for the actions of Chechen militants did increase perceived suffering, which increased feelings of compassion, again suggesting that external explanations can generate compassion, even when the outgroup is perceived as being in control of its negative actions.[72]

The third study was the same as the first, with some additional measures: identification with outgroups and depth of cognitive processing. The depth of cognitive processing moderator was measured via the need for cognitive closure, or NFCC; those high in NFCC prefer quick and certain answers, while those low in NFCC engage in extended contemplation. Deep thinkers (low in NFCC) were more likely to perceive suffering as being a result of external explanations compared to shallow thinkers (high in NFCC). As a result, deep thinkers showed more compassion than shallow thinkers in the face of external explanations; similarly, and perhaps unsurprisingly, those who identified more strongly with the outgroup had more compassion than those who did not identify with the outgroup.[82]

In study four, participants were educated about the negative behaviors of a fictitious outgroup; the presence or absence of external explanations varied. In addition, participants were placed under either a high or low cognitive load during the learning process; this entailed identifying various high- or low-pitched sounds. Results showed significantly reduced perceived suffering

among those in the high cognitive load condition compared to those in the low cognitive load condition when external explanations were provided. There was no effect on perceived suffering between high and low cognitive load conditions when internal explanations were provided.[82]

Forscher et al.[83] used the IAT as a tool in an intervention aimed at provoking awareness of implicit bias in study participants. The authors hypothesized that, in treating implicit bias as an undesired habit, individuals could break the prejudice habit via the same methods used to break other habits: motivation, effort, and awareness. The latter of these would certainly be the most difficult, due to the nature of implicit bias, but the authors expanded upon an intervention by Devine et al. that involved measuring participants' levels of implicit bias with the IAT and then discussing the results of the test with the individual participants during a feedback session. The feedback session was then followed by a presentation that demonstrated how implicit bias leads to discriminatory behavior that is harmful regardless of intent. Finally, participants were educated about cognitive strategies to reduce bias, such as increased intergroup contact, perspective taking, and stereotype replacement. The initial study by Devine et al. had encouraging results at two weeks post-intervention, but Forscher et al. wondered about the long-term effects.[83] Of note, this method of IAT assessment/acknowledgement of implicit biases/discussion of ways to combat an individuals' implicit biases is still the approach currently used in implicit bias training programs.[44,53,54]

Similar to the initial study, the authors followed up with the participants two weeks after the intervention, at which time the participants reported being more likely to notice bias, label bias as wrong, and seek out interracial interactions with relative strangers. But would the effects of the intervention endure? At a two-year follow-up, participants reported being more likely to confront bias by writing comments on an article that advocated racial stereotyping, suggesting that the intervention did in fact have a lasting effect on breaking the so-called prejudice habit.[83,69] For the latest data regarding success of implicit bias training programs and similar interventions, we refer readers to an annual review published by the Kirwan Institute, entitled "State of the Science: Implicit Bias Review," which can be found at http://kirwaninstitute.osu.edu/researchandstrategicinitiatives/implicit-bias-review/.

Strengthening communication is important as well. Baron and Jacksteit [84] developed a method to establish productive conversation patterns between people who have difficulty communicating due to negative perceptions or stereotypes, polarizing views, and distrust. The method attempts to facilitate conversations that allow the participants to truly understand

each other's values, concerns and motivations rather than those that devolve into reinforcement of negative stereotypes or assumptions. The so-called Public Conversations Project relies on several elements, including the setting of ground rules and structures for speaking, listening to others, allowing equal participation, sharing core beliefs, exploring doubts and uncertainties, asking genuine questions of others, and avoiding inflammatory language. The goal of the project is not for parties to reach an agreement, but rather to listen to and understand one another.[84] Effective communication allows individuals to voice their points of view without attacking another's views, and without feeling attacked.[85]

Social cohesion has decreased in the U.S., but improving social cohesion and increasing access to affordable housing and health care may buffer the negative effects of poor living conditions and increase overall well-being.

The far-reaching effects of poverty have been well documented; the material hardships associated with poverty, including food insecurity and difficulty meeting basic medical and housing needs, lead to worse health outcomes.[86] An inability to provide for family members leads to parental stress, which compromises marital and parent-child relationships due to a reduced capacity for warm and responsive interactions. The chaotic home lives and the community conditions characteristic of low SES areas — such as community violence and substandard housing — are linked to worse socioemotional outcomes for children. Poorer quality schools, high levels of unemployment, social isolation, and a lack of positive peer influences are common in high-poverty areas.[87]

Those living in poverty are often socially excluded due to the financial inability to participate in social activities. Social networks, including family, friends, work-based, and community relationships, whether face-to-face or remote, are important. Interaction with others does affect outcomes, as relationships can facilitate the sharing of resources, help increase opportunities, and improve livelihood. In general, high levels of social capital in a community are associated with lower crime rates, better health, and overall well-being.[87] People who are more satisfied with life and who have a greater sense of well-being are more likely to be socially engaged, manage their health problems better, and live longer than those with high levels of negative emotion. The concept of positive health posits that people desire well-being above and beyond even the relief of their suffering.[88]

In a cross-sectional analysis of data from 2,554 Latino participants in the National Latino and Asian American Study, Alegria[89] investigated the relationships between family support, friend support, family cultural conflict, and neighborhood social cohesion with self-reported physical and mental health to determine how the three domains of social connection — family, friends, and community — were associated with the physical and mental well-being of Latinos. The social connection variables were measured using various scales, including a social cohesion scale assessing neighborhood characteristics, including the ability to trust and rely on neighbors; a family support scale assessing the ability to rely on family members for emotional support; a friend support scale; and a family cultural conflict scale. Physical and mental health were rated on a five-point scale from poor to excellent.[89]

The study found that physical health was significantly associated with both social cohesion and friend support *(P* < 0.001); there were also associations with the family support and cultural conflict scales, though these were less significant. Mental health, however, was significantly associated with all four scales, and had the strongest associations with friend and family support *(P* < 0.01). Household income was significantly associated with all scales except family cultural conflict, and social cohesion was significantly associated with family and friend support *(P* < 0.001). These results suggest that family, friends, and social cohesion have significant effects on the physical and mental well-being of Latinos.[89]

In a review of the literature on social cohesion, Schiefer and van der Noll[90] note a pervasive ambiguity in the research. This ambiguity involves both the definition of social cohesion and the parameters by which it is assessed and measured. In reviewing the literature, Schiefer and van der Noll identified three essential dimensions of social cohesion: social relations, identification with the geographical unit, and orientation toward the common good. The authors provide a somewhat broader definition of social cohesion as a descriptor of the quality of collective togetherness and, as such, social capital is also an important part of social cohesion, and includes measures such as perceived fairness, perceived helpfulness, group membership, and trust. This quality of a society changes gradually over time.[90]

Social cohesion has declined in the U.S. in recent decades, due in large part to the deprivation and inequality experienced by those in poverty as the gap between the rich and the poor continues to widen. Social erosion is a term that may be applied to the degradation of social cohesion.[91,92] Participation in social events and acting in favor of the common good become particularly difficult when income and resources are low. An unequal distribution of resources isolates the less fortunate, excluding them from sociocultural life.[90,93]

Conversely, when individuals or groups have equal access to resources, this allows for equal participation and networking, promoting a sense of trust and belonging, security and self-worth. This in turn strengthens the desire for social participation and fosters social cohesion. An increase in social cohesion can create feelings of solidarity, and this manifests as eagerness to help others, on an individual level, and enhanced social welfare systems, on an institutional level. A cohesive society is an inclusive one; a society without significant disparities in health, wealth and income, one that values individuals' backgrounds, integrating those from different backgrounds in such a way that everyone can relate to one another. Studies by Uslaner[94] and Stolle et al.[95] have found that while increased neighborhood or community diversity has a negative effect on trust and social cohesion, this negative effect is mediated by direct contact

between in-group and out-group members. This suggests that it is the development of out-group hostility, isolation, and segregation (both socioeconomic as well as racial/ethnic) as a response to increased diversity, rather than the increase in diversity itself, that erodes social cohesion. Social cohesion should therefore represent the capacity of a society to ensure the long-term physical and psychological well-being of its members.[90,94,95]

A survey of population samples in 10 cities across the U.S. found that city mortality rates were significantly correlated with mean hostility scores in each city; additionally, measures of interpersonal trust were strongly correlated with both mortality and income inequality, and income inequality was significantly associated with violent crime and homicide. These correlations suggest a robust and systematic association between income inequality, social relations, and the social environment within a society.[93] Furthermore, state mortality rates are more closely related to income distribution than median income, suggesting that, when income is a measure and determinant of social status, it has an impact on health.[96] In a study of associations between the measures of social capital — perceived fairness, perceived helpfulness, group membership, and trust — and income inequality and mortality, all four measures were associated with mortality. Additionally, the relationship between mortality and income inequality was moderated by reduced social capital as income inequality increased.[93]

Social status and social relationships are important influences on population health. Early emotional trauma, poor attachment, and domestic conflict, which are common among those living in and raised in poverty, also create stress in similar ways as low social status and lack of social support, negatively impacting health due to insecurity, fear of inadequacy, and lack of confidence. The social hierarchy as it stands is essentially a hierarchy of human worth, with the most successful and competent at the top. Friendships and other social affiliations can counteract these negative affects by providing positive feedback, increasing confidence and feelings of adequacy and self-worth.[96]

One example of a connected community effort is the redevelopment of Sunnydale, the largest public housing community in San Francisco. Sunnydale has been defined by poor housing and extreme poverty and violence. Baseline data, including social and physical needs, was collected on all Sunnydale residents prior to starting redevelopment, which will include replacement of all existing housing with the addition of new units as well as a fitness center, educational facilities, arts program, health clinic, farmers market, and acres of green space. Additional data on the residents will be collected over time to determine the social and physical impacts of the project, which also aims to find jobs for Sunnydale residents in growing job sectors.[97]

Social media can be used to affect social change and alter negative perceptions about racial/ethnic groups and those living in poverty.

While much has been said about the detrimental effects of social media on relationships, it is also clear that social media can be used to bring people together, and to bring about social change. The #BlackLivesMatter movement began on Twitter in 2016 after the acquittal of George Zimmerman for the shooting death of Trayvon Martin. It has reached and engaged

millions of people across America, becoming an organization with chapters in more than 30 cities across the United States. The death of Trayvon Martin, and the subsequent deaths of Michael Brown, Freddie Gray, Breonna Taylor, and others at the hands of police, illustrated that traumatic events often lead to social sharing and seeking of support, in this case leading to the growth of a movement that strives to end systematic racial inequality against blacks and people of color.[98] Following the death of George Floyd at the hands of police in May 2020 and a rise of protest for social and racial justice, about 66% of U.S. adults said they support the Black Lives Matter movement, according to a 2020 Pew Research Center survey. This sentiment reverberates across race/ethnicity groups, with most Blacks (86%), Latinos (77%), Asians (75%), and even Whites (60%) expressing they strongly or somewhat support the movement.[8] The same Pew survey also found that "37% of those who use social networking sites say they have posted or shared content related to race or racial equality on these sites" in the past month.[8]

Movements have also been created to address inequity in the U.S. and worldwide, including the Occupy movement, a sociopolitical movement against social and economic inequality that incited hundreds of occupy protests around the world. Information was spread using various forms of social media, including a blog called "We are the 99 Percent," where people shared stories of economic struggles. Similar democratic movements began on social media during the 2008 and 2012 Obama campaigns, as well as smaller movements such as Rebuild the Dream, an anti-Tea Party movement with goals of fairer tax rates and fair pay, better public education, and Medicare for all.[99]

Social media has the ability to empower and connect. In 2009 and 2010, in response to the continued deportation of youth eligible for the Development, Relief, and Education for Alien Minors (DREAM) Act, Latino youth took to social media to mobilize and organize sit-ins in Congressional offices, marches, and symbolic graduations. An online undocumented youth advocacy group called DREAM Activist was formed, and in 2009, the founders of the group organized 500 youth to participate in the National DREAM Act Graduation in Washington, D.C., a symbolic graduation ceremony for undocumented Latino youth. At the same time, solidarity graduations took place in 12 states. On New Year's Day 2010, four undocumented students from Miami-Dade College set out on a 1500-mile march from Florida to Washington, D.C. to advocate for the DREAM Act; they called their trek the Trail of DREAMs, and documented their journey via blog, Facebook, YouTube, and Twitter posts. Along the way, they collected 30,000 signatures in support of the DREAM Act to deliver to President Obama when they arrived.[100]

Social media platforms are also important tools for advocacy groups. Obar et al.[101] conducted a survey of 169 representatives from 53 advocacy groups, inquiring about social media use and general perceptions about social media, including the use of social media for civic engagement and collective action. Most of the participants responded that social media is useful in strengthening outreach efforts. The National Hispanic Coalition noted that a social media presence helped to increase exposure, and the National Council of La Raza, the largest civil rights group for Latinos, remarked upon the opportunity to reach and educate new people and turn those people into engaged voters. The groups also linked speed of communication with a heightened ability to put interests into action, with the National Council of La Raza stating that social media helps them mobilize groups quickly.[101]

In a review of available research on media and communications and their effect on identity-based violence and violent extremism, Ferguson[102] found that most of the current literature is focused on countering violent propaganda with a positive alternative; the author found no definitive evidence that counter-narratives are effective in disassembling violent extremism. There is evidence, however, that alternative media approaches may have some effect. Radio and television dramas that address the issues of identity, reconciliation, and tolerance, for example, have been shown to positively impact behavior and attitudes, and seeing an ingroup member share a platform with an outgroup member has been shown to positively impact understanding and tolerance of the outgroup. Ferguson notes that both trust and credibility of the media are crucial for these alternative approaches to be effective, and that the most effective interventions are those that endeavor to encourage empathy and awareness, allay misinformation, and encourage conversation rather than trying to change minds.[102]

CONCLUSIONS

- Inequality, including but not limited to income and healthcare inequality, is perpetuated by implicit racial or ethnic bias. Implicit bias influences behavior regardless of intentions and can result in unintentional bolstering of inequity.
- System justification is a way in which advantaged individuals justify the status quo to help buffer stress from negative events and cope with guilt and distress associated with the existing socioeconomic order. The disadvantaged also engage in system justification, though this may be detrimental to their psychological well-being.
- People living in rural areas have less access to physical and mental health services and the internet, as rural areas are often isolated and economically depressed.
- The Affordable Care Act has increased access to health care and reduced barriers to care, but disparities still exist for low-income as well as racial and ethnic groups.
- Intergroup contact, both in person as well as demonstrated in video, has been shown to have a positive effect on in-group feelings toward out-group members.
- Social cohesion is an important determinant of population health and well-being, and includes social relations, group membership, and an orientation toward interest in the common good.

- Social media facilitates connections around the world, harnessing collective power and helping to mobilize individuals to engage in efforts toward positive social change.

POLICY AND PRACTICE IMPLICATIONS

- Decision-makers and the public should increase financial support for trauma care and basic health care services via higher reimbursements, especially in rural areas and vulnerable communities, to stem the closure of facilities that treat these populations.
- Medicaid coverage for children should be strengthened. In addition, coverage should be extended to the undocumented and uninsured/underinsured in states without Medicaid expansion.
- Health services should be culturally competent, and providers should undergo cultural sensitivity training.
- Intergroup contact should be promoted early, beginning with children, as contact has an inverse relationship with prejudice. These interactions can be promoted in the classroom or at the community level using interventions such as the Public Conversations Project dialogue. Additionally, communications can be used to alter cognitions and emotions to build a basis for support for policies that modify systems to make them more equitable in a more cohesive culture.
- Local leadership, such as city or county officials, should recruit leadership from within the Latino community, creating a collaborative and integrated community.
- There should be an emphasis on collaboration between government agencies. Currently, funding for health, housing, economic development, and other community needs comes from different agencies, creating a barrier to collaboration and thus a barrier to social cohesion.

FUTURE RESEARCH NEEDS

It is important to research the relationship between socioeconomic status and education to identify and reduce the risk factors through the improvement of school systems and the development of intervention programs.[5,10]

Additional studies are also needed to examine the relationships between implicit bias and health care outcomes. This will provide vital information for the development of interventions that target these implicit biases, which have been shown to contribute to disparities in health care between whites and minority groups such as Latinos. This implicit bias influences individuals' behavior regardless of counteracting intentions and as such is more difficult to identify and address.[49]

It is also important to continue research on health disparities. The National Academies of Science, Engineering, and Medicine (NASEM) established a Roundtable on the Promotion of Health Equity to promote health equity and eliminate health disparities via understanding the inequities in health care among ethnic and racial populations, making those inequities known to

the public, and increasing research. The roundtable held a workshop in November 2017 titled "Immigration as a Social Determinant of Health;" the goals of the workshop were to describe why the health of immigrants is important to the United States, explain how immigration history contributes to today's immigration, economic, and health policies, and discuss the role of immigration as a social determinant of health.[103]

The workshop noted that federal immigration policy historically emphasized the reunification of families, but cultural changes have contributed to a backlash from U.S. natives, and federal deadlock on immigration policy has led to confusing state rules and regulations. In addition, a lack of dialogue between those working on immigration issues and those working on social determinants of health issues has resulted in missed research and policy opportunities.[103]

This is especially important where mental health is concerned. Policies and mental health programs should be developed to address the traumatic stressors that are associated with assimilation; currently, the U.S. Department of State's Reception and Placement program works with several agencies to help place immigrants and refugees in communities based on the immigrant's needs and the available resources. The program provides assistance with language, mental health, medical care, employment, housing, and education, but is only available to immigrants and refugees for three months following arrival in the U.S. So while the Office of Refugee Resettlement provides certain mental health screenings within 90 days of arrival, many refugees have no way to seek treatment once that three-month period is over. Research into the needs of immigrant populations should seek to develop strategies to engage children and youth and address mental health issues in schools, as almost 40% of the refugees settling in the U.S. are children.[104]

The California Health Interview Survey was cited as a potential model for understanding the health needs and health disparities of immigrant populations. This survey was started in 2001 and interviews more than 20,000 children and adults every year; it is the largest continuous state-based health survey in the United States and is conducted in seven languages. Specific immigration-related questions were added to the survey in 2015 to provide information for research regarding health outcomes for immigrant populations.[103]

Similar efforts are needed to examine the associations between income poverty, material hardship, and health. In New York City, the Robin Hood Foundation and a group of researchers from Columbia University created the New York City Longitudinal Study of Wellbeing, nicknamed the "poverty tracker." The poverty tracker surveys approximately 2,300 residents of New York City; interviews were conducted every three months over a two-year period. The

purpose of the tracker was to provide a multidimensional understanding of economic disadvantage, including housing hardship, unmet medical needs, food insecurity, inability to pay bills, and running out of money. Results showed that nearly two thirds of black and Latino families experienced at least one type of hardship, and almost half experienced persistent hardship (that is, at baseline and follow-up). These types of studies are important drivers for the development of initiatives to address issues of hardship, including emergency food assistance, eviction prevention, and navigator-type services.[105]

In a review of the literature regarding the relationship between racism and child health, Pachter and Garcia Coll[106] found that the majority of studies regarding racism and behavioral, mental and physical child health outcomes were conducted on African Americans, adolescents and older children. In addition, many did not have a standardized method of measuring racism, and many of the measures used were created for use in adult populations. The authors noted that more studies are needed that include other racial and ethnic minority groups, including Latinos. These studies should also include younger children and should use measures that are better suited for assessing the effects of racism on younger children rather than adults.[106]

Additional research into prejudice- and system justification-based interventions is necessary as well. Future research into this area should focus on longitudinal study designs to determine the long-term effects of such interventions. These interventions also require strengthening; those based on developmental research hold the most promise. The development of alternative approaches to changing intergroup attitudes are important; this includes the involvement of parents, teachers, and peers to aid in the promotion of positive intergroup socialization. One interesting subset of intergroup communication, and one that needs further investigating, is that which occurs on the Internet. We know that social media can bring people together to help effect social change, but why, and how can this be used to further improve intergroup attitudes?[78,102]

And what about social cohesion? How do we counteract the attitudes and environments that prevent unity and equality, and reverse moral disengagement? The Sunnydale initiative in San Francisco is a great example of instituting changes for the collective good while gathering long-term data on the impact of these changes, and similar data-gathering efforts should be mounted in other areas where steps are being taken to improve communities. Equally important, though, is a change in the attitude of the haves toward the have nots, the privileged versus the less fortunate: we need to directly refute the mechanisms of moral disengagement by debunking the idea that social programs create dependency, reversing stereotypes, and educating people about poverty. As McAlister and Patnaik succinctly put it, reducing disparities among the poor "requires change in the heart and minds of the more fortunate."[71]

A concerted, collaborative effort between federal and local governments, health departments, hospitals and hospital systems, school systems, community organizations, and community members is necessary to address the significant racial/ethnic and socioeconomic disparities in the United States, and to create a cohesive culture where everyone can thrive.

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