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RETHINKING RACE AND ETHNICITY IN HEALTH DISPARITIES

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Introduction

Health disparities are commonly framed in terms of essential human differences rather than more accurate, albeit more complex, interactions between human physiology, geography and social forces. The use of racial and ethnic categories is more often a response to bureaucracy, politics and other structural issues than to careful analytic approaches to understanding human identity and variation.

The oft-cited OMB Directive 15, as well as other US funding agency coding requirements developed to facilitate grant tracking, along with the categorical nature of surveillance databases, scientific journal guidelines and the social processes of editorial review, together create *a priori* frames into which diverse and complex social groups are made to fit. These administrative categories do enable us to measure and monitor racial disparities as health consequences of systemic disadvantage. However, they do not elucidate the underlying causal pathways that result in worse health status for many individuals, despite assumptions made in much of the socio-behavioral research that they do.

Understanding Categorical Thinking

Anthropologists are uniquely positioned to connect the relationships between these bureaucratic policies with the various meanings of "race" or "ethnicity" as they play themselves out in everyday life, even in scientific contexts. Across the scientific and medical literature, the same terms "race" or "ethnicity" are posited interchangeably as factors in different causal frameworks: access to health services, medical outcomes, risk factors, behaviors and ancestry. They lead to the proliferation of statements such as "blacks have

higher rates of hypertension,” and the impulse to trace genetic pedigrees to map kindred susceptibility.

I recently undertook a document analysis of grant programs funded by the National Cancer Institute that support social and behavioral research to reduce cancer disparities. I am finding that socio-cultural and behavioral researchers fall back on superficial categorical labels within “race” and “ethnicity” because alternative sociocultural constructs are theoretically anemic, lack validated metrics and can rarely be compared across studies.

We know social position, poverty and systemic disenfranchisement are fundamental drivers that contribute to various disparities in health status. Factors like migration, education or employment, social support and geography further modify group identity and individual lived experience. Many of the proposals I reviewed, however, fail to address such stratification. Further, they rarely distinguish between mediating pathways, contributing factors and biological mechanisms; slippage between these concepts within single proposals was rampant. Yet these are important distinctions; if we fail to understand them analytic confusion persists, obstructing the development of theoretical frameworks leading to real public health interventions.

What Can Anthropology Contribute?

Anthropology can contribute to public health an explicit awareness of the specific, at times shifting, cultural values regarding disease prevention and control, and that there are a range of values within any population monitored by public health officials. Anthropologists track the direct effects of public health policy, and they do epidemiology, but they also seek a qualitative understanding of these variables in relation to local understandings and values and the social perspectives of policymakers and others in positions of power.

Quantitative methods, on the other hand, predispose scientists, even those in behavioral and social sciences, to think in terms of independent variables and additive linear causality. Consequently when scientists observe “interactions” involving variables labeled as “race” and “ethnicity,” they are often treated as “contaminated by confounding,” rather than meaningful data in and of themselves.

Anthropologists can help scientists studying bio-behavioral axes like psychoneuroimmunology to look beyond atomistic units of analysis to consider how these dynamics engage with the context of subjects’ lives in real times and places. While human physiology provides a common template, we still cannot approach patients or at-risk populations as brains-in-vats, ignoring the particular social environments that color how different people respond to the same health challenge. By helping scientists pay attention to these processes, we can move

the study of racial and ethnic disparities in health past description to true intervention and alleviation.

Sociocultural and medical anthropologists already contribute to how health services research improves delivery while also promoting a qualitative understanding of patients and providers as social beings in ecological contexts. For instance, my and my colleagues' ethnographic fieldwork in clinics and community hospitals, as well as experiences in chronic disease management at various academic medical centers, suggests that many healthcare organizations are not equipped to facilitate continuity of care for their patients. Fortunately, initiatives to design patient navigator programs to guide newly diagnosed patients through the labyrinth of tertiary medical care centers may offer strategic insights for improving access and delivery of care to people with complex diseases.

Addressing Social Justice

Further, recent support by funding agencies for community-based participatory research (CBPR) represents a significant advance in the social ethics of health disparities research. The full participation by community stakeholders in research to understand and reduce health disparities should encourage both theoretical and empirical studies of the role of power and knowledge in medicine and health science practice. In many cases, anthropologists' ties to local communities and to institutions of research and higher education position us to bridge these important initiatives.

Of course, new technologies and scientific knowledge should continue to seek cures and improve treatments. Anthropologists, in turn, are called to investigate those developments in theory and in application as problems for socio-cultural, even political economic, analysis. Our interrogation of universal principles has direct relevance to societal ideologies that underpin public health policy formation. People are quick to mark some differences as "cultural" in moves that deny individual agency by ignoring the reality that many people do make poor choices. At the same time, naturalizing claims that such differences are cultural can mask the structural inequities constraining those behaviors.

Assertions of difference often stand in for unexamined ideas that reflect assumptions about blame and responsibility, the locus of agency and social causality. For example, some initiatives in "cultural competency" or "cultural literacy" seem to suggest that only certain groups have "culture," and having that culture becomes the obstacle to the receipt of otherwise quality care. Culture cannot be treated as a binary variable reduced to the normal or the pathological, just as the complexity of the interactions between genes and environments rarely reduces simply to nature versus nurture.

The poor, the underserved, the under- or un-insured are groups that crosscut categories of race and ethnicity. It will take targeted interventions by

social and behavioral scientists, working with nurses, physicians and other local advocates, to reach individuals in those communities. We require more nuanced theories of human difference and social interaction to succeed. Many public health researchers lack training to understand how social stratification functions in the context of their research.

Ethically Translating Science to Practice and Policy

Empirical social science methodologies lend themselves to critical public health scholarship. For so many of us who are participant-observers in the labs, conference rooms and hallways of health science and medicine, our questions and conversations in the course of daily work inform research direction, policy decisions, even new funding strategies. We can critique the social processes of research programs by investigating the relationship between public health needs and the production of scientific knowledge, including how study design shapes the identification and constitution of groups as “at-risk,” how public health manages the politics of identity as it strengthens epidemiological science. We can interrogate the design and implementation of pragmatic interventions for particular demographic groups, and how medically-relevant differences may have been appropriated by race politics, be it racism or racialism, and reflect on the role of the research community in responding to such discourses.

Throughout American history, racial and ethnic identities have been, and remain, undeniably empowering for many individuals and communities. Furthermore, there *are* real differences in the incidence and prevalence, mortality and social burden of cancer and other adverse health conditions that exist among various population groups. It is certainly imperative to relieve suffering and ensure a fair distribution of resources wherever possible. The statistics we use to track health disparities in the US are crucial to describing the problem and directing our efforts. However, the wholesale importation of statistical categories into behavior and social science interventions masks the complexity of the interactions between human physiology and socio-cultural experience within environments in which real people live and work.

Anthropology injects a productive skepticism about how people use concepts of human difference when we speak of race and ethnicity as factors in health status or medical care. The emphasis on advances and applications of new health science technology must come with concomitant attention to equivalent problem-solving at higher and more integrative levels of analysis. This is both a domain for anthropological research itself, and a field for advocacy with the goal of furthering ethical research practice and science policy through a critical engagement with health disparities as a modern problem.

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