
White Privilege, White Poverty: *Reckoning with Class and Race in America*

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Among the many threats to America, perhaps the most serious is our inability to face them together. The democratic institutions, civic practices, and social values that enable a polity to listen, learn, and find common ground are frayed and by some accounts broken.¹ How can we build that ability? If cultural frames and social power set the terms and possibilities of civic learning and acting in common purpose, which cultural frames and sources of power need to be interrogated?

One facet of any adequate response to these questions is the need to reckon with White privilege and White poverty. *White privilege* refers to the economic, political, cultural, and psychological advantages of Whiteness.² Deflection, discomfort, and denial of such advantages have been called “white fragility,” considered by some to be widespread.³ White poverty is multidimensional, too, with economic, cultural, psychological, and symbolic facets.⁴ Politicians, the press, and the public have long ignored it; poor White people may hide it too,⁵ for it is a source of shame and stigma.⁶

The problem of Whiteness we describe refers to the realities of White privilege and poverty and to their suppression. Suppression can occur intentionally, for example, when White people know yet ignore or actively approve of the advantages conferred by Whiteness or when politicians, motivated by racial animus, neglect White poverty in order to portray poverty as a problem of Black and brown “others.”⁷ It can also occur in more subtle and insidious ways when Whiteness acts as an unstated standard against which others are compared

and evaluated.⁸ Upper-class interest in suppressing class consciousness is also implicated, as are meritocratic narratives about personal responsibility and deservingness.⁹ Color-blind and postracial discourses, bolstered by cherry-picked evidence, including the two-term presidency of Barack Obama, also contribute.¹⁰

Whiteness frames some of our most pressing democratic challenges yet is mired in confusion. America does “not know how to think straight about whiteness, nor what it means to be white.”¹¹ This collective deficit has compromised America’s civic health and public health. Our refusal to acknowledge two realities simultaneously—Whiteness confers advantage to White people, and the majority of poor people in America are White—creates dissonance and division in our political discourse and undermines our capacity for civic learning and common purpose on issues in which we all have a stake. Those stakes include public policies that could improve the health and well-being of all Americans.

The Poor State of America’s Population Health

Americans live shorter, sicker lives than their counterparts in other high-income and some middle-income countries.¹² Relative to peer countries, the United States has higher mortality rates from most major causes of death, such as ischemic heart and hypertensive diseases, drug overdoses, suicide, homicide, diabetes, infectious diseases, pregnancy and childbirth, and mental and behavior disorders.¹³ Cancer and cerebrovascular diseases are exceptions. U.S. life expectancy began losing pace with that of other countries in 1980, stopped increasing in 2010, began to decrease in 2014, and could take “more than a century to reach the average life expectancy that other high-income countries had achieved by

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2016.”¹⁴ America suffers what experts call a “health disadvantage.”

Within the United States, different populations experience vastly different health and longevity from one another. Experts describe a nation fractured into two or more Americas.¹⁵ Among U.S. census tracts (census districts of a few thousand people), residents of the longest-lived 5 percent of tracts have lifespans 13.1 years longer than do residents of the bottom 5 percent.¹⁶ Whiteness in America generally, though not always, protects health. On most measures of physical health, White people fare better than African Americans, Native Americans, and Latinx people with long-term residence in the United States.¹⁷ But White people also fare worse than Asian Americans and recent Latinx immigrants on many health indicators and have mental health worse than or equal to that of African Americans.¹⁸

These cross-country and within-country differences are attributable largely to differences in the social, material, environmental, and political conditions in which people grow up, live, work, play, and age, conditions referred to as the *social determinants of health*. These conditions embody resources and risks to which people have differential access or exposure and, consequently, markedly different health outcomes.¹⁹ Class and race are the most potent predictors of access or exposure to resources and risks.²⁰ Class position, as measured by differences in educational and income levels, shapes exposure to adverse early-life conditions, poor-quality schools, resource-poor neighborhoods, low-paying high-risk jobs; exposure to crime and violence; and exposure to environmental pollutants and toxins.²¹ These conditions get under the skin, no matter its color. Millions of White people are born poor and live, work, and die in and of hardscrabble circumstances. But being White increases one’s odds of being born into, or being able to climb into, more protective conditions.²²

Whiteness also protects against race-based forms of discrimination and mistreatment that take direct and indirect tolls on the health of people of color.²³ Overt and covert racist practices in education, employment, housing, and legal rights—legacies of enslavement and Jim Crow—have been foundational to U.S. society and unjustly limit the life and health chances of Black and brown people.²⁴ Racism helps explain why higher levels of education and income do not pay the same “health dividend” to racial minorities as they do to White people. For example, a baby born to a college-educated Black woman is 2.5 times as likely to die during infancy as a baby born to a college-educated White woman, and the longevity prospects of college-educated Black men and women are four years shy that of their college-educated White counterparts.²⁵

Class and race are “related but not interchangeable systems of inequality.”²⁶ And these are not the only two axes

of power and oppression in the United States: sexism, heterosexism, and anti-indigeneity (to name just some) are all operating in tandem, together propping up the idol of the benevolent White male landowning patriarch of a family unit. Experts agree that socioeconomic differences largely explain health differences between racial groups, meaning “class has the more powerful effect.”²⁷ Social gradients in health, documented in all fourteen major causes of death, demonstrate the potency of class.²⁸ These stepwise gradients reflect a dose-response relationship between class advantage and health.²⁹ Significant class-based health inequalities are also documented within racial groups. For example, the longevity prospects for White women and men without high school degrees are, respectively, some ten and twelve years less than those for their college-educated White counterparts, while the longevity prospects for Black women and men without high school degrees are roughly five and nine years less than those for their Black college-educated counterparts.³⁰

Indeed, educational attainment is surpassing race and gender as the most robust predictor of life span in the United States, as illustrated by two distinct but related White mortality trends. Researchers have documented a rise in midlife mortality in White people with a high school degree or less and an absolute decline in life expectancy in White people who lack high school diplomas.³¹ These trends seem to have merged in public discourse, with the premature deaths now labeled “deaths of despair” due to the roles of drug overdose, alcohol misuse, and gun-related suicide. These deaths have been traced to globalization, deindustrialization, automation, associated wage loss and stagnation and loss of benefits (such as health care insurance and pensions), and consequent familial disintegration and personal distress and pain—processes and experiences involved in the unraveling of socioeconomic status and expectations.³² Yet, as historian Nancy Isenberg shows, talking about class is “not who we are.”³³

Whiteness may be implicated. Some evidence suggests that unmet material expectations and status loss take a heavier psychological toll on White people than on people of color, whose communities have long endured and coped with socioeconomic deprivation and market volatility.³⁴ Whiteness likely also abetted White people’s access to opioid prescriptions.³⁵ Racism has long impeded African Americans’ access to pain management.³⁶ Other research has foregrounded the role of “status threat” in these mortality trends, which in this case refers to the perception among White people that their social status as a racial group is threatened by gains in socioeconomic status by people of color.³⁷ Some researchers argue that economic anxiety and status anxiety interact to generate psychological and physiological stressors that explain White mortality trends.³⁸

How can the people of the United States begin to make social and political choices that improve our collective health? One thing people must do is think and talk about White privilege and poverty in new ways.

Beliefs in meritocracy, integral to America's "pull yourself up by your bootstraps" class ideology, may also be at work. White people who rely on meritocratic explanations to justify their flourishing and floundering—and Whites may be more inclined to do so than people of color, who are more aware of the structural nature of inequality³⁹—may blame Black and brown "others" for interfering with their expectations, or alternatively, they may internalize their frustration in the form of self-blame. Both reactions appear to harm health.⁴⁰

The Poor State of America's Civic Health

The poor state of the nation's health poses a serious civic challenge because the remedies require collective action. Experts point to a broad range of contributors, including high rates of adult and child poverty; limited access to quality childcare; inadequate employment and labor protections; low levels of social mobility; threadbare social safety nets; fragmented health care systems that leave millions uninsured; underfunded public health systems; historic levels of income inequality; built environments designed for cars, not active people; and racial disparities in all these domains. Reforms will need to respond just as broadly, with policy measures that cut across Americans' lives, from child welfare, education, labor and employment, health care and public health, housing, and taxation—a whole-of-society strategy advocated by the "population health approach" that works toward a "culture of health" and "health in all policies."⁴¹

The prerequisites of such civically minded collective action are, however, in short supply. Such action needs to be made on the basis of good scientific evidence, but Americans' trust in evidence, the scientific experts who generate it, and the government institutions that would be involved in implementing it are at a low point.⁴² Declining participation in civic, religious, and political institutions; deepening divides along lines of class, race and ethnicity, geography, and gender; and elevated levels of political animosity—exacerbated by a media ecosystem that drives polarization—have severed connections and lines of communication.

Discord is not new in America, but the nation's back is straining. Former President Donald Trump's investment in

preserving White privilege and White supremacy may have supplied the last straw. His use of Whiteness proved pivotal in the 2016 election when he leveraged White working-class despair to scapegoat racial minorities and make empty promises about bringing back mining, manufacturing, and a mythic "great" American way of life. Even though White voters across the economic spectrum backed Trump in large numbers, immediate post-election analyses of Trump's unanticipated victory pinned it on White working-class voters, explaining their support in terms of either "economic anxiety" or "social status anxiety."⁴³ However, subsequent analyses suggest that these anxieties are intertwined in the form of "racialized economics"—which entails the belief that "undeserving groups" are getting ahead while one's own group is left behind (socioeconomically).⁴⁴ White privilege and White poverty are gumming up our capacity for civic discourse, debate, and decision-making.

Polarized politics anchored in Whiteness are not the only obstacle to the reforms America needs. Core American values and features of our system of government, which can be traced to Whiteness, may also stand in the way. America's particular brand of individual liberty, self-reliance, free enterprise, and federalism and the role of religion may help "create configurations of policies that can act as an upstream underlying cause, or as a systematic explanation for downstream health consequences."⁴⁵ These values and governmental features can be subject to careful study and (re)interpretation to assess their meaning and application.⁴⁶ Instead, they are often used as blunt and inflexible ideologies to bat back universal social programs that would protect the health of all.

These ideologies also help to maintain and suppress White privilege and poverty. Evidence suggests, for example, that opposition to comprehensive social programs can be traced to racist beliefs about the undeservingness of Black and brown people and to meritocratic narratives about personal responsibility and self-sufficiency.⁴⁷ Racist and meritocratic justifications are more readily available to economically secure White people who do not see or knowingly accept the race-based and class-based inequities of a society in which affluent Whites inherit advantages. The suppression of White poverty (such as by denying the existence of a class system or failing to depict White poverty in the media as a social problem deserving of at-

tion and resources) makes such justifications seem all the more appropriate, by painting a false picture of White superiority—whether explained in racist or classist terms. That even poor, sick, and dying White people sometimes invoke racist and meritocratic beliefs to oppose programs they themselves desperately need speaks to the power of these ideologies.⁴⁸

As explicit racism has become less widely acceptable, meritocratic narratives may be filling the void, working in tandem with tropes about free enterprise, small government, and state control to build a bulwark against efforts to create social programs and protections that would benefit the health of all.⁴⁹ As Jennifer Malat and colleagues argue, “[T]he limited economic safety net and few guaranteed benefits for workers puts a ceiling on the potential physical health that the population can achieve, which disproportionately harms people of color, but can also harm whites who are numerically larger.”⁵⁰

Civic Listening and Learning: Democratic Possibilities

How can the people of the United States begin to make social and political choices that improve our collective health? One thing people must do is think and talk about White privilege and poverty in new ways. Americans’ habits of mind have long histories, but humans can change. We suggest three steps involved in reckoning with Whiteness. The first is to frame White people’s life chances in relation to those of Black and brown people, because they are deeply interconnected. In the arena of population health, this means health studies should, whenever possible, be conducted and reported intersectionally, bringing class-, race-, and gender-related disparities simultaneously into view.⁵¹ Reporting health data only by race and ethnicity, which remains relatively common, risks buttressing a noxious form of race consciousness and hiding White poverty and associated poor health outcomes. Health data reported only by race and ethnicity often set White populations as the standard against which racial and ethnic minority populations are compared, even when minority populations fare better. This practice may reinforce a false “definition of whites as the norm or standard for human, and people of color as a deviation from that norm, amplifying the hegemony of whiteness.”⁵² Such practices may also prop up the false idea that race is a biological or inborn genetic difference that can explain health differences between White people and racial and ethnic minorities.⁵³ Reporting health data only by race and ethnicity also papers over significant class-based health disparities within racial categories, suppresses class consciousness, and hides a lot of pain and misery.

Health studies can instead show that we all have skin in the game. Take deaths of despair. This story was told

as a problem that affected White people because, up until about 2013, it largely was. But Black and brown people are affected, too, and young high-income Black women are at exceptionally high risk of opioid misuse.⁵⁴ Moreover, what is happening to poor and working-class White communities happened *first* to poor Black and brown communities, who were devastated decades ago by a crack cocaine epidemic with roots in many of the same economic and social forces now undoing poor White communities.

Or take infant mortality rates. In the United States, White and Black women with less than a high school education experience far too many infant deaths: 8.8 deaths per thousand and 11.6 deaths per thousand, respectively, which translates into 1,337 White infant deaths and 1,013 Black infant deaths.⁵⁵ Recall, too, that college-educated Black women are at a much higher risk of infant mortality than are college-educated White women, and the overall rate of U.S. infant mortality is much higher than that of high-income and some middle-income countries.⁵⁶ These data should be a call to national action to improve outcomes for pregnant women of all races and classes.

Finally, recall the U.S. health disadvantage. Health outcomes at the lower ends of the socioeconomic distribution populated by people of all races—including some 18 million officially poor White people⁵⁷—appear to explain much of the U.S. health disadvantage.⁵⁸ But not all of it. America’s middle and upper classes of all races also live shorter and less healthy lives than do their counterparts in other rich countries.⁵⁹ As Yukiko Asada and colleagues note, “[N]o single group or health outcome represents the whole story of health inequalities.”⁶⁰

The second step we recommend is that White people need to understand that they are White. That recommendation may sound obvious, but White people do not always comprehend that they belong to a racial group.⁶¹ It might also sound dangerous, given the rise of White supremacist ideologies and their investment in being White and “keeping” America White.⁶² The racial awareness we recommend, however, is critical in nature and aimed at White people who reject racism but who also fail to understand that they benefit from a racialized social system.⁶³ It is one thing to comprehend oneself as protected from racist discrimination and mistreatment; it is another to comprehend that one benefits from the structures that generate those harms. That step may be particularly difficult for White people who began and live their lives steeped in economic and class-related adversity. The step from the first to the second realization is small, but the failure to take it may help explain why some White people who identify as “not racist” may get defensive when talk turns to Whiteness.

A critical class consciousness must accompany a critical racial consciousness. Most Americans of all races have far more in common with one another than they do with the

wealthy class that makes the rules the rest of us must follow.⁶⁴ Those rules have created a winner-take-all economy that leaves most people behind. A “race-class narrative” that unites cross-racial majority interests against the economic interests of elites may be crucial for achieving the social and economic reforms needed for the whole population to thrive.⁶⁵

The third thing Americans need is time and space to think and talk together about their respective struggles and to set priorities for action. In the last two decades, the U.S. health sector has taken a participatory turn, with health agencies and academics increasingly creating opportunities for involving members of the public and patients in health research and system change. Deliberative democratic forms of engagement are particularly promising. These forms of public deliberation engage people from diverse backgrounds in reasoned reflection and dialogue grounded in nonpartisan information, create time for careful consideration of all perspectives and the values that underpin them, and search for collective solutions all consider legitimate.⁶⁶ Deliberative democratic engagement has been shown to yield more informed, considered, civic-minded, and egalitarian discussions.⁶⁷ A controlled trial of deliberative methods demonstrated that it can increase participants’ knowledge about complex topics regardless of education level, race, or ethnicity and is especially valued by members of minority and low-education groups.⁶⁸ Community engagement also yields valuable evidence for researchers because community members have genuine expertise in their respective niches in society (whether it is the challenges of nutritious family meal preparation or the obstacles to outdoor exercise in a neighborhood). Such expertise should be actively and humbly sought out.⁶⁹

Democratic public engagement grounded in good evidence and leavened by a race-class critical consciousness is no guarantee that people will agree on which health inequalities constitute health inequities. As White deaths of despair illustrate, people may not agree that such inequalities constitute an injustice, and even if people do, they may not agree on what constitutes a just response.⁷⁰ But we need not agree on everything in order to do something.⁷¹

Democratic conversations may be one important route to helping people see that public health is about “us,” not “them.” Democratic engagement that gets people talking across boundaries of race and class—and especially talking about race and class—may also help resist White supremacist efforts to fill the void created by Americans’ collective reluctance to acknowledge and talk critically about White privilege and poverty.

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