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Racialization and Belonging: A Critical and Empirical Analysis of Hispanic Discrimination in Everyday Life

Chunxi Guo[1]
Stony Brook University, Stony Brook, NY, USA

Khadeja Kausar
Stony Brook University, Stony Brook, NY, USA

John A. Rizzo
Stony Brook University, Stony Brook, NY, USA

Abstract: This paper examines how Hispanic adults are racialized across everyday U.S. institutional settings and barred from full civic belonging. Grounding our analysis in socio-legal theories of belonging, intersectionality, and language politics, we evaluate inequities across seven everyday domains: healthcare, housing, work, job applications, policing, shopping, and social services. We use nationally representative data from the 2021 Medical Expenditure Panel Survey (MEPS) Full-Year Consolidated file (N = 9,346). Survey-weighted bivariate comparisons and multivariable logistic regressions control for an extensive set of sociodemographic, economic, and health-related confounders to isolate ethnic disparities. The empirical baseline reveals that Hispanic adults face significantly higher adjusted odds of perceiving discrimination when shopping (OR = 2.97, $p < .01$), interacting with police (OR = 2.02, $p < .01$), applying for housing (OR = 1.48, $p < .05$), and at work (OR = 1.28, $p < .05$) relative to non-Hispanic White adults. Higher educational attainment and poorer perceived mental health are also associated with elevated odds, illustrating intersectional vulnerabilities. English use operates as a protective factor in gatekeeping domains such as healthcare and social services but is unrelated to exposure in retail and policing. We synthesize these findings within critical ethnic frameworks to demonstrate that everyday discrimination reflects structural racialization rather than isolated interpersonal events, but that this racialization is domain-differentiated rather than uniform, operating through distinct mechanisms across settings and therefore requiring domain-specific remedies.

Keywords: structural racialization, language politics, Hispanics, intersectionality, MEPS

[1] Corresponding author; a doctoral student in the Program in Public Health and Department of Family, Population, and Preventive Medicine, Renaissance School of Medicine at Stony Brook University, Stony Brook, NY, USA, 11794. E-mail: chunxi.guo@stonybrook.edu

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Discrimination remains a prevalent public health issue that permeates various facets of society in the United States (Devakumar et al., 2020; Gulliford, 2019). These biases stem from diverse social, demographic, and economic identities (Gulliford, 2019). Such systemic prejudices may adversely affect health, decrease productivity and personal well-being, and create financial burdens (Elias & Paradies, 2016; Wright et al., 2015; Yetsenga et al., 2024).

To evaluate these inequities, researchers rely on both direct evidence (Bertrand & Duflo, 2017; Bohren et al., 2025) and personal perceptions (Pascoe & Smart Richman, 2009). The direct

Differential treatment of Hispanic adults is well-documented across key settings, including employment, housing, healthcare, policing, retail, and public assistance. However, prior research typically has not examined these domains simultaneously within a single, nationally representative sample. A primary contribution of this paper is evaluating whether Hispanic adults experience statistically significant discrimination relative to non-Hispanic White adults across seven distinct domains using a single, consistent national database. As a distinct second contribution, we also examine whether this discrimination operates as a generalized exposure that follows individuals throughout daily life, or if it is driven by setting-specific mechanisms. By estimating identical statistical models across all seven domains, we can observe whether ethnic disparities—and associated protective factors like English proficiency—achieve statistical significance in certain contexts while shifting or disappearing in others. This unified approach clarifies exactly how prejudice functions across different environments and identifies where tailored policy remedies are required.

Research Goals and Questions

Our study examines the following areas of daily life to identify where Hispanic adults report experiencing unfair treatment: healthcare, housing, work, job applications, policing, shopping, and social services. Instead of treating these experiences as disconnected incidents or isolated statistical data points, we show how these daily encounters reveal a broader pattern of exclusion in the United States. By using national data from the 2021 MEPS, we look beyond raw percentages to explore how a person's likelihood of perceiving discrimination is shaped by ethnicity, language, geography, and socioeconomic background.

Specifically, this study addresses three central questions:

- How do individual perceptions of discrimination among Hispanic adults compare to non-Hispanic White adults across different public, retail, and legal settings?
- How do individual perceptions of discrimination vary across these distinct domains?
- How do language barriers and English use affect a person's likelihood of encountering bias in essential service sectors compared to everyday commercial spaces?

Literature Review

Research on ethnic discrimination in the United States has developed along two largely parallel tracks. One tradition, rooted in economics and social psychology, uses experimental and audit designs to establish that differential treatment occurs and to estimate its magnitude under controlled conditions (Bertrand & Duflo, 2017; Bohren et al., 2025). A second tradition, rooted in epidemiology and public health, measures what individuals report experiencing and links those reports to health and well-being (Pascoe & Smart Richman, 2009). The two literatures answer different questions. Audit studies establish that a landlord or employer

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behaved differently toward otherwise identical applicants; self-report studies capture the accumulated weight of those encounters as the person carries it. The review below is organized by domain, following the seven settings measured in the MEPS Social Determinants of Health module, and closes by identifying the gaps this study addresses.

Healthcare

Healthcare is among the most heavily studied domains regarding perceived discrimination, yet its findings remain particularly unsettled. A substantial body of work documents that Hispanic patients report being dismissed, receiving less information, and rating the quality of their care lower than non-Hispanic White patients. Much of this literature treats ethnicity as the operative mechanism. A competing account emphasizes language: Ellahham (2021) argues that limited English proficiency and non-standard accent independently degrade communication, patient safety, and experience, such that what is coded as ethnic discrimination may in part reflect the institutional consequences of linguistic mismatch. These accounts are not mutually exclusive, but they carry different policy implications. If the driver is ethnicity, the remedy is bias training and workforce diversification; if the driver is language, the remedy is interpreter provision and Title VI enforcement. Distinguishing between them requires models that include both ethnicity and English use as separate covariates, which much of the existing literature does not do. Downstream, perceived discrimination in medical settings is consistently associated with mistrust, delayed care-seeking, and poorer mental health (Andrade et al., 2021; Brenes, 2019), so the distinction matters for outcomes as well.

Housing

Housing discrimination has been documented through experimental paired-testing designs more rigorously than in almost any other domain. In these studies, matched pairs of researchers—differing primarily by ethnicity but presenting identical qualifications—apply for the same housing units. Large-scale national studies conducted for the U.S. Department of Housing and Urban Development found that Hispanic applicants were shown fewer available units and offered less favorable lease terms than equally qualified White applicants (Turner et al., 2013). This bias extends directly into the public sector: Einstein and Glick (2017) audited public housing bureaucrats and found that inquiries from senders with distinctively Hispanic names received fewer responses and less courteous treatment than identical inquiries from White senders. The significance of these findings extends well beyond the housing transaction itself. Williams and Collins (2001) argued that residential segregation operates as a fundamental cause of racial health disparities, because where a person lives determines their exposure to environmental hazards, the quality of their schools, their access to healthy food and medical care, and the labor markets available to them. But what the audit literature cannot tell us is how often Hispanic applicants perceive this treatment, or which subgroups perceive it most, since testers are trained observers rather than people navigating the market on their own behalf.

Employment and Job Applications

The employment literature distinguishes between discrimination in hiring and discrimination on the job, and the evidence for each differs. On hiring, field experiments provide the strongest evidence available. Pager and Western (2012) synthesize a body of correspondence and in-person audit studies showing that Hispanic applicants receive systematically fewer callbacks than White applicants with identical credentials. The most

striking result comes from Pager et al. (2009), who found that in low-wage entry-level labor markets, Hispanic applicants with no criminal record received callbacks at rates comparable to White applicants who disclosed a felony conviction. This finding is important because it establishes that an ethnic penalty in hiring can be large enough to offset a signal that employers treat as strongly disqualifying. Discrimination within the workplace, by contrast, is harder to establish experimentally and has been studied largely through self-reports. Jones et al. (2016) show in a meta-analysis that subtle forms of workplace discrimination are associated with outcomes at least as adverse as overt forms, which suggests that measures capturing only explicit incidents will systematically understate the burden employees carry.

Policing

Disparities in police contact are among the most extensively documented in American social science, and among the most contested in interpretation. Hispanic individuals are disproportionately stopped, questioned, and searched relative to their share of the population, and these disparities persist in many analyses after adjustment for location and offense rates (Andrade et al., 2021). The psychological consequences extend beyond those directly stopped: anticipation of police contact shapes routine decisions about where to drive, when to be outdoors, and whether to report victimization. This makes policing distinctive among the seven domains studied here. A person can, at some cost, avoid a hostile retailer or a discriminatory landlord. Police contact is not avoidable in the same way, and the consequences of an adverse encounter are more severe. For Hispanic residents in jurisdictions where local law enforcement cooperates with federal immigration authorities, an ordinary traffic stop carries risks that have no analogue in the other domains, and this holds regardless of the individual's own citizenship status.

Retail and Consumer Settings

Consumer discrimination has received far less research attention than bias in employment or housing, despite how often people interact in retail settings. Dovidio et al. (2010) found that Hispanic shoppers face more frequent surveillance, additional requests for identification, and harsher treatment than White shoppers in similar retail transactions. Retail spaces are an important area of study because access depends only on a person's ability to pay. When individuals face mistreatment in spaces that are supposed to be open to everyone, it sends a clear message about who is viewed as belonging in public life. In addition, while a single unfair retail encounter may seem minor on its own, these interactions happen so often that they can add up to a significant portion of a person's overall experience with bias.

Public Assistance and Social Services

Access to public benefits depends not only on formal eligibility, but on the discretionary choices of the street-level bureaucrats who process applications and enforce program rules (Lipsky, 2010). This represents a distinct institutional environment from private market domains. Where employers or landlords are private actors declining a commercial transaction, social service staff are public agents mediating access to statutory entitlements that individuals are legally qualified to receive.

For Hispanic adults, differential treatment in this domain often operates through administrative friction and discretionary burdens rather than explicit denials. Empirical evidence shows that Hispanic applicants experience disproportionate delays, language access barriers, and heightened demands for documentation compared to non-Hispanic White

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applicants when seeking public assistance (Pratt & Hahn, 2021). Because frontline caseworkers exercise substantial latitude in interpreting compliance, unreturned phone calls, confusing instructions, and unhelpful interactions effectively convert a formal legal right into a conditional one—creating a pattern of exclusion that is largely invisible to external oversight.

Health Consequences and Cumulative Burden

Across domains, the health literature converges on the finding that perceived discrimination is associated with worse mental and physical health. Pascoe and Smart Richman (2009) established this association meta-analytically across a wide range of populations and outcomes. Among Hispanic adults specifically, perceived discrimination has been linked to anxiety, depressive symptoms, and substance use (Brenes, 2019; Cano, 2020; Zvolensky et al., 2022), and Cano (2020) found that the association with alcohol use disorder varies with English proficiency, again implicating language as a moderator rather than merely a confounder. At the population level, Elias and Paradies (2016) and Wright et al. (2015) have estimated the economic costs of discrimination-related morbidity, and Yetsenga et al. (2024) extend this accounting to appearance-based discrimination. Devakumar et al. (2020) and Gulliford (2019) argue on this basis that racism should be treated as a public health exposure in its own right rather than as a background social condition.

Gaps in Existing Evidence

Three limitations occur across this literature. First, the great majority of studies examine a single domain. This is understandable given data constraints, but it precludes any comparison of effect magnitudes across settings within a common sample and specification. Second, many self-report studies rely on convenience samples, single localities, or surveys with low response rates, limiting generalizability. Third, and most consequentially for the present study, the multi-domain analyses that do exist have been statistically underpowered relative to their model complexity. Findling et al. (2019) provide the closest antecedent to this study, estimating multivariable models across several discrimination types for Hispanic and non-Hispanic White respondents within a single survey. However, their models include 15 to 17 explanatory variables while the number of non-Hispanic White respondents reporting discrimination is small in most domains. Under the widely used rule that logistic models require roughly ten events per predictor (Harrell et al., 1996), models of this specification are prone to overfitting, producing unstable coefficients and standard errors that do not generalize beyond the estimation sample (Zabor et al., 2022). Recent national estimates confirm that perceived everyday discrimination is both common and socially patterned among U.S. adults (Mattingly et al., 2025), which makes adequately powered multi-domain estimation more tractable than it was when the earlier studies were designed. The present study addresses these three gaps by estimating parallel models across seven domains within a single large, nationally representative, complex-survey sample.

Theoretical and Conceptual Framework

We integrate three analytical frameworks to examine perceived discrimination: racialization, language, and intersectionality.

Racialization and Belonging

Racialization theory holds that racial meaning is produced by social practices that attach significance to specific institutional spaces, rather than being an inherent trait of individuals (Omi & Winant, 2014). These shifts focus from personal attitudes to structured environments—like rental offices, retail stores, or traffic stops—that enforce distinct norms about who belongs.

For Hispanic populations, racialization operates primarily by constructing identity as foreign, a perception that persists across generations regardless of legal status. Consequently, exclusion varies by setting: policing enforces spatial control through traffic stops, housing and employment rely on gatekeeping, and retail involves surveillance. This framework yields a clear expectation: if racialization is structural, ethnic disparities will persist after controlling for socioeconomic factors and vary in size across settings based on how access is managed.

Language as an Institutional Barrier

Language serves as an institutional sorting mechanism. Standard American English is often treated as an implicit requirement for competence, causing non-English speech or accents to be viewed as deficiencies. This results in concrete barriers, such as delayed applications, unreturned inquiries, and poorer service. Ellahham (2021) documents these dynamics in healthcare, where language barriers measurably degrade care quality and patient experience.

Linguistic effects should vary by domain. English proficiency functions as a protective credential in gatekeeping settings where an agent must evaluate an applicant—such as a caseworker, clinician, or landlord. However, language offers no protection when initial judgments rely on visual appraisal, such as police traffic stops or retail surveillance, where assessments occur before any interaction. Cano (2020) supports this moderating role, showing that English proficiency alters how discrimination impacts health outcomes among Hispanic immigrants.

Intersectionality Across Settings

Intersectionality posits that race, gender, and social class do not operate as independent or additive factors, but interact to produce distinct positions of advantage and vulnerability (Crenshaw, 1989). In an empirical context, this framework explains why demographic predictors should not be expected to exert uniform effects across different institutional domains.

This yields two key expectations for our domain-specific models. First, gender restructures *where* discrimination is encountered rather than simply altering overall exposure; racialized men face heightened surveillance in police encounters, whereas racialized women frequently report greater bias in administrative and healthcare settings. Second, socioeconomic status does not function as a simple shield against marginalization. While human capital models predict that higher education insulates individuals from bias, intersectional theory recognizes that higher-status minority adults (Abreu, 2026) navigate predominantly White institutional spaces more frequently and face distinct structural barriers. Examining demographic coefficients across distinct settings directly tests whether socioeconomic and gender effects shift depending on the institutional rules of the domain.

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Methods

Data

We analyze data from the Medical Expenditure Panel Survey (MEPS) Full-Year Consolidated data file (FYC) in 2021 (Agency for Healthcare Research and Quality, 2021a). In addition to the discrimination variables, the MEPS database includes a rich set of person-level data on sociodemographic and economic characteristics, health status, and geographic region for the civilian non-institutionalized US population. The large sample size and detailed information available in MEPS allow us to control for a large set of confounders to better isolate the impact of ethnicity on discrimination and evaluate other risk factors affecting discrimination.

The analytic sample was limited to adults aged 18–64 who self-identified as Hispanic or non-Hispanic White. The MEPS data use a complex survey design including oversampling for less-representative groups, multi-round interviews, stratification, and clustering to reduce bias from the study design. The analytic sample included 9,346 valid respondents (6,409 non-Hispanic White adults and 2,937 Hispanic adults).

Variables

The Social Determinants of Health Survey (SDOH) collected in the 2021 MEPS and included in the MEPS Full-Year Consolidated data file (FYC; Agency for Healthcare Research and Quality, 2021b) provides seven types of self-reported perceived discrimination that provide the key outcome variables for our analysis. Survey respondents were asked whether they had ever perceived discrimination in the following settings: receiving healthcare, applying for housing, at work, applying for jobs, with police, when shopping, and applying for social services or public assistance.

We hypothesize that perceived discrimination will be greater for Hispanic than for non-Hispanic White respondents across the seven domains considered, though the magnitude of these relationships is likely to vary and the hypothesis may not hold in every domain. In addition, it is reasonable to expect that sociodemographic and health-related factors may also affect discrimination perceptions. The independent variables include race/ethnicity (Hispanic or non-Hispanic White; reference group, referred to hereafter as *Ref*: non-Hispanic White), gender (male or female; *Ref*: female), health insurance (any private insurance, public insurance only, uninsured; *Ref*: any private insurance), education level (less than high school, high school, some college, college, graduate school; *Ref*: high school), age group (18–24, 25–34, 35–49, 50–64; *Ref*: 35–49), income, marital status (married or not married), number of chronic conditions (these conditions are listed in the legend to Table 1 below), perceived health status (excellent, very good, good, fair, poor; *Ref*: excellent), perceived mental health status (excellent, very good, good, fair, poor; *Ref*: excellent), whether the subject was born in the US or not, whether the subject was an English speaker or not, and geographic region (Midwest, South, West, Northeast; *Ref*: Northeast).

Statistical Methods

We employed bivariate analysis with p-values from chi-square tests for categorical variables and t-tests for continuous variables to examine the distribution of study variables across the two groups and seven types of perceived discrimination by ethnicity. We estimated multivariable logistic regressions with adjustment for complex survey design, employing

weights, stratification, and clustering to obtain nationally representative estimates for Hispanic and non-Hispanic White subjects aged 18 to 64. Seven separate models were estimated, one for each type of discrimination, employing the same set of covariates.

Results

Descriptive Statistics

As shown in Table 1, Hispanic and non-Hispanic White respondents differ significantly by annual family income, resident region, marital status, education, age group, English skills, country of birth, perceived mental health, and perceived physical health. In 2021, 13% of Hispanic subjects reported family incomes greater than $150,000 and 16% less than $25,000, while 25% of non-Hispanic White participants had family incomes exceeding $150,000 with just 11% earning less than $25,000. Educational attainment is markedly lower among Hispanic respondents. In Table 1, only 15% of Hispanic adults hold college degrees and 6% achieved graduate degrees. The corresponding figures for non-Hispanic White adults are 26% and 16%, respectively. A significantly lower proportion of Hispanic respondents are married compared with non-Hispanic White respondents (47% vs. 58%, $p < .01$). Fewer Hispanic participants are English speakers (46% vs. 78%, $p < .01$), and they display a younger overall age profile.

Table 1
Descriptive Statistics of Sociodemographic and Health Characteristics Among Hispanic and Non-Hispanic White Adults, MEPS 2021

Variable	**White** (76.6%)[1]	**Hispanic** (23.4%)[1]	***p-value***[2]
Gender			.900
Female	51%	51%	
Male	49%	49%	
Insurance			<.001
Any private	82%	57%	
Public only	13%	22%	
Uninsured	5%	22%	
Annual Family Income in 2021			<.001
FAMINC21<25k	11%	16%	
FAMINC21:25k~65k	25%	38%	
FAMINC21:65k~100k	19%	20%	
FAMINC21:100k~150k	19%	14%	
FAMINC21:150K+	25%	13%	
Region			<.001
Northeast	18%	13%	
Midwest	27%	9%	
South	35%	38%	
West	20%	39%	
Married			<.001
Not married	42%	53%	
Married	58%	47%	
Education			<.001
Less than high school	8%	22%	
High school	24%	32%	
Some college	25%	24%	
College	26%	15%	
Graduate school	16%	6%	

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Table 1

Continued

Variable	White (76.6%)[1]	Hispanic (23.4%)[1]	*p-value*[2]
Age			<.001
18~24	11%	16%	
25~34	21%	26%	
35~49	31%	36%	
50~64	38%	22%	
English			<.001
Non-English User	22%	54%	
English User	78%	46%	
Born in USA			<.001
No: not born in the USA	5%	48%	
Yes: born in the USA	95%	52%	
Number of Chronic Conditions[3]	1.32 (1.44)	0.86 (1.18)	<.001
Perceived Health			.006
Perceived excellent health	20%	20%	
Perceived very good health	44%	39%	
Perceived good health	27%	31%	
Perceived fair health	7%	8%	
Perceived poor health	1%	1%	
Perceived Mental Health			.011
Perceived excellent mental health	21%	26%	
Perceived very good mental health	43%	39%	
Perceived good mental health	28%	27%	
Perceived fair mental health	7%	7%	
Perceived poor mental health	1%	1%	
Have Usual Source of Care			<.001
Refuse/Don't know	2%	3%	
No	26%	42%	
Yes	72%	55%	

Note. [1]%; Mean (SD); [2]Pearson's χ^2: Rao & Scott adjustment; design-based Kruskal–Wallis test; [3]Chronic conditions: high blood pressure (multiple diagnosis), high cholesterol, cancer (any type), diabetes, joint pain, heart disease (any type), stroke, emphysema, arthritis, asthma, and chronic bronchitis.

Bivariable Analysis

Table 2 indicates that Hispanic adults perceived statistically significantly more discrimination in five scenarios: in healthcare, at the store (shopping), with police, applying for housing, and applying for social services. The largest disparities are in terms of in-store discrimination and police discrimination. The prevalence of experiencing police discrimination among Hispanic adults is twice that observed among non-Hispanic White adults (12% *vs*. 6%, $p < .01$). For perceived discrimination at stores, Hispanic adults display more than twice the prevalence of experiencing discrimination compared to non-Hispanic White adults (19% *vs*. 8%, $p < .01$). Hispanic adults also perceived significantly more discrimination in housing (8% *vs*. 4%, $p < .01$) and when applying for social services (8% *vs*. 5%, $p < .01$). Finally, Hispanic adults experience moderately more discrimination in healthcare (9% *vs*. 7%, $p = .037$).

Table 2

Bivariable Analysis of the Prevalence of Perceived Discrimination by Setting Among Hispanic and Non-Hispanic White Adults, MEPS 2021

Variable	White (76.6%)[1]	Hispanic (23.4%)[1]	*p-value*[2]
Healthcare Discrimination	7%	9%	.037
Workplace Discrimination	15%	16%	.400
Applying Job Discrimination	12%	12%	.600
Housing Discrimination	4%	8%	<.001
Police Discrimination	6%	12%	<.001
Social Services Discrimination	5%	8%	<.001
At Store Discrimination	8%	19%	<.001

Note. [1]%; [2]Pearson's χ^2: Rao & Scott adjustment

Domain-Specific Multivariable Findings

The seven adjusted models in Table 3 do not behave uniformly. Hispanic ethnicity is an independent predictor of perceived discrimination in four of the seven domains, so the hypothesis stated above is supported in four settings and not in the remaining three. The largest effect appears in retail settings, where Hispanic respondents have nearly three times the adjusted odds of reporting discrimination when shopping (*OR* = 2.97, 95% CI [2.33, 3.79], $p < .01$). Police encounters follow (*OR* = 2.02, 95% CI [1.48, 2.76], $p < .01$), then housing applications (*OR* = 1.48, 95% CI [1.05, 2.09], $p < .05$) and the workplace (*OR* = 1.28, 95% CI [1.02, 1.61], $p < .05$). In the remaining three domains the ethnic coefficient is positive but the confidence interval includes unity: healthcare (*OR* = 1.14, 95% CI [0.84, 1.56]), job applications (*OR* = 1.21, 95% CI [0.92, 1.58]), and social services (*OR* = 1.22, 95% CI [0.92, 1.62]). It is worth noting that the bivariate results in Table 2 showed significant Hispanic–White differences in healthcare and social services as well; those differences do not survive adjustment, which indicates that they are attributable to the sociodemographic and health composition of the two groups rather than to ethnicity operating independently.

Table 3

Multivariable Logistic Regression Analysis of Perceived Discrimination Across Seven Settings Among Hispanic and Non-Hispanic White Adults, MEPS 2021

Variable	Healthcare	Work	Applying for a job	Housing	Shopping	Police	Social Services
Hispanic (Ref: White)	1.14 (0.84, 1.56)	1.28 * (1.02, 1.61)	1.21 (0.92, 1.58)	1.48 * (1.05, 2.09)	2.97 ** (2.33, 3.79)	2.02 ** (1.48, 2.76)	1.22 (0.92, 1.62)
Male (Ref: Female)	0.49 ** (0.41, 0.6)	0.52 ** (0.45, 0.62)	0.92 (0.79, 1.08)	0.92 (0.74, 1.15)	0.78 ** (0.66, 0.93)	1.26 ** (1.07, 1.5)	0.89 (0.72, 1.09)
Insurance (Ref: Private)							
Public only	1.53 ** (1.19, 1.97)	0.91 (0.74, 1.13)	1.31 * (1.04, 1.64)	1.77 ** (1.27, 2.46)	0.95 (0.76, 1.2)	1.39 * (1.05, 1.86)	1.57 ** (1.2, 2.06)
Uninsured	1.32 (0.91, 1.9)	0.99 (0.74, 1.32)	1.19 (0.88, 1.6)	1.52 (0.95, 2.43)	0.92 (0.66, 1.27)	1.38 (0.94, 2.01)	0.97 (0.64, 1.47)

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Table 3

Continued

Variable	Healthcare	Work	Applying for a job	Housing	Shopping	Police	Social Services
Family Income (Ref: <25k)							
Family income 25k~65k	0.92 (0.69, 1.23)	1.23 (0.97, 1.56)	0.87 (0.69, 1.08)	0.91 (0.65, 1.27)	1.05 (0.82, 1.36)	0.89 (0.66, 1.2)	0.84 (0.65, 1.09)
Family income 65k~100k	1.05 (0.77, 1.43)	1.15 (0.87, 1.52)	0.92 (0.69, 1.23)	1.01 (0.69, 1.48)	1.19 (0.89, 1.6)	0.74 (0.53, 1.04)	0.75 (0.52, 1.08)
Family income 100k~150k	0.81 (0.52, 1.28)	1.30 (0.94, 1.79)	0.79 (0.58, 1.07)	0.75 (0.48, 1.17)	1.14 (0.79, 1.65)	0.63 * (0.42, 0.95)	0.56 ** (0.37, 0.85)
Family income 150K+	0.58 * (0.38, 0.88)	1.08 (0.81, 1.45)	0.72 (0.51, 1.01)	0.61 * (0.39, 0.95)	0.99 (0.7, 1.41)	0.81 (0.55, 1.19)	0.29 ** (0.17, 0.5)
Region (Ref: Northeast)							
Midwest	0.95 (0.68, 1.33)	1.10 (0.84, 1.43)	1.21 (0.92, 1.59)	1.03 (0.68, 1.56)	1.33 (0.95, 1.88)	0.74 (0.52, 1.06)	1.29 (0.89, 1.87)
South	1.32 (0.97, 1.79)	1.20 (0.94, 1.53)	1.48 ** (1.14, 1.91)	1.50 * (1.03, 2.19)	1.66 ** (1.26, 2.19)	0.98 (0.71, 1.36)	1.51 * (1.07, 2.14)
West	1.48 * (1.05, 2.08)	1.32 * (1.01, 1.71)	1.56 ** (1.16, 2.09)	1.64 ** (1.13, 2.38)	1.8 ** (1.35, 2.41)	1.14 (0.81, 1.59)	1.36 (0.91, 2.02)
Married (Ref: Not married)	1.03 (0.84, 1.27)	0.86 (0.73, 1.02)	0.99 (0.82, 1.2)	0.98 (0.76, 1.26)	0.89 (0.73, 1.08)	0.68 ** (0.53, 0.88)	1 (0.77, 1.28)
Education (Ref: High school)							
Less than high school	0.85 (0.6, 1.21)	0.62 ** (0.47, 0.82)	0.68 * (0.5, 0.92)	0.90 (0.63, 1.28)	0.84 (0.61, 1.15)	0.63 ** (0.45, 0.88)	0.73 * (0.54, 0.98)
Some college	1.11 (0.85, 1.45)	1.16 (0.94, 1.43)	1.23 * (1.01, 1.51)	1.24 (0.91, 1.69)	1.36 ** (1.09, 1.71)	0.89 (0.69, 1.15)	1.12 (0.88, 1.43)
College	1.19 (0.87, 1.61)	1.31 * (1.04, 1.64)	1.47 ** (1.14, 1.9)	0.82 (0.57, 1.18)	1.17 (0.91, 1.49)	0.73 (0.53, 1.01)	0.62 ** (0.45, 0.85)
Graduate school	1.77 ** (1.24, 2.53)	1.6 ** (1.25, 2.05)	1.99 ** (1.53, 2.61)	0.88 (0.56, 1.38)	1.56 ** (1.16, 2.11)	1.09 (0.81, 1.48)	0.55 ** (0.35, 0.84)
Age							
18~24	0.49 ** (0.3, 0.8)	0.63 ** (0.45, 0.89)	0.57 ** (0.4, 0.81)	0.39 ** (0.24, 0.62)	0.63 ** (0.45, 0.88)	0.36 ** (0.24, 0.53)	0.33 ** (0.21, 0.54)

Table 3
Continued

Variable	Healthcare	Work	Applying for a job	Housing	Shopping	Police	Social Services
25~34	0.92 (0.7, 1.21)	0.92 (0.74, 1.13)	0.83 (0.65, 1.05)	1.24 (0.93, 1.66)	0.96 (0.77, 1.19)	0.93 (0.72, 1.2)	0.66 ** (0.49, 0.89)
50~64	0.57 ** (0.46, 0.71)	0.86 (0.72, 1.03)	0.86 (0.7, 1.05)	0.64 ** (0.47, 0.88)	0.64 ** (0.51, 0.79)	0.6 ** (0.46, 0.77)	0.63 ** (0.49, 0.81)
Number of chronic conditions	1.16 ** (1.08, 1.25)	1.13 ** (1.07, 1.2)	1.2 ** (1.12, 1.27)	1.21 ** (1.11, 1.33)	1.13 ** (1.05, 1.23)	1.08 (0.99, 1.17)	1.15 ** (1.06, 1.26)
English users (Ref: Not English user)	0.74 * (0.58, 0.93)	0.99 (0.82, 1.2)	1.05 (0.85, 1.29)	0.66 ** (0.51, 0.86)	1 (0.81, 1.23)	0.81 (0.65, 1.01)	0.74 * (0.56, 0.98)
Born in USA (Ref: Not born in USA)	1.11 (0.8, 1.56)	1.05 (0.81, 1.38)	0.97 (0.73, 1.28)	0.93 (0.65, 1.32)	1.2 (0.9, 1.6)	1.44 * (1.01, 2.04)	0.82 (0.59, 1.15)
Perceived Health Status (Ref: Perceived excellent health)							
Perceived very good health	0.83 (0.56, 1.21)	0.88 (0.68, 1.15)	0.95 (0.73, 1.24)	1 (0.67, 1.49)	0.87 (0.64, 1.17)	1 (0.69, 1.43)	1.1 (0.78, 1.55)
Perceived good health	1.04 (0.69, 1.56)	1.02 (0.76, 1.36)	1.11 (0.82, 1.51)	0.95 (0.62, 1.46)	1.03 (0.73, 1.46)	1.15 (0.79, 1.68)	1.32 (0.88, 2)
Perceived fair health	1.05 (0.61, 1.8)	0.92 (0.64, 1.33)	0.86 (0.59, 1.27)	0.8 (0.46, 1.39)	1.18 (0.75, 1.84)	1.21 (0.73, 2.02)	1.61 (0.96, 2.7)
Perceived poor health	1.4 (0.72, 2.75)	1.2 (0.62, 2.3)	1.06 (0.54, 2.06)	1.33 (0.55, 3.22)	1.85 (0.9, 3.8)	2.39 * (1.16, 4.94)	2.28 * (1.14, 4.56)
Perceived Mental Health Status (Ref: Perceived excellent mental health)							
Perceived very good mental health	1.52 * (1.09, 2.11)	1.35 * (1.03, 1.76)	1.13 (0.88, 1.46)	1.12 (0.79, 1.59)	1.17 (0.85, 1.6)	1.1 (0.77, 1.57)	1.06 (0.77, 1.48)
Perceived good mental health	1.67 ** (1.18, 2.36)	1.77 ** (1.32, 2.36)	1.55 ** (1.19, 2.02)	2.14 ** (1.4, 3.25)	1.33 (0.94, 1.88)	1.3 (0.89, 1.92)	1.42 (0.98, 2.07)
Perceived fair mental health	2.4 ** (1.59, 3.63)	2.09 ** (1.48, 2.95)	1.87 ** (1.33, 2.63)	2.42 ** (1.5, 3.9)	1.78 ** (1.23, 2.57)	1.69 * (1.02, 2.8)	1.34 (0.87, 2.07)
Perceived poor mental health	4.55 ** (2.3, 9.01)	3.98 ** (2.06, 7.7)	2.74 ** (1.42, 5.3)	2.86 * (1.18, 6.95)	1.95 (0.83, 4.58)	3.25 ** (1.79, 5.92)	1.44 (0.66, 3.13)

Note. *$p \leq .05$. **$p \leq .01$.

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Chronic conditions: high blood pressure (multiple diagnosis), high cholesterol, cancer (any type), diabetes, joint pain, heart disease (any type), stroke, emphysema, arthritis, asthma, and chronic bronchitis.

Gender does not simply increase or decrease discrimination—it shifts the specific settings where it happens. Men report significantly lower odds of discrimination in healthcare (*OR* = 0.49, 95% CI [0.41, 0.60], $p < .01$), at work (*OR* = 0.52, 95% CI [0.45, 0.62], $p < .01$), and while shopping (*OR* = 0.78, 95% CI [0.66, 0.93], $p < .01$), but significantly higher odds in encounters with police (*OR* = 1.26, 95% CI [1.07, 1.50], $p < .01$). This setting-specific reversal supports the intersectional premise that demographic characteristics interact with institutional rules.

The education gradient runs counter to human capital predictions. Relative to high school graduates, respondents with graduate degrees report higher adjusted odds of discrimination in healthcare (*OR* = 1.77, 95% CI [1.24, 2.53], $p < .01$), at work (*OR* = 1.60, 95% CI [1.25, 2.05], $p < .01$), applying for jobs (*OR* = 1.99, 95% CI [1.53, 2.61], $p < .01$), and shopping (*OR* = 1.56, 95% CI [1.16, 2.11], $p < .01$). Conversely, respondents with less than a high school education report lower odds at work (*OR* = 0.62, 95% CI [0.47, 0.82]), in job applications (*OR* = 0.68, 95% CI [0.50, 0.92]), with police (*OR* = 0.63, 95% CI [0.45, 0.88]), and in social services (*OR* = 0.73, 95% CI [0.54, 0.98]). Social services are the sole domain that inverts this positive gradient: both college (*OR* = 0.62, 95% CI [0.45, 0.85]) and graduate-educated respondents (*OR* = 0.55, 95% CI [0.35, 0.84]) report lower odds, consistent with lower utilization of means-tested assistance. These patterns reflect either greater exposure to predominantly White institutional environments or heightened recognition of subtle bias; both undercut the assumption that socioeconomic ascent is uniformly protective.

Income protections are domain-specific. High-income respondents (family income ≥ $150,000) report lower odds of discrimination in healthcare (*OR* = 0.58, 95% CI [0.38, 0.88], $p < .05$), housing (*OR* = 0.61, 95% CI [0.39, 0.95], $p < .05$), and social services (*OR* = 0.29, 95% CI [0.17, 0.50], $p < .01$). However, income provides no significant protection in retail (*OR* = 0.99), at work (*OR* = 1.08), or in job applications. Income buys distance from resource-rationing institutions, but does not prevent visual profiling in commercial or workplace spaces.

Insurance status shows broader associations with bias than income. Compared to those with private insurance, respondents with public insurance only face elevated odds in five domains: healthcare (*OR* = 1.53, 95% CI [1.19, 1.97], $p < .01$), housing (*OR* = 1.77, 95% CI [1.27, 2.46], $p < .01$), social services (*OR* = 1.57, 95% CI [1.20, 2.06], $p < .01$), policing (*OR* = 1.39, 95% CI [1.05, 1.86], $p < .05$), and job applications (*OR* = 1.31, 95% CI [1.04, 1.64], $p < .05$). Uninsured respondents do not differ significantly from the privately insured. Marital status is significant in only one setting: married respondents report lower odds with police (*OR* = 0.68, 95% CI [0.53, 0.88], $p < .01$).

English language use is protective specifically where gatekeepers evaluate applicants, reducing odds in healthcare (*OR* = 0.74, 95% CI [0.58, 0.93], $p < .05$), housing (*OR* = 0.66, 95% CI [0.51, 0.86], $p < .01$), and social services (*OR* = 0.74, 95% CI [0.56, 0.98], $p < .05$). In contrast, English use is null in retail (*OR* = 1.00) and statistically insignificant in policing (*OR* = 0.81, 95% CI [0.65, 1.01]). Native U.S. birth is unrelated to perceived bias in six domains, but increases odds in policing (*OR* = 1.44, 95% CI [1.01, 2.04], $p < .05$). Linguistic facility and generational assimilation mitigate bias in discretionary evaluations, but offer no protection against visual appraisal.

Health status correlates broadly with perceived bias. Each additional chronic condition increases odds in six settings (*OR*s = ~~1.08–1.21~~1.13–1.21, $p < .01$, except policing). Poor mental health exhibits steep associations across domains, including healthcare (*OR* = 4.55),

employment (*OR* = 3.98), policing (*OR* = 3.25), housing (*OR* = 2.86), and job applications (*OR* = 2.74), with fair mental health showing moderately elevated odds across six domains.

Finally, age and geography exert strong independent effects. Younger adults aged 18–24 report lower cumulative lifetime odds across all domains (*OR*s = 0.33–0.63), largely reflecting shorter exposure time. Regionally, relative to the Northeast, living in the West elevates odds in five domains, and living in the South increases odds in four, confirming that geographic context influences institutional exposure independent of individual characteristics.

Discussion

This study evaluates how broader patterns of systemic exclusion translate into personal, daily experiences of discrimination for Hispanic adults in the United States. By pairing social and legal theory with representative data from the 2021 MEPS, we analyze seven distinct areas of daily life to map where these barriers to full civic belonging occur.

Our multivariable results reveal a highly segmented landscape of exclusion. When adjusting for full sociodemographic, health, and economic covariates, Hispanic ethnicity remains a strong predictor of perceived discrimination in four separate domains: shopping (*OR* = 2.97), interactions with police (*OR* = 2.02), housing applications (*OR* = 1.48), and within the workplace (*OR* = 1.28). These results support our structural racialization framework, indicating that the spaces of everyday commerce, housing, and labor continue to operate as racialized zones where Hispanic identity triggers conditional belonging or outright exclusion.

Contextualizing Findings

Our results expand upon and contrast with foundational discrimination research in several significant respects. While early field experiments (e.g., Bertrand & Duflo, 2017; Pager & Western, 2012) emphasize objective, direct gatekeeping metrics in employment and housing, our subjective metrics demonstrate that the psychological and emotional burden of perceived discrimination extends into ordinary commercial transactions such as shopping. The pronounced retail disparity found here (*OR* = 2.97) aligns with Dovidio et al. (2010), who observed that Hispanic shoppers face heightened institutional surveillance and conditional respect in commercial settings.

In contrast, the lack of statistically significant independent ethnic effects in our multivariable healthcare models (*OR* = 1.14, $p > .05$) runs counter to a segment of public health literature that alleges sweeping ethnic discrimination in medical care. However, our data are consistent with language operating as a mechanism in this domain, although we did not test mediation formally. English users exhibit significantly lower odds of healthcare discrimination (*OR* = 0.74, $p < .05$) and social service barriers (*OR* = 0.74, $p < .05$) compared to non-English users, consistent with Ellahham (2021) and Cano (2020), who position standard English use as an institutional prerequisite for healthcare safety and administrative respect.

Furthermore, our intersectional analysis uncovers a notable paradox regarding education and social class. Rather than serving as a protective shield, higher educational attainment, and graduate-level education in particular, elevates the odds of perceiving discrimination across healthcare, work, job applications, and shopping. This pattern is consistent with intersectional and critical ethnic theories: highly educated minority individuals frequently face greater exposure to institutional glass ceilings while simultaneously possessing a heightened awareness and vocabulary to identify subtle, systemic biases. This contrasts sharply with traditional human capital models, which assume that upward mobility and socio-economic integration uniformly protect individuals from marginalization.

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The pattern we find is not unique to the United States. Research on North African and Middle Eastern migrants in Western Europe reports the same barriers in housing, employment, and policing, and finds that people who are not White and do not speak the national language as natives are treated as foreigners regardless of citizenship or how long they have lived there (European Union Agency for Fundamental Rights, 2024; Lentin, 2020). That two very different contexts produce similar results points to a common cause: labor markets that sort workers by ethnicity and language.

Gendered Differences by Context

The gender findings provide compelling support for an intersectional framework by illustrating how risk varies across settings. Men in our sample are roughly half as likely as women to report discrimination in healthcare (*OR* = 0.49) and at work (*OR* = 0.52), and less likely while shopping (*OR* = 0.78)—yet significantly more likely to report it during police encounters (*OR* = 1.26). Gender does not dictate the total amount of discrimination a person faces so much as the specific setting in which it occurs.

Studies that rely on a single composite discrimination index collapse these setting-specific dynamics into an overall summary score. When opposing coefficients across domains are combined, the setting-specific effects cancel each other out, giving the impression that gender plays a minimal role. Disaggregating by domain reveals two distinct patterns of institutional exposure and underscores Crenshaw's (1989) core insight that demographic factors interact directly with context.

Limitations

Several limitations qualify these findings. The data are cross-sectional, so the associations reported here cannot establish causal direction. The outcome measures are self-reported and ask about lifetime experience, which introduces recall bias and makes the age gradient partly an artifact of exposure duration rather than a substantive finding. Perceived discrimination is also not equivalent to discriminatory behavior; it captures the subjective burden of differential treatment, which is the outcome of interest here but is not interchangeable with the objective incidence that audit designs measure. The seven domains, while broader than in prior work, are not exhaustive, omitting education, financial services, and public accommodation. Finally, while MEPS provides detailed national origin subcategories (such as Mexican, Puerto Rican, Cuban, and Central or South American), we aggregated these subgroups into a single Hispanic category to maintain adequate statistical power across all seven setting-specific logistic models. Consequently, our estimates represent average effects across a culturally and demographically heterogeneous group whose individual experiences with racialization may vary by subgroup origin.

Policy and Institutional Implications

To address the domain-specific disparities identified across these settings, policymakers and institutional administrators can consider several targeted strategies:

- Language Access and Administrative Equity: Because English proficiency functions as an institutional credential in healthcare and social services, federal and state agencies could strengthen Title VI compliance. Enhancing support for certified medical interpreters, expanding bilingual caseworker

capacity in high-density areas, and standardizing application protocols can reduce discretionary administrative friction.

- Civil Rights Monitoring in Consumer and Housing Markets: Disparities in retail surveillance and housing applications suggest a role for expanded paired-testing and monitoring. Standardizing identification requirements in retail settings and improving transparency in property management leasing procedures can help limit subjective gatekeeping.
- Independent Oversight in Public Safety: Given elevated reports of bias during police stops among Hispanic adults and among men, public safety agencies could improve data transparency regarding traffic and pedestrian stops. Expanding independent civilian review and regular monitoring of stop data can help ensure consistent accountability.
- Integrated Community Health Supports: The strong cross-sectional association between mental health distress and perceived discrimination suggests a need for accessible, community-based support. Expanding trauma-informed mental health resources within community health centers and workplace wellness programs can help address the psychological impact of chronic exposure to unfair treatment.

Relevance Beyond the United States

Our results point to a distinction that should apply well beyond the United States. In some settings an official review a person before deciding — a clinician taking a history, a caseworker determining eligibility — and speaking the language fluently helps, as it does in our healthcare, housing, and social services models. In others the judgment is made on sight, before any conversation: a shopper followed through a store, a driver signaled to pull over. Fluency arrives too late, and in our data, it offers no protection in retail or policing. European research on migrant populations finds the same division across housing, employment, and policing (European Union Agency for Fundamental Rights, 2024; Lentin, 2020).

Conclusion

This study demonstrates that discrimination against Hispanic adults in the United States does not operate as a single, uniform problem. Instead, bias varies significantly by setting—from subtle gatekeeping in healthcare and public assistance to visual profiling in retail stores and traffic stops. Because the drivers of bias differ across these settings, generic policy solutions and summary measures obscure how discrimination actually happens. Evaluating institutional settings independently allows researchers and policymakers to match specific solutions to specific problems.

This multi-domain approach highlights three key insights for research and policy:

- Language barriers depend on the setting: English proficiency helps protect against bias in administrative encounters where staff review applications or provide services (such as housing or healthcare). However, language offers no protection during police stops or while shopping, where initial judgments are based entirely on visual appearance.
- Demographic factors do not offer blanket protection: The impact of gender and education depends heavily on the setting. Men report lower discrimination in healthcare and workplaces than women, but significantly higher discrimination in police encounters. Similarly, higher education does not shield individuals from bias; highly educated adults report higher

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discrimination in most settings, likely reflecting greater exposure to predominantly White institutional environments and a sharper recognition of subtle unfair treatment.

- Policy solutions must match the setting: Language access programs address administrative barriers, while independent monitoring and data collection are needed to address appearance-based profiling.

European research on migrant populations describes the same division, which suggests it is not peculiar to the United States. Comparative work would do better to ask which institutional arrangements produce it than to compare overall rates between countries.

Future research can build on these findings by using longitudinal data to track how discrimination impacts health over time, and by examining specific national origin subgroups to understand differences within the broader Hispanic population.

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Ethics Statement

This study analyzed the 2021 Medical Expenditure Panel Survey Full-Year Consolidated file, a de-identified, publicly available public-use data set released by the Agency for Healthcare Research and Quality (2021a). The analysis involved no interaction or intervention with human participants, and no identifiable private information was accessed or obtainable. The study therefore does not constitute human subjects research as defined in 45 CFR 46.102(e), and was exempt from Institutional Review Board review. No attempt was made to re-identify respondents, and all analyses were conducted in accordance with the MEPS data use agreement. Because the analysis used existing de-identified secondary data, informed consent was not required.

Data Availability Statement

The data-analyzed in this study are publicly available from the Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, at https://meps.ahrq.gov/.

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The authors have no acknowledgments to declare.

Conflicts of Interest

The authors declare no conflicts of interest.

Authors' Contributions

Chunxi Guo organized and analyzed the MEPS data, prepared the tables and edited the manuscript. Khadeja Kausar contributed to the theoretical framework and reviewed and edited the manuscript. John A. Rizzo conceptualized the study, supervised the project and prepared the first draft of the manuscript. All authors read and approved the final manuscript.

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Notes on Contributors

Chunxi Guo is a PhD student in the Population Health and Clinical Outcomes Research program at Stony Brook University. Her research focuses on applied economics, racial and ethnic disparities, pharmaceutical expenditure, unequal access to healthcare, healthcare utilization, healthcare costs, and advanced statistical methods.

Khadeja Kausar is a PhD student at Stony Brook University, Director of Business Intelligence and Value-Based Management Analytics, at Maimonides Medical Center, and Adjunct Professor at Fordham University. Her research examines health services, healthcare quality, health equity, and healthcare delivery, with a focus on advance care planning, age-friendly health systems, caregiver support, and health disparities. She has published in journals including the American Journal of Hospice and Palliative Medicine and Journal of General Internal Medicine.

John A. Rizzo is a Professor in the Department of Family, Population, and Preventive Medicine at Stony Brook University. His research examines health economics with a focus on racial and ethnic disparities, alongside physician, hospital, and pharmaceutical market dynamics. He specializes in applied economics, healthcare market competition, pharmaceutical economics, cost-effectiveness analysis, and advanced statistical methods for outcomes research. His work is widely published in top-tier economics and health services research journals.

ORCID

Chunxi Guo, https://orcid.org/0009-0005-6586-0911
Khadeja Kausar, https://orcid.org/0000-0001-7152-968X
John A. Rizzo, https://orcid.org/0000-0002-0366- 8503