White Privilege vs. White Invisibility and the Manifestation of White Fragility: How Social Normativity Negatively Impacts White Health

By

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To my bedrock of a family, my wise friends, my infinitely supportive fiancé,

To those who have passed on that have paved the road to be less rocky for my travels.

I love you all.

Finally, to those who have suffered under the weight of whiteness, who have been rendered

silent by its violent pervasiveness in society, whose lives have been troubled and cut short by the

waif-like fragility of it, I hear you, I see you, and I hope this does some slight justice for the

strange fruit still hanging from the trees.

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Introduction

Long before DaVinci's Vitruvian Man, scholars in medicine and science have inadvertently searched for a being that is the base, the beginning, the comparative copy from which research can be based from. Even if it wasn't an actual being, it was a sense of center, a normalcy of health and wellbeing, that spurred the balancing of the humors, that drove the first decoding of a human genome, that pushed eugenics to find the fittest of all American citizens. Norms in this country have supported curiosity and violence, pushed growth and decline, and with our public health system situated within U.S. society, one cannot expect the initiatives of research of be in a vacuum untouched by national politics, economics, and social pinnings.

For this thesis, "whiteness" is the observed norm, meaning that it has majority access to power, control of resources, and having the ability to enforce its values (Hitchcock, 1998). The aim is to explore whiteness in this country, just as many scholars explore blackness, to better understand how this concept and ideology affects individuals experience in health. Many public health scholars have connected the factor of race, as well as socio-economic status (SES), with outcomes in individual and group health. Similar research has shown that individuals who ascribe to African-American Blackness - culturally, ethnically, phenotypically- consistently lead to lower life span health in the United States, regardless of SES, gender, or wealth attainment over the years (LaVeist, 2005). However, this does not explain negative health issues in European-American individuals, especially those who phenotypically "look white". The "whiteness" of such people is usually used in public health research as a norm to contrast against the lesser health of a racial minority, while contrawise the comparison is not employed.

This project asserts three arguments. First is that whiteness, as a social and economic property, is a normative driving force in both American social culture and public health. Second,

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this normative whiteness informs and impacts the health of individuals regardless of race, but relatively unacknowledged in its racial impact on individuals who phenotypically or categorically are "white". Third, this lack of acknowledgement, "unmarked" status of whiteness (and by extension "white people"), as well as being socially considered as a "race-neutral" category, this develops a cognitive dissonance between how the individual is socialized and the "raced" reality of their and others existence, resulting in "white fragility". This fragility negatively impacts how those individuals understand and respond to important health decisions, as well as make them socially unable to affiliate with health positions that could benefit them.

Public Health is not a stranger is critical race theories and the idea that ones' race influences your health and personal experience in the United States; many scholars have produced literature on how race, specifically Blackness, can inadvertently impact ones' health. However, the key trait and overall issue of whiteness is that even when manifesting explicitly, its presence is normative and implicit, which makes identifying and approaching it extremely difficult. This problem implies the total possible influence and power of whiteness, which is both the argument and the assertion. Overall, this research asks for public health to become discontent and unpack the black box of normative Whiteness, to de-center it and challenge it as a influence on individual and group health, in order to better understand the health of "privileged" and "disenfranchised" races in the United States.

Literature Review

In *Categorically Unequal*, Douglass Massey argues that the root of any racial stratification system is in its ability to categorize and rank certain human beings. Without this categorization, he posits that a society cannot build the social or physical barriers that create inequality or

oppression. Richard Delgado quotes Noel Ignatiev from his paper *The Point Is Not to Interpret Whiteness but to Abolish It*, saying "Whiteness has nothing to do with culture and everything to do with social position…It is nothing but a reflection of privilege, and exists for no reason other than to defend it. Without the privileges attached to it, the White race would not exist, and the White skin would have no more social significance than big feet". Delgado also quotes Dr. Evelyn HuDehart, professor and chair of the department of ethnic studies at the University of Colorado-Boulder:

> I think critical White studies is a very important and critical part of new directions in ethnic studies…Whiteness studies was dearly influenced by ethnic studies theories, and in turn, it is now positively influencing ethnic studies to see Whiteness as also a historically contingent and socially constructed racial category, one defined, to be sure, by privilege and power rather by marginalization and domination. But Whiteness and the other racial categories are part of the same racial order and racial hierarchy in the history of this country and in contemporary social reality.

Whiteness studies has sprung up drastically over the past two decades, though it is not a foreign concept hasn't been approached by scholars before. Sociologist W.E.B. DuBois speaks of the "wages of whiteness" in *Black Reconstruction in America*, noting the effects of racism and white supremacy on Southern white workers and demonstrating that these whites, despite their similar class oppression, were unable to unite with Black workers. Though critical race theorists and critical legal theorists have been mulling over the origin of the study of Whiteness well before the early 1990s, its contemporary focus is rooted in the study of people of color. Books like Delgado's *Critical White Studies*, David Roediger's *The Wages of Whiteness: Race and the Making of the American Working Class* (1991), Ruth Frankenberg's *White Women, Race Matters: The Social Construction of Whiteness* (1993), Alice *McIntyre's Making Meaning of Whiteness: Exploring Racial Identity with White Teachers* (1997), Alexander Saxton's *Rise and Fall of the White Republic* (1990) and Toni Morrison's *Playing in the Dark: Whiteness and the*

Literary Imagination (1992), are examples of works that confronted this issue directly.

The various scholastic attempts to understand white privilege span from DuBoisian ideas in *The Souls of Black Folk* and *Black Reconstruction,* to *Understanding White Privilege* by Frances Kendall (2012), to the impact of racism on White Americans (Bowser & Hunt, 1996). The enactment of Whiteness in America (Kincheloe, Steinberg, Rodriguez, & Chennault, 2000) has also been explored, and whiteness has been acknowledged to better understand health disparities (Griffith, Metzl, & Gunter, 2011). Whiteness has played a huge role in understanding race relations and the health outcomes that stem from such relations. Even in everyday language, though most scientists hold that the current use of race is not a valid scientific category, the persistence of the "one drop" rule defines many social interactions, medical terminology, and actions. Unpacking whiteness is needed to understand our society as a whole, and if one focuses on laymen articulation of health through this framing of whiteness, understanding health implications on both a personal and social scale will be more accessible.

Since Whiteness Studies, as an official focus, is fairly young, the body of literature has yet to develop a cohesive theoretical analysis that successfully marries the various interests of researchers (some scientists focus on oppressed people, other the stratification system, and yet other focus on what race is). However, this lack of clear social object is an issue in the larger race literature, but does not deter this literature base from exploring its limitations accurately. It has also undergone criticisms, such as scholars and laymen alike, such as columnist Barbara Kay, who write that whiteness studies "points to a new low in moral vacuity and civilizational self-loathing" and is an example of "academic pusillanimity." According to Kay, whiteness studies "cuts to the chase: It is all, and only, about white self-hate." (Rodriguez, 1999) Other scholars accuse individuals who deal in Whiteness Studies with sloppy thinking, and as

mentioned before, a lack of cohesive stratagem in defining and approaching Whiteness. While this could be attributed to white fragility and discomfort of being and discussing 'unmarked' bodies, it is still relevant argument to be made. This goes hand in hand with scholars confounding the terms and usage of 'White People' and 'Whiteness', which only add to confusion and misinterpretation of intent. But using Cheryl Harris' *Whiteness as Property* argument that laws come to be embody and legitimize benefits of white citizens, this paper will argue that 'Whiteness' and 'White People' is a commodity that is owned (or "rented") through various practices and privileges, consciously or unconsciously. It makes Whiteness less of an identity and more of a economic investment and social currency, which coincides with the idea of 'white privilege' and 'white fragility', as well as avoids the pitfalls of speaking of an identity that individuals may not ascribe to.

Ladelle McWhorter (2005) argues that Whiteness Studies theories have not thoroughly critiqued the juridical conception of power that they have inherited from traditional political theory; as a result, they cannot get away from psychological accounts of the origins of racism, even though they usually state very clearly that they believe racism is an institutional phenomenon and racist subject positions are formed within networks of power. She asserts that success of this field in its attempt to accomplish both its analytical and its political goals, needs to pay attention to Foucault's work on biopower. This will place the development of white racial subject positions alongside the growing focus of biopower in 1970s, showing that the growth of social and economic control over populations is connected to the prevlance of Whiteness.

Scholars that contextualize Whiteness in the United States are critical to these points, such as David Roediger [The Wages of Whiteness: Race and the Making of the American Working Class], George Yancy [Look, A White!: Philosophical Essays on Whiteness, Black Bodies,

White Gazes: The Continuing Significance of Race, White on White/Black on Black], and

George Liptiz [The Possessive Investment in Whiteness], and the arguments against their work,

to better understand the implications of Whiteness, especially in the context of public health.

Authors with focus in other countries could be utilized but with the U.S. American context being

the cornerstone to the formation of Whiteness in this country, the use of other data could only be

used as a comparison.

In *The Souls of Black Folk* (1903)*,* W.E.B. DuBois speaks of a "second sight" and "two-

ness" that Black people obtain as they encounter and are confronted by a racialized and racist

society. This sight allows the 'American Negro' to not only see themselves and their interactions

in society, but also how White Americans (and White America) view them. Robin DiAngelo

argues that white people in the U.S. live in a social environment that shields them from race-

based stress, which is beneficial to their comfort and is a cornerstone in their "white privilege",

but also lowers their ability to handle race-based stress (2010). Individuals who ascribe to

Whiteness as it is a prevailing norm in both race and society lack that "second sight" and usually

have no self-conception of race, or greater conception of norms. (Zuberi & Bonilla-Silva, 2008).

Similar to immigrant populations that "became White" (Brodkin, 1998) through assimilation,

time, and skin color, the hyphens of their identity ('Irish-American', 'Polish-American') are

erased by the body, label, and social ascription to whiteness.

This leads to "white fragility", which DiAngelo (2011) describes as "a state in which even

a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves.

These moves include the outward display of emotions such as anger, fear, and guilt, and

behaviors such as argumentation, silence, and leaving the stress-inducing situation. These

behaviors, in turn, function to reinstate white racial equilibrium". DiAngelo asserts that due to

the privileges that Whites are given due to their Whiteness, they have underdeveloped cognitive or affective skills to adequately engage in racialized situations. In regards to health, this can lead to decisions or actions that are detrimental to the individual or group because of a fervent disassociation with raced identities and racialized situations. Similar to risky behavior that solidify hegemonic masculinity for a male individual (Griffith, Metzl, & Gunter, 2011), this separation of the self with race solidifies an individuals' "unraced" whiteness, but increases the risk of exposure to adverse arrangements due to social and economic placement.

Methods

Using my literature as solid footing, three issues will be addressed that will challenge and utilize thr definition of Whiteness given by *The Wages of Whiteness* by David Roediger, *Whiteness as Property* by Cheryl Harris, and *The Possessive Investment in Whiteness* by George Lipsitz to give health implications of white ownership. When defining Whiteness as less of an identity and more of an economic investment and social currency, economic and social implications can be found throughout U.S. society. Resistance to the Affordable Care Act (also known as Obamacare) will be considered, with poor white men rejecting legislation that ultimately economically and physically benefits them the most. One can hypothesize that if poor white men support such legislation, it will conflict against the "from your own bootstraps" ideology of the 'universal American Dream' (which ties into whiteness by being inadvertently defined as "American"), as well as acknowledge a "renting", not ownership, of whiteness by those who challenge the definition of whiteness (Wray, 2006). Parallels can be made of the identity of "American" being a moniker for "white" or "whiteness".

Welfare, as well as the arguments against it, is another approach. The current discussion of

the 'face' of welfare, social/mass media sentiments towards it, as well as the arguing points of the dismantling of it will not only discuss social norms in the United States, but will bring to light how Whiteness affects issues with public health implications. The lack of social support of welfare by white men and women, despite their overwhelming use of such programs, can be rooted in fears of the "Black welfare queen", social stigma against "government handouts", and the pushback against federal financial waste. The third issue is the national response to the current Heroin epidemic, showing how its representation and handling is starkly different than the "Black" face of Crack Cocaine at the beginning of the "War Against Drugs". As the face of heroin has increasingly become white, harsh drug sentences and lack of funding for rehabilitation has suddenly been seen as overly cruel and despotic.

Findings

The "Welfare Queen"

Though the Supplemental Nutrition Assistance Program (SNAP), better known as food stamps, are a well known form of welfare, public assistance programs exist in forms outside of dietary aid. American social welfare started with President Franklin Roosevelt and the Social Security Act of 1935, as a response to the social and economic difficulties of the Great Depression. This government program has grown to encompass two forms: social insurances, which is based on the accumulation of pay earned by an individual, and public assistance, commonly known as "welfare", which is based on individual financial need (Marx, 2014). The six programs most associated with "welfare" are 1) Temporary Assistance for Needy Families (TANF), 2) the Food Stamp Program (FSP) or Supplemental Nutrition Assistance Program (SNAP), 3) Supplemental Security Income (SSI), 4) Medicaid, 5) housing assistance, and 6) the

Earned Income Tax Credit (EITC). The federal government is the initial funder for all six, though TANF and Medicaid require a 25–50% funding match from the state, and all programs are administered locally (by the states, counties, or local federal agencies), excluding EITC. (MaCurdy & Jones, 2008). A number of government agencies were created to maintain welfare services, such as the Department of Health and Human Services (HHS), the Department of Housing and Urban Development (HUD), the Department of Labor, the Department of Agriculture, and the Department of Education.

Former President Bill Clinton and a Republican-controlled congress ended federally controlled welfare with the approval of The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), allowing states to dictate eligibility and create limitations on assistance (Welfareinfo.org, 2015). PRWORA instituted TAMF July 1, 1997, which replaced President Roosevelt's Aid to Families with Dependent Children (AFDC) program—which had been in effect since 1935—and supplanted the Job Opportunities and Basic Skills Training program (JOBS) of 1988. But welfare did not have its only major reform in the late 1990s. In 1976, former President Ronald Reagan introduced the U.S public to one of its most hated enemies – the "welfare queen". "There's a woman in Chicago," Reagan stated, according to the defunct Washington Star. "She has 80 names, 30 addresses, 12 Social Security cards. ... She's got Medicaid, getting food stamps and she is collecting welfare under each of her names. Her tax-free cash income alone is over $150,000." The crowd attending the campaign rally at the time loudly gasped, and the entire American public did the same (Levin, 2013). This woman who President Regan described is Linda Taylor, a Black but racially ambiguous woman in Chicago, Illinois, that was just as eccentric and excessive as he announced, doing the things he mentioned all while driving a pink Cadillac. The Chicago Tribune actually coined the phrase "welfare

queen", but the idea swiftly made itself known throughout the U.S. by Reagans consistent lamentations about welfare reform and abuse, drastically impacting how public assistance was socially accepted and quickly making it a shameful program to rely on.

Though President Reagan didn't explicitly mention the race of Ms. Taylor, the speech played on American racial anxieties. This "welfare queen" matched the fears individuals had of African-Americans taking governmental checks to cash at the local liquor store, all while living lavishly. The inclusion of a pink Cadillac didn't help the image. From there the story has snowballed: she may or may not use illegal substances; has copious amounts of children, possibly from different fathers, to increase the benefits she receives from government programs like SNAP or TANF; and she gleefully misuses "hard-working tax-payer dollars" for her petty personal gain. Though "welfare" ended 20 year ago, the "welfare queen", and by extension her Black family, is seen as a continuous menace to U.S. society and is the reason the "safety net" of public assistance shouldn't exist in the first place.

Reagan's "welfare queen" re-emerges occasionally, especially during campaigns for public office. Rick Santorum, 2012 Republican presidential candidate, directly singled out blacks as being recipients of assistance through federal benefit programs. At a campaign stop in Sioux City, Iowa, he told a mostly-white audience "I don't want to make black people's lives better by giving them somebody else's money; I want to give them the opportunity to go out and earn the money", which was greeted with solemn agreement from the attendees (Madison, 2012). The same year in Plymouth, New Hampshire, another GOP presidential hopeful Newt Gingrich announced "I will go to the NAACP convention, and explain to the African-American community why they should demand paychecks instead of food stamps" (Younge, 2013). In these cases, there is a brazen connection of fraud and Black people, giving false life to fears of

welfare abuse and reifying stereotypes that Black people only succeed by the help of the government and not of their own intellect, opportunities, or capabilities. Even in "colorblind" allegations of the worthlessness of welfare, asserted descriptors and implications still dogwhistle the same racialized categories that incensed the American public when Reagan first introduced the idea of a "welfare queen".

The Numbers

The National Census counted the population of the United States at 308,745,538 individuals in 2010. It is projected for 2014 to be 318,857,056. Of that 2010 population, White/European-Americans counted for 77.4% of the population, or 223,531,770 people. For the 2014 estimate, the percentage is 77.4%, or 256,795,361. For Blacks/African-Americans, they are 12.6% - or 38,901,938 people – with the 2014 estimate at 13.2%, or 42,089,131. The Department of Commerce states that for 2016, welfare demographics for recipients are 38.8% white, 39.8% Black, with 35.4% (110,489,000 people) of the U.S. American population benefiting from such programs (U.S. Department of Commerce, 2016). The percentages of the population on welfare by race from the 2012 U.S. Census was 41.6% for Blacks and 13% for Whites. Politically conservative sites use sources that introduce even larger percentage gaps.

The Center for Immigration Studies (CIS) published a report called "Welfare Use by Immigrant and Native Households", headed by their director of research Steve Caramota, which covers a large amount of the welfare programs introduced previously. Using the 2012 Census Bureau's Survey of Income and Program Participation (SIPP) data, Carmota and CIS found that 54.6% of Blacks utilized welfare compared to 23.1% of Whites. This large welfare gap by the races is seen

in every welfare program available, including "Welfare Use by Native Households with

Children" (Caramota, 2015). American Renaissance, the website that used this report, concluded:

> According to data in the CIS report, there are 39.88 million households in the US receiving some
> sort of means-tested welfare. Of those households, just 19.66 million–or 49 percent–are either
> native or immigrant whites (Middle Eastern immigrants are classified as "whites"). That means
> the majority of US households on welfare are now non-white.
>
> As mass Third-World immigration continues, the US will have an ever-burgeoning dependent
> class of non-whites. Black voters will be joined by increasing number of Hispanic voters in their
> support for more handouts. When they vote in 2016, a majority of black and Hispanic
> households are likely to be on welfare–just as they were in 2012. Arguments about freedom and
> limited government will mean nothing to them. Obamacare is just the beginning. Whites must
> decide if this is the future they want for their children and grandchildren. If they don't take action
> soon, blacks and Hispanics will decide for them. (Devlin & Wolff, 2015)

Implications

However, the implications of these percentages are incorrect. In observing the 2012 U.S.

Census data, though the percentage of welfare recipients were majority Black, the raw numbers

for those percentages speak of a different picture. With those percentages, in 2012 only 17

million (16,183,206) Black U.S. citizens were using welfare programs compared to close to 30

million white citizens (29,059,130). With the larger conservative figures in 2014 estimated

populations, there were 22,980,666 Blacks receiving welfare versus 59,319,728 Whites. In other

national numbers, 2013 U.S. Department of Agriculture data state that 40.2 % of SNAP

recipients were white, 25.7% Black, 10.3% Hispanic, 2.1% Asian, and 1.2% Native American

(Brown, 2015). There's a hefty racial population difference utilizing welfare, even with the most

extreme of percentages, with Whites consistently taking advantage of and benefiting from these

programs.

The sole use of percentages without raw population numbers explanation or comparisons paints a

picture that reifies concerns about minority and immigrant abuse of public assistance. Whether it

is inadvertent or blatant, this perpetuation of false stereotypes of racial populations – specifically Blacks – with misleading statistics enforce social misunderstandings and incorrectly inform the layman voter. Not supporting the idea of the slothful, unmotivated, unemployed, exploitative Negro, these numbers are significant because they explicitly poke holes in the rhetoric of "the welfare queen" while unmasking the truth of the poor and struggling white person in the midst of the still-prevalent American Dream.

In the state of Iowa at the time of Rick Santorum's statement, only 9% of Black individuals were on welfare while 84% were white. This is the same state that the U.S. Census projected to be 92.1% white and 3.4% Black in 2014; which would make only 0.3% of Iowa citizens were Black and on welfare, while 77% were white. While Iowa isn't the bastion of racial diversity, and regional/state numbers can differ due to the racial makeup of the area, the discrepancy of perception and reality is clear. Though the "welfare queen" was proven to exist, President Regan exaggerated her abuses and characterized her as the prototype welfare recipient. Despite historical poverty, disenfranchisement, and discrimination that has Blacks with the largest population percentage on Welfare (and other populations not to far behind), there are few questions as to why there is such a large need for welfare in Black communities.

Kaaryn Gustafson, author of "Cheating Welfare: Public Assistance and the Criminalization of Poverty.", states that "This image of the lazy African-American woman who refuses to get a job and keeps having kids is pretty enduring. It's always been a good way to distract the public from any meaningful conversations about poverty and inequality" (Blake, 2012). Though the "welfare queen" was not a myth, the inference of black indolence and criminality created a war on the working poor and a separatist appeal for working-class whites who desperately try to appear less as unemployed "White Trash" (Wray, 2006). This persists

even as the majority of households receiving government assistance are lead by a working adult, with 56% of welfare dollars between 2009 and 2011 sustaining employed families and individuals (Jacobs, Perry, and MacGillvary, 2015). In some industries and employment opportunities, close to half of the workforce relies on welfare to make ends meet, despite welfare programs losing their purchasing impact (Coverty, 2013). It is poor paying jobs and a lack of a living wage, not voluntary unemployment by lazy poor Blacks, that stretches the American welfare system. Many of these governmental programs represent an outlet for growth to individuals and families, keeping millions out of poverty, increasing access to food, and offering housing/employment opportunities not readily available to some.

With nonwhite voters climbing to the majority by 2050, many believe "welfare queen" rhetoric will cease. However, even with the majority of welfare recipients blatantly being white, the face of welfare and welfare abuse is still Black. With the percentages of Blacks receiving welfare higher than whites, the "ghost of the Welfare Queen is still lurking" (Blake, 2012) in the minds of the American public and brutally utilized by the mouths of politicians, as one can see in the current 2016 Presidential race. Calls for drug testing welfare recipients (with close to 100% testing negative), assertions that poor people "need to learn how to work", direct accusations of 'minorities' being lazy and manipulative, and other anti-poverty/anti-welfare arguments that could easily fall on racial lines are used currently to sway the U.S. constituency. It seems that though the "welfare queen" stereotype may not be directly invoked, well known is the indirect impact of fearmongering whites to disavow an impactful program that has consistently benefited them since its conception.

The Affordable Care Act (ACA)

As the paper is focused on the health impacts of structures, a topic that has been at the forefront of tenuous national political debate for many presidencies needs to be addressed. Found in many European countries and Canada, universal healthcare has been championed as the savior for our overwhelmed and underperforming healthcare system. The Patient Protection and Affordable Care Act (PPACA) 2010 HR3590, or Affordable Care Act (ACA) for short, is the newest healthcare reform law in the U.S. and is well known by its nickname "Obamacare". Since March 23, 2010, the ACA's intention is to provide U.S. Americans with better health security, all by implementing healthcare and health insurance reform. This includes, but is not limited to, expansion of healthcare insurance coverage to more Americans, higher accountability for health insurance companies, lower health care costs, and an increase in the quality of healthcare for all citizens (Medicaid.gov, 2011).

With its approval by the Supreme Court on June 28, 2012, this legislation expands Medicaid coverage to more of the United States' low-income citizens, and improving on health insurance for children (Supeme Court of the United States, 2011). Full implementation occurred on January 1, 2014, when "individual and employer responsibility provisions took effect, state health insurance Exchanges begin to operate, the Medicaid expansions take effect, and the individual and small-employer group subsidies begin to flow" (Rosenbaum, 2011). It has been marketed as a non-discriminatory, all-encompassing, equitably minded piece of mixed market healthcare legislation that will benefit all citizens of the United States; whether all groups in the U.S. echo that is questionable.

Both pieces of legislation that make up the ACA - the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) – are focused on covering the 30 million previously uninsured people in the U.S. (Glied & Ma, 2015). Opponents of this legislation say that it will catastrophically harm the economy, add to our already looming national deficit, and cause the cost of health care to skyrocket, not plummet like it is intended to. Criticisms include heavier workloads for both patient and provider, ineffective implementation of healthcare for those who still can't afford the payments and penalties, limited resources of our healthcare system to cope with the newly insured, an exacerbation of shortage of healthcare workers to patients, and a heavy financial burden on the federal government and state (Anderson, 2014). Supporters assert that this law expands access to [quality] healthcare and over time will lower federal spending, reduce the national deficit, all while boosting an economy still recovering from the 2008 recession. Praises include the focus on quality (not quantity) of healthcare, availability of drug coverage and preventative healthcare, expanded and affordable coverage for the middle class, young adults, and employees, strengthening of primary and community care system, and eventually pay towards the national deficit.

The Numbers

The impact of the ACA is still debated due to its rocky start (e.g. healthcare marketplace website has crashed a few times), incomplete national coverage due to the ability of states to opt out of expanding Medicare, and recent full implementation of Obamacare in 2014. However, the information available speaks to its growing effectiveness. The Congressional Budget Office estimates that the ACA will have provided coverage to 33 million Americans who would otherwise be uninsured (Congressional Budget Office, 2012). For families making less than

133% of the poverty line, they will be insured through Medicaid with capped premium payments, while individuals making less than 400% will have tax credits to afford private insurance (Klein, 2012). As of February 2016, 16.4 million individuals are covered with insurance through the implementation of the ACA, with independent data sources like the Commonwealth Fund, Gallup, the Rand Coroporation, and the Urban Institute reporting that the number of U.S. citizens without insurance fell by roughly 10-12 million (ObamaCareFacts.com). With the 11.4 million that used the ACA Healthcare Marketplaces during the 2015 open enrollment, 87% are receiving some form of cost assistance.

Hospitals are also reporting that they are encountering fewer uninsured patients. Compared to the 47 million citizens – 17.1% - uninsured before Obamacare, by January 2015 the uninsured rate was 12.9%, dropping 4.2% points (Levy, 2015).

Premiums for health insurance marketplaces and employers are not rising quickly (The Henry J. Kaiser Family Foundation, 2014), and though many individual/employer insurances were canceled due to ACA compliance, "over half of this population is likely to be eligible for coverage assistance", and now can find health care coverage at a lower prices with better quality (Ungar, 2014). Among U.S. adults between 18 and 64, the National Health Interview Survey found that "for every poverty status group, a significant decrease was seen in the percentage who were uninsured between 2013 and 2014" (Cohen & Martinez, 2014).

With 2013-2014 marked the beginning of the major coverage expansion for the ACA, U.S. citizens defined as "poor" or "near-poor" saw an uninsured rate drop of about seven percentage points (Culp-Ressler, 2015). Healthcare costs also appear to be rising at historically low rates. This is assisted by the recession, which may have costs rising faster at a later date. However,

experts also assert that this is because the healthcare industry is becoming more efficient – which is partly due to the ACA and its included incentives (Cohn, 2014). Overall, the goal of the ACA seems well focused – many who would not be insured have health coverage in some way, many have the ability to receive financial help if they can not afford it, and the quality of care seems beneficial to all.

Implications

Though this healthcare reform law itself is not racialized, the nickname of "Obamacare" pushes it firmly into the stigma and racism that has surrounded our first Black POTUS, President Barack H. Obama. Surveys have shown that more Americans oppose this healthcare law when the President's name is attached than when it is called by its legal name (CNN Political Unit, 2013). This stigma is doubled by the consistent view of more socialized healthcare, similar to "welfare", being an unearned "handout" and conditioning U.S. citizens to be slothful and "entitled". However, this legislation was increasingly a bi-partisan reform law (ObamaCareFacts.com), that is similar to other health care reform plans put forward in the past like Richard Nixon's Comprehensive Health Insurance Plan (CHIP), Sen. John Chafee's HEART Act of 1993, Rep. Paul Ryan and Sen. Tom Coburn's Patients' Choice Act of 2009, and even 2012 GOP Presidential hopeful and former Governor of Massachusetts Mitt Romney's state healthcare law (USNews.com, 2016). With difficulty, the ACA offers expanded medical and healthcare for many U.S. citizens not currently insured, but with two things that Republicans detest: more government intervention and higher taxes (Flavelle, 2015).

The all-encompassing aspect of the ACA has been labeled "socialism", which has enraged conservative citizens and turned that part of the political spectrum against the

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legislation. The Republican party under President Obama has increasingly become the "Party of No", vowing from his inauguration that he will have a firm opposition from the GOP (Khan, 2013). "If [President Obama] was for it," former Ohio Senator George Voinovich stated, "we had to be against it" (Grunwald, 2012). Despite its similarity to past and present GOP healthcare legislation, there has been strong opposition against "Obamacare", with citizens supporting GOP representatives with actions to "break Obamacare" with plans of non-cooperation, which have led to previous government shutdowns (Snell & DeBonis, 2015). However, with arguments for possible reform and replacement of Obamacare, there are few agreed-upon plans to implement, especially since reform/replacing will be too financially expensive for conservative tastes. (Salam, 2014).

The majority of states that have opted out of expanding Medicare coverage are increasingly conservative, and half exist in the U.S. South. From that decision, 1/3 of their lowest-income residents remained uninsured in 2014, which despite a national trend of gaining insurance, was virtually unchanged from 2013 (Young, 2014). Studies have shown inconclusive evidence as to whether or not states gain financially from opting out, but show negative impact on the uninsured populations in those areas (Young, 2014).

In 2013-2014, hospitals in Medicaid expansion states saw an overall increase in Medicaid discharges, increase Medicaid revenue, and decreased cost of care for low-income patients (Cunningham, Garfield, & Rudowitz, 2014). Hospitals in states that have opted out of expansion saw a small increase in Medicaid discharges, but declining Medicaid revenue, and growth of care costs for the poor. Among adults who exist under the poverty wage line in non-expanded states, the uninsured rate is 36% of the population, compared that to states that adopted the expansion, whose uninsured population dropped from 28% to 17% (Young, 2014).

Though there is room for improvement in making the transition from poverty to middle class less pitted with taxes and possibly unaffordable premiums, the ACA has still benefited countless individuals that were previously uninsured or trapped in an unhelpful plan. However, from the association of "Obamacare" to President Obama, who has had an uncooperative conservative base from the moment he stepped in office, to the ACA implementing healthcare with high government influence and mandatory taxes, the majority-white Republican base of the country has not welcomed the expansion well. From filibustering possibly beneficial federal bi-partisan laws, opting out of the state level Medicare, and refusing to enroll in individual healthcare, there is something this group of individuals are valuing more than their own health. The ACA itself, though passed, has been marred by partisan compromises, manipulation, and ill-informed citizen outrage, limiting the possible positive impacts of expanded healthcare (Cunha, 2015). This is not to argue that ACA is the key to the country's burdened healthcare system, but with "Obamacare" – a label promoted by Republican strategists – being more opposed than the Affordable Care Act simply by the difference in the name (Obernauer, 2013), negative assumptions about race can be made. It seems that deep seated racial bias coupled with fears of socialism, government interference, and partisan animosity have been deemed more valuable than preserving and improving the health of U.S. citizens.

White Heroin Drug Use

The Existential Pain of being Young, White, and Affluent. This is the title of a March 8, 2016 article in The Atlantic discussing the ravages of the current heroin epidemic impacting the United States. Born from the abuses of prescription and opioid drugs, this wave of addition is out pacing gun and car crashes as the leading cause on injury death (Block, 2016); manifesting in affluent white youth, leaving its past as a rural, stereotypical "White Trash" habit (Wray, 2006).

With many of the generation between 1984-1990 abusing painkillers (the cause of three out of every four overdoses) like OxyContin 40% more than any other generations before them (Miech, Bohnert, Heard, & Boardman, 2013), a study published in Health Affairs suggests that the "increase in fatal drug overdoses among youth has grown so severe that it is a "major contributor" in the gap between life expectancy in the U.S. and other major income countries" (Ho, 2013).

The Numbers

So why is it considered to be an "epidemic" (Khazan, 2014)? According to the Centers for Disease Control and Prevention, 47,055 people died from overdoses alone in 2014, including 28,647 from opioids (Rudd, Aleshire, Zibbell, & Gladden, 2016). Close to 1.7 million individuals between 12 and 25 – which factors to be over 4500 per day – abused a prescription drug for the first time in year 2011, and that number is growing. (National Insititutes of Health, 2013). White youth counted for three-fourths of that population (Science Daily, 2013). In 2009, 88% of individuals admitted for treatment for opioid-based medication abuse, as well as 66% of individuals admitted for stimulants were also white. The face of collegiate prescription drug abuse is more likely to be white, as well as male, come from an educated background, and perform poorly in academics (Science Daily, 2008). Many of these users come from comfortable backgrounds with stable support systems, and are ushered in the the misuse of prescription drugs – then heroin – due to the pressures and stresses of growing up, moving out, experiencing college, and handling issues they were never brought up to face. The epitome of "white fragility".

Implications

The public health impact of illicit drug use can go without mentioning – so why is this important now? The New York Times gives this opinion: "the visibility of drug users may be partly attributed to the nature of the epidemic, which has grown largely out of dependence on legal opioid painkillers and has spread to white, urban suburban, and rural areas" (Seelye, 2016) In other words, the "new face" of life-threatening, future-shattering, and neighborhood-ruining drug use is now overwhelmingly white (Carrol, 2014; Amsden, 2014). This changing outward representation of opioid use is prompting pressure against life sentences for first time non-violent drug offenders, and influencing the creation of treatment centers and rehabilitation for drug addicts. Even Congress is investing in the shift, adding a $600 million funding measure to the Comprehensive Addiction and Recovery Act to finance federal efforts in to prevention and treatment. This funding measure includes "treatment, prevention and recovery efforts at the state level, as well money for local treatment and enforcement programs. It also includes $50 million for intervention programs, including better monitoring of drug prescriptions" (McAuliff, 2016). There have been pleas to change verbal and legislative rhetoric about addicts (Cook, 2015), and has become a hot topic for 2016 Presidential hopefuls to answer as they run campaigns for citizen voters (Grim, 2015).

More importantly, a 'softening' of the "War on Drugs" has been demanded, decriminalization of drug possession has been strongly supported (Piper, 2016), transforming this crisis into a public health issue has been argued, and Naloxone – a drug that reverses the effects of Heroin - has approved by the FDA and available for EMT and police responder use (Aleccia, 2016). In New England and Midwest areas that are hardest hit, local police departments have stopped punishing heroin users – those who walk into some police stations with

paraphernalia asking for help will be diverted to treatment centers, not jail cells (Seelye, 2015).

Thirty-two states have passed "good Samaritan" laws that protect people from prosecution if

they call Emergency to report an overdose, and the mayor of Ithaca, NY is willing to be the first

city with a "supervised heroin injection site" (Barron-Lopez & Cherkis, 2016).

This forgiving mood is starkly different when the War on Drugs was majority Black with

crack cocaine ravaging communities of color. Marc Mauer, the executive director of the

Sentencing Project, which examines racial issues in the criminal justice system stated:

How these policies evolve in the first place, and the connection with race, seems very
stark…Both the image and reality is that this is a white and often middle-class problem, and
appropriately so, we're having a much broader conversation about prevention and treatment, and
trying to be constructive in responding to this problem. This is good. I don't think we should
lock up white kids to show we're being equal (Seelye, 2015).

When there were protests against the severe treatment of crack-cocaine users (majority

Black / people of color) compared to powder-cocaine users (majority white), political figures of

both parties defended such policies as necessary to control violent crime. The 100/1 sentencing

disparity for crack cocaine – which means for every 100g of powder cocaine, 1g of crack cocaine

carries the same sentencing -, also included the mere possession of crack, unlike any other drug

which required an intent to distribute. (Common Sense for Drug Policy, 1999). Before 1968, the

average sentence for Blacks in non-violent drug related crimes was 6% longer than the average

sentence for whites. After mandatory minimums ushered in the crack/powder sentencing

disparity, the average sentence was 93% longer for Blacks than whites (Drug Policy Alliance,

2015). This blatant demonization of communities of color, as well as the mistreatment and

targeting of these communities by federal and local officials, hid the fact that whites and Blacks

both dealt in illicit activities at roughly the same rate (Fellner, 2009). The implementation of the

"War on Drugs" was ultimately a declaration of war on communities of color and the poor – with

the face of drugs 'colored', millions of homes were torn apart by mandatory minimums, and generations of individuals will have a "less than" citizenship due to rights being taken away for felons (Kain, 2011).

This is not to assert that opioid use for African Americans has not increased in the past decade – it has risen almost 200%. However, due to community disenfranisement and historical housing segregation, it is less likely for Blacks to find it through previous prescription abuse. Opioid painkillers are less likely to be prescribed to Blacks, even young children (Doyle, 2015), for the same aliments whites endure (Hausmann, Gao, Lee, & Kwoh, 2013). Also due to the lack of access to quality pharmacies, even if a prescription was filled, there would be no place to fill it. "There's a well-known phenomenon that there's less opioids available in segregated minority communities…You can't find them in the pharmacies. There's less medical access." (Cherkis, 2016).

This recent heroin phenomenon has acutely affected Whites the harshest, yet legislation for needle exchange programs are still being banned nationwide. Though such programs provide clean needles to people who inject drugs (PWIDs) to minimalize contamination and spread of diseases like HIV, as well has been proven effective in those efforts (Stapleton, 2010). However, recent legislation has prohibited funding, with fears that it will "send a message" that illegal drug use positive, and attract more drug users (Normand, Vlahov, Moses, 1995). This "voting against your own benefit" is seen also with the previous cases of welfare, and with the Affordable Care Act (ACA). Yet with middle aged white deaths pushing up the nationwide mortality of the United States due to suicide and drug deaths (Khazan, 2016), what will stymie this rising epidemic if the people who are mostly affected refuse to vote against it?

Discussion

The assertion of a norm in medicine and American society carries its own issues. This claim rails particularly against the idea of medicine and public health as neutral and objective, though many scholars in the fields of feminism and Science and Technology Studies would agree. The argument of a "colorblind" society is a "neutral" argument when speaking about Whiteness and privilege, and how individuals embody that privilege. However, this approach forgoes individual ascriptions to race, and how racist hierarchies have continued to influence legal, economic, and social life, despite slight advancements in equitable legislation.

This project does not assert that individuals who ascribe inadvertently or deliberately to Whiteness with their bodies are consistently negatively impacted by this racial labeling like other racial categories. Studies, specifically critical race studies and public health research, show that being White in the U.S. generally places individuals in positions of better access to objects that can positively impact one's being (e.g. social mobility, health, wellness, education). This 'white privilege' that is carried around via invisible knapsack, as Peggy Macintosh (2004) would state, allows individuals of this group to have the access to, and privilege of, existing in a body that is relatively considered normal. Excluding gender and sexual barriers/differences, generally there is no need for 'cultural competency' with Whiteness because it is usually the center of study and focus to begin with.

However, this privilege can be a double edged sword. As seen in the misconception of the Black Welfare Queen with many mouths to feed, impoverished single white women with children who dominate welfare need are overlooked and impacted by initiatives that cut welfare benefits to discourage 'slothful' minority disuse. Many poor whites lament similar arguments

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seen with poor Blacks - not enough focus on them and their communities for them to succeed in our general society. With health disparity research, much focus is on the intervention, uplift and understanding of minority communities; thus, white members of this research are relegated as a control of sorts, a normative figure of health that minorities are compared to. Also, Blacks with enough privilege and access to lead lives similar (though health is usually lower) to their socially successful white counterparts are less focused on for studies (usually focused on lower-class minorities) but have more attention on them than whites of their similar status.

This is not to argue that Whites have larger burden than Blacks and their racial minority counterparts, nor that disenfranchised groups no longer need consistent and intense focus to improve their individual and group health. However, W.E.B. DuBois' question in *The Souls of Black Folk* (1903) – "How does it feel to be a problem?" – should be directed towards Whites too, not just Blacks. The existence, definition, and explicit/implicit use of "Whiteness" should be troubled and problematized, just as much as race theorists have contemplated Blackness. Whiteness deserves to be raced just like every other racial category that exists in the United States. It is not only identified by itself as 'unmarked category', but defined by the existence and relation to Blackness (a 'marked category'), and whatever is thought of as existing between Black and white. Whiteness and Blackness are not two different things, whatever they may be, but are two sides of the same coin, determined by each other. The definitions and boundaries of one are strengthened or weakened by the challenging of the other; thus the need for swift and continuous policing by society. Though one can make that argument for any raced identity (or any identity for that matter), Whiteness makes this difficult due to its lack of blatant discourse in public health. However, its 'unmarked-ness' allows it to be pinpointed, just like how one can see where a color ends in a color spectrum when another color can be noticed. Though the literature

discussing Whiteness usually stands in other disciplines outside of public health, the informative nature of such works can easily be transplanted for implications in this field.

If this ideal about Whiteness and Blackness is sound, both are fluid in dynamic and push against each other to redefine their norms, 'abnorms', boundaries, -isms, etc., similar to the location in Alaska at the "place where two oceans meet" (Alaska Dispatch News, 2013). However, just how lighter, sediment and iron heavy, glacier water eventually mixes with the rest of the Gulf of Alaska, the 'lines' that are intellectually, socially, economically, politically, and emotionally drawn between Whiteness and Blackness blur every single day. It brings a difficulty which is shown in the use of the word and ideology of "race", as it trips and attempts to avoid the historical grounding and contextual framework that race has been woven into. Inaccuracies in the use of race must be spoken about, but also must be avoided in order to prevent from falling into the same flaws. A new framework is needed to look at racialized health, and this paper asserts that looking at the race that is the least socially "raced" is the key. But as stated before, this "gazing on the gazer" is very difficult; this is an attempt to read between the lines of some public health literature that is already desperately trying to find its own existence between the lines of a general health narrative.

Individuals who immerse themselves in critical race theory understand that intersectionality is a complicated structure that attempts to define the tangled knot that is race relations in the United States. Yet with the privileged position of Whiteness, it is difficult to acknowledge that the least socially "raced" category is not only extremely raced, but raced in such a blatant way (a constant comparison against Blackness) that it renders the ones it benefits the most invisible to even their privilege. Racial theory does an excellent job of critiquing whiteness, but fails to acknowledge the White people who "rent" instead of "own" said

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Whiteness ("poor white men"), as well as the health disparities that we observe in White populations. This is also complicated by individual identity and [dis]association with Whiteness because identity is not monolithic, even when it is the norm. Many White people not only do not verbally ascribe to Whiteness, but denounce its normativity and privileges to disassociate themselves from that category.

The aforementioned active examples of white fragility at work are mired in political conflict. Social and political affiliation definitively impacts decision-making for anyone affiliated with particular ideal or group, but to have that affiliation override beneficial health decisions as seen in the findings is a concern. It is as if individuals and groups who physically ascribe to whiteness are invested in "a positive interest in seeing the world wrongly" (Alcoff, 2007), perpetuating white privilege, and the power of that facade regardless of consequences. Current applications of health interventions may work within the structure of Whiteness, but there appears to be a need to transcend said structure as well. This is not asserting that pretending that norms do not exist will solve racial health disparities; again, "colorblindness" is not effective in solving such problems. However, current applications of interventions and discourse around racism, racial health, and racial health disparities immensely improve understanding of these topics but have only chipped away at the yawning gap between Black and White health.

Double pronged methods that affect current health situations and impact the structures that perpetuate them are desperately needed to slow and reverse health disparities. The "de-centering" and problematizing of Whiteness in research language and implementation can be an effective approach to start that process. With acknowledging its normativity but attempting to go above the constraints of that norm by critiquing the structure of it, that manner could make the invisible visible. White fragility will make this transition hard; as we see currently,

#AllLivesMatter backlash against #BlackLivesMatter assertions is just one manifestation of individuals reifying the structure of Whiteness and pushing against race-based discussions (Bry, 2015). Yet as a prevailing public health concern, continuous efforts to challenge norms and transcend past social limitations is needed since this overarching structure of Whiteness impacts all health. The concept of this paper may only practically apply to the discourses surrounding racial health disparities and the state of racialized structures in the U.S.. Nevertheless, breaching the silence of structural Whiteness, white fragility, and making such rhetoric normative is the first step towards the destruction of racial hierarchy and breaking the perpetuation of racial health inequalities.

Future Research

Expansion of this thesis could explore the Alcoff's thesis of epistemic advantage (2007) – how members of marginalized and disenfranchised communities that obtain DuBoisian "second sight" have an advantage of individuals who ascribe to normativity and suffer from the "white fragility" mentioned previously. Being socially conditioned to understand racist situations in a racialized world resemble a minor privilege that racial minorities could have, though one could argue that having such a "second sight" comes with disadvantage that outweighs the privilege. This extension could even discuss the "respectability politics" of Whiteness and how do individuals and groups remain in good standing within it. Comparing the benefits and risks of physically adhering to a social majority and minority appears to supplement claims made in this paper, but only further research can confirm.

The next portion of this work could be observing "performative utterance" of language (Austin, 1955, 1962) supplemented by focus groups, which are sentences that not only describe a

given reality, but also changing the social reality they are describing, focus is needed on this mechanism as an embodiment of these health implications and normative values, and see how such things place themselves in an individuals everyday life. The completed and pending transcripts of the focus groups of Dr. Jonathan Metzl and Dr. Derek Griffith (Vanderbilt) that focus on the health of white and African-American men in Michigan and Tennessee, were at first included in this thesis. These focus groups overall highlighted individual/group embodiment differences between the races of the participants, and how men of different and similar races cope with their masculinity and health. However, with the theoretical basis of this paper, an extensive literature review was needed before moving forward in the field. This focus will continue the "norm unpacking" of this thesis, challenging the idea of medicine and health as being "neutral", and allow us for a closer look as to how these norms impact the health experience and masculinity of individuals that are socialized differently due to their race. It brings the gaze not only to marked bodies that have been studied before, but also to unmarked bodies that are considered the norm.

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