

The Ostrich, the Albatross, and Public Health: An Ecosocial Perspective—Or Why an Explicit Focus on Health Consequences of Discrimination and Deprivation Is Vital for Good Science and Public Health Practice

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Concern for social inequalities in health in the United States is increasingly becoming part of the mainstream public health and health research agenda. Responding to organized efforts within and outside the health sector, the Department of Health and Human Services (DHHS) is supporting programs dedicated to eliminating social disparities in health,¹ and within DHHS, the National Institutes of Health (NIH) are supporting research into health disparities.² The NIH Office of Research on Women's Health³ (founded in 1990) and the new National Center on Minority Health and Health Disparities⁴ (including socioeconomic disparities) are, for example, focusing attention on multiple health outcomes in relation to specified social determinants, rather than parsing out ailments solely by body parts. At issue are ways in which population patterns of health, disease, and well-being, from conception to death, reflect societal conditions, including social inequality, across the lifecourse.^{5,6}

Challenges to conducting work on social disparities in health are numerous—partly because the research requires development of new theories and methods, but also because it has encountered political opposition. Addressing the scientific challenges, new theoretical work is underway to develop explicit frameworks, such as ecosocial theory, that systematically conjoin biological and social analyses of population health in order to explain how individuals embody societal conditions—and why social inequalities in health exist.⁵⁻⁷ In terms of methodology, lively debates concern how best to measure—for purposes of both monitoring and etiologic research—the social constructs of socioeconomic position, race/ethnicity, gender, and sexual identity, as well as the experiences of and buffers to the types of



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discrimination that in part define such social groups.⁵⁻
¹⁴ Potentially stymieing these scientific endeavors, however, is the charge that work on social inequalities in health is “ideologically” motivated, biased, and not only unscientific but unworthy of being funded^{15,16}—as if ignoring or discounting these challenging scientific questions and centuries of evidence were somehow a “neutral” stance and good scientific practice.^{17,18}

Providing context to contemporary controversies are the past century’s debates. Among the key themes of 20th century research on racial/ethnic disparities in health, as pinpointed by ecosocial theory, were “accountability” and “agency”: who and what is responsible for social inequalities in health—as well as who is responsible for the research on and interventions developed to address these disparities?^{5,7} At issue was why, not whether, racial/ethnic inequalities in health existed within the United States. Thus, however debatable the racial/ethnic classifications employed,^{10,11,19} during the first decades of the 20th century it was common knowledge that groups then termed “Negroes” and American Indians, as well as immigrants from southern Europe and Jews from Eastern Europe, had poorer health than the “native” population (meaning US-born white citizens) and immigrants of Northern European ancestry.²⁰⁻²⁶ Dominant explanations—routinely expressed by the era’s leading public health professionals, in the pages of its leading public health journals—sought causes *within* the worst-afflicted groups, separately and in combination, due to their inferior “constitution,” intellect, and morals.^{19,23-26} A minority view, by contrast, located the source of social inequalities in health as inequitable race relations *between* groups, with one price of white privilege being the poorer health of the “colored” and “ethnic” populations.^{22,23}

Notably, the dominant belief in innate inferiority, far from representing crude ignorance, was in fact the accepted scientific wisdom of the times. Premised on the theoretical framework of Social Darwinism, the widely accepted view was that societal success—and failure—were but an expression of the natural law of “survival of the fittest.”^{19,27,28} This thesis received considerable boosting with publication of the greatly influential 1896 opus *Race Traits and Tendencies of the American Negro*,²⁹ written by Frederick L. Hoffman, one of the early 20th century’s leading actuaries and a key player in the development of US vital statistics systems and the health insurance industry.^{30,31} According to Hoffman, unbiased scientific analysis of the evidence amply demonstrated that “it is not in the conditions of life but in race and heredity that we find the explanation”²⁹ (p. 312) for racial/ethnic dispari-

ties in health. Article after article in the 1915 special issue of the *American Journal of Public Health* devoted to the “Negro health problem”³²⁻³⁶ likewise argued that the sickly state of the “Negro” population and the unsanitary, overcrowded conditions in which much of this population lived were due to “a want of initiative”³⁴ (p. 198). Grounds for public health action were thus “the moral obligation of a higher race to an inferior race dependent upon it; and further on the practical and selfish ground that it is impossible to protect the white people and neglect the black”³⁵ (p. 211).

Not all, however, accepted the data or theoretical frameworks employed by Hoffman and like-minded colleagues. Deploying new sociological theories along with older abolitionist arguments,^{37,38} a handful of scholars critiqued both the methods and assumptions of Social Darwinist science and offered alternative explanations for observed racial/ethnic disparities in health.^{22,23} At the cusp of the 20th century, the American Negro Academy published its first paper, a substantive “Review of Hoffman’s Race Traits and Tendencies of the American Negro,” written by Kelly Miller.^{39,40} Contesting Hoffman’s reliance on “disputed data” and his selective focus on a small proportion of “Negroes in the large cities”³⁹ (p. 35), Miller cited alternative evidence concerning the poor health status of poor whites and also recent gains in “Negro” fertility and health status. Reframing black/white inequalities in health as historically contingent, rather than inevitable, Miller thus argued that cross-sectional black/white disparities should be viewed dynamically and construed as evidence that “Negro” health lagged behind that of whites, rather than being permanently worse. Believing that these gaps could potentially be closed, Miller optimistically averred that the “discouraging facts of observation may be due to the violent upheaval of emancipation and reconstruction, and are, therefore, only temporary in their duration”³⁹ (p. 35).

Stated simply, the countervailing thesis was that failing to consider the impact of past and present *de jure* and *de facto* discrimination necessarily produced incomplete and biased understandings of population health. Similar critiques were offered by W.E.B. Du Bois in his classic 1906 treatise, *The Health and Physique of the Negro American*,⁴¹ and again in 1916 by the Assistant Surgeon General of the US Public Health Service, John W. Trask, whose comprehensive review of mortality statistics led him to conclude:

- (1) That the colored death-rates of most communities of the United States are not discouragingly high; (2) that they are undoubtedly lower than they have been in the past; (3) that they are as low as many white

population groups possessed twenty or thirty years ago; and (4) that with the economic and industrial progress of the colored population its death-rate will gradually approach nearer to that of the white population.⁴² (p. 259)

Both Du Bois⁴¹ (p. 89) and Trask⁴² (p. 258–9) also speculated that economic disparities in health were likely to rival if not exceed black/white disparities, a hypothesis not then easily tested due to an absence of socioeconomic data in readily available health records. Putting this idea to the test, however, in the 1920s and 1930s, a small body of work began to generate empirical evidence that black/white socioeconomic inequalities strongly contributed to black/white disparities in health.^{43–46} Even so, the legacy of scientific racism and its doctrine of innate inferiority and fundamental biological differences between the “races” remained strong. Among its myriad early 20th century “achievements” were: the passage of the Immigration Restriction Act of 1924 and its exclusion—on eugenic grounds—of immigrants not of Northern European ancestry;^{19,26,28} the ongoing enforcement of Jim Crow policies—including by public health and medical institutions—premised on the “one drop” rule of racial classification;^{19,23} and the conduct of the now infamous Tuskegee syphilis study, unnaturally intended to determine if the “natural history” of untreated syphilis in blacks was the same as that previously observed in whites, in light of hypothesized differences in their nervous systems.^{47,48}

Where are we now, at the start of the 21st century? On the one hand, public health researchers are still compiling evidence on—and still fiercely debating—the contributions of socioeconomic conditions, genetic traits, and cultural mores to racial/ethnic disparities in health, within and across generations. Moreover, the call is still out for the collection of more and better socioeconomic and racial/ethnic data for public health monitoring and research purposes.^{6,8,9,12,49,50} On the other hand, breaking new ground, novel investigations informed by the Civil Rights, women’s rights, and other social movements have begun to analyze the health impact of non-economic as well as economic forms of racial discrimination and the ways in which these insults can be buffered or amplified by community characteristics.^{6,49–51} The new studies, increasingly conducted by and with the active participation of members of affected groups, are drawing attention to the differential health statuses of diverse racial/ethnic “sub-groups” lumped into the crude categories of “American Indian,” “Asian,” “black,” or “Hispanic” and to observations that not all racial/ethnic health disparities follow black/white patterns of inequalities

in health. The operative assumption, now explicitly stated in federal documents, is that “race/ethnicity” is a “social-political construct” and not a scientifically based category,⁵² and that elimination of racial/ethnic disparities in health is a priority.^{1,2}

Reminiscent of earlier eras, the predictable backlash—by those whose power and privilege are called into question by the new work on social determinants of health—asserts that: (a) social inequalities in health are due to self-perpetuating cultures of dependency, commingled with personal irresponsibility plus rarely specified “gene-environment” interactions, and (b) bringing attention to social determinants of health is an unwarranted intrusion of politics into science.^{15,16}

What constitutes a professional response to these polemics? If history offers any guide, an ostrich-like stance of avoiding the realities and challenges of analyzing and eliminating social disparities in health ill serves the public’s health. To do so constitutes bad scientific practice and bad public health practice. Indeed, to continue the avian imagery, it is long past time to discard the albatross that explicit attention to discrimination and deprivation renders our science unscientific. Rather, without this focus, our understandings of population health will be deeply flawed. Confronting the challenges of monitoring, researching, and providing expertise relevant to rectifying social inequities in health will, in turn, require the utmost conceptual and methodologic rigor. Obviously, the public health profession alone cannot solve societal ills. To suggest otherwise would be hubris—and clearly absurd. It is, however, our public health mission—as aptly stated by the Institute of Medicine—to fulfill “society’s interest in assuring conditions in which people can be healthy”⁵³ (p. 7). If we do not contribute, with our public health knowledge, to the democratic discourse needed to assure conditions whereby *all* people may live healthy and dignified lives, who will?

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