

Inequality, Diversity, and Health: Thoughts on “Race/Ethnicity” and “Gender”

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Race. Ethnicity. Race/ethnicity. Gender. Sex. Sexual orientation. Diversity. Identity. Multiculturalism. Difference. Variation. Inequality. Women's health. Minority health. Racism. Sexism. Homophobia. Poverty. Socioeconomic status. Social class. Underclass. Underrepresented. Underprivileged. Underserved. Disadvantaged. Marginalized. Special populations. Vulnerable populations. Acculturation. Discrimination. Social inequalities in health.

These words and phrases appear with increasing frequency—and only occasional definition—in US public health, clinical, and biomedical literature. We use them to describe and explain population patterns of health, disease, and well-being, and to develop policies and interventions to alter these patterns. Some terms, such as “minority health,” “women’s health,” “special populations,” and “disadvantaged,” have even attained official recognition. In 1985, the US Department of Health and Human Services established the Office of Minority Health, lodged under the Secretary of Health, and in 1990, the National Institutes of Health created the Office of Research on Women’s Health.¹ *Healthy People 2000*, one of the central documents guiding public health efforts in the United States, expresses concern for and structures many US health goals with reference to “special populations,” defined as “low-income groups, minority groups, and people with disabilities.”^{2(p 29)} Another federal publication, *Health of the Disadvantaged*, focuses on “those who because of race, ethnic background, sex, or economic status have been historically excluded from quality health care and entry to the health and allied professions.”^{3(p 1)} These groups are also embraced by the term “diversity,” which, in 1994, set the theme of the 122nd Annual Meeting of the American Public

Health Association: “Public Health and Diversity: Opportunities for Equity.”

But what do all of these phrases mean? And when we use them, do we all mean the same thing? Are “race” and “ethnicity” and “race/ethnicity” synonymous? Do they refer to biology, to culture, or to something else? How about “sex” and “gender”? Are they identical, overlapping, or distinct concepts? Why are some populations “special” and others not? Who are the “advantaged” implied by “disadvantaged”? And what counts as “diversity”?

These questions are not merely academic. Clarity of language matters because words can be used for good and for ill: to reveal and to obscure responsibility, to focus and to divert action. These dual uses of language are evident in US research about racial/ethnic, gender, and socioeconomic disparities in health. At issue is who and what accounts for social inequalities in health and thus what is to be done—by whom—to attain comparably good health for all.

What’s in a Word?

Despite decades of scholarship demonstrating that “race” is a powerful social, not biological, construct, born of and feeding racial oppression, scientific research continues to regard race as a biological characteristic.⁴⁻⁹ Other interpretations of race cling to notions of lifestyle and culture as principal determinants of poorer health among people of color as compared to whites, following a kind of cultural determinism as powerful as that of its biological counterpart. In both cases, social institutions and policies contributing to racial inequality remain hidden from scientific scrutiny. Where, after all, are studies of health effects of discriminatory lending practices by banks, discriminatory law enforcement practices, and racially coded attacks on public welfare programs, as well as of everyday experiences of racial discrimination at school, at work, on the street, or in public settings? Tellingly, the number of studies explicitly documenting how

discrimination can harm health remains painfully small.^{4,5}

Drawing on anthropologic and other social science literature, some health researchers have turned to the word “ethnicity” to avoid spurious biological connotations of race.^{10,11} Ambiguity nonetheless remains, for the term ethnicity has a history enmeshed in notions of race.¹²⁻¹⁵ Notably, the *American Heritage Dictionary* defines ethnic groups as “sizable groups of people sharing a common and distinctive racial, national, religious, linguistic, or cultural heritage.”¹² Extension of this term to include people of color in the United States, moreover, is a recent phenomenon that further highlights how race and ethnicity are intertwined. Before the 1960s, “ethnic” referred chiefly to not-yet-assimilated Euro-American immigrants; it did not include groups whose presence in the United States embodied histories of slavery (African Americans) and territorial conquest (Native Americans and Latinos), or non-European immigrants who could not assimilate across the color line (eg, Asian and Pacific Islanders).^{14,15} It was only in 1970 that the US census supplemented the term “race” with “ethnicity,” but used the latter solely to demarcate people of Hispanic versus non-Hispanic origin.¹⁶ Thus, despite efforts to distinguish between race and ethnicity, it remains all too easy to find scientific articles that use these terms interchangeably.¹¹

Even if limited to a strictly cultural meaning, however, the term ethnicity does not necessarily imply distinctions based on racial discrimination.^{11,14,15} Challenging increasingly common use of ethnicity as an umbrella term to refer at once to nonoppressed cultural groups and to racially oppressed groups, some researchers have begun to use the term “race/ethnicity.”^{4,16} The phrase is intended as a reminder of how ubiquitous oppressive race relations in the United States are deeply entangled with people’s cultural, and not necessarily oppressive, heritage (see sidebar). Others find race/

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ethnicity problematic. They argue that combining the two terms is confusing, that the concepts are distinct, and that race should be replaced by “racialized group,” since this phrase clarifies that such groups are not determined by innate characteristics, but forged through legal and social forms of racial subordination.¹⁷ A construct such as “racialized ethnic group” may thus provide a clearer way of speaking simultaneously about racism and cultural heritage.

As this discomfort with language about race and ethnicity suggests, attention to which terms we use matters, because they expose—and can challenge us to articulate—frameworks and assumptions that inform our work. The point, after all, is to conduct research and design programs that explicitly take into account how the public’s health is shaped by both painful histories of expropriation, conquest, slavery, and discrimination, and also rich legacies of culture, resistance, ancestry, and heritage. One step toward this goal is clearly defining terms, avoiding euphemisms, and confronting hard truths about everyday realities of racism in our society.

Similar issues bedevil work on gender and health. All too often, articles employ terms like “sex” and “gender” interchangeably, even though these words have vastly different meanings.¹⁸⁻²² “Sex” properly refers to biologic characteristics pertaining to ability to reproduce. “Gender,” by contrast, refers to a social construct regarding culture-bound conventions, roles, and behaviors for, as well as relations between, women and men and boys and girls. Thus, gender, like ethnicity, does not necessarily imply distinctions based on inequality. Even so, many gender-based distinctions are premised upon notions of innate, biologically determined differences between women and men, leading to women’s subordination to men at home, at work, and in society at large. These gendered forms of inequality can be expressed through physical and sexual violence, unequal wages for comparable jobs, restrictions on access to education, or socially sanctioned conventions about what types of jobs and roles women and girls can—and cannot—assume. We need to name and measure the health effects of these gendered inequalities.

Reluctance among health professionals

Ecosocial Definitions¹⁸

Race/ethnicity: A social, *not* biological, category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations and justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and possession of selective and arbitrary physical characteristics (eg, skin color).

Social class: A social category referring to social groups forged by interdependent economic and legal relationships, premised upon people’s structural location within the economy—as employers, employees, self-employed, and unemployed, and as owners, or not, of capital, land, or other forms of economic investments.

Sex: A biological category, defined by biological characteristics pertaining to ability to reproduce (for example, for females, the presence or not of vaginas, ovaries, uteri, and mammary glands).

Gender: A social construct regarding culture-bound conventions, roles, and behaviors for, as well as relations between, women and men and boys and girls.

Gendered expression of biology: Refers to how biologic processes influence gender roles, relations, and conditions.

Biologic expression of gender: Refers to incorporation of social experiences of gender into the body and expressed biologically, in ways that may or may not be associated with biological sex.

to engage in frank discussion about social inequality in health is also revealed by use of euphemisms that divert attention from who maintains—and benefits from—social inequality (see table). Combinations of outright political censorship and unspoken self-censorship have led some scholars to shy away from terms like “inequalities in health,” a phrase popularized by the 1980 *Black Report* on class-based disparities in health in England,²³ and replace them with seemingly “neutral” phrases like “heterogeneities”²⁴ or “variations”²⁵ in health. Although there clearly are variations in health among populations not resulting from social inequalities (eg, higher incidence of cancer among elderly as opposed to young people), to use “variations” in

lieu of “inequalities” is another matter entirely. The British government did just that, however, in the just-issued report on *Variations in Health*,²⁵ where, according to Richard Wilkinson, “the experts agreed to adopt their hosts’ view of political correctness by referring to health ‘variations’ rather than ‘inequalities.’”^{26(p 1177)} Additionally, government officials in charge of the report limited discussion to what the National Health Service and the Department of Health could do; in Wilkinson’s words, “Poverty, housing, job insecurity, the rationing of health services, and other embarrassing problems were left outside” to ensure “political safety.”^{26(p 1177)}

US government publications likewise employ euphemisms to sidestep frank

Common Euphemisms in Public Health, Clinical, and Biomedical Literature*

Euphemism	Really Means	Who and What Is Not Named by Euphemism
Variation Heterogeneity Difference Diversity	Social inequalities in health, especially regarding racial/ethnic, gender, and class disparities in health	Social and economic forces driving inequitable population distributions of health, disease, and well-being, eg, racial oppression, profit motive
Special populations Vulnerable populations Underprivileged Women and minorities	Social groups in part defined by discrimination and harmed by discrimination and/or fiscal policies producing economic deprivation	Social and economic groups who benefit from social inequalities they help produce and maintain, eg, members of racially dominant groups, men, owners and managers of financial capital, and their political representatives

* Note: some of these terms have legitimate meanings that are not euphemisms, eg, “variations” in health when referring to differential patterns not caused by social inequalities.

discussion of social inequalities in health. Examples include “special populations”^{2(p 29)} and “disadvantaged.”³ “Special populations” is particularly offensive because what, after all, is so special about being poor or marginalized or oppressed? Although the term may be intended to make visible groups rendered invisible by those in socially dominant groups (ie, whites, men, people with wealth, and people who are able-bodied, in their overlapping permutations), it provides no insight about why certain groups are special and others are not. The term “disadvantaged” likewise obscures how people with “advantage” promulgate their own privilege and structure societal distributions of deprivation. Here, as US sociologist Erik Olin Wright has cogently noted, regarding the top 1% of US households now owning 40% of the nation’s wealth and their political representatives, “powerful and privileged actors ... have an active interest in maintaining poverty. It is not just that poverty is an unfortunate consequence of their pursuit of material interests; it is an essential *condition* for the *realization* of their interests.”²⁷ Words like disadvantaged divert attention from this insight for, as Raymond Williams, a noted British scholar of society and culture, has observed, this kind of word, like underprivileged, “catches almost exactly that combination of sympathy for the victims of a social order with the conviction or unnoticed assumption that such an order will or must continue to exist.”^{14(p 324)}

Finally, consider the term “diversity.” In recent years, this word has come to occupy a prominent place in US discussions both outside and inside public health and medicine about race/ethnicity, gender, and, to a lesser degree, sexual orientation (social class typically does not appear in the discourse about diversity). The *Oxford English Dictionary* defines diversity as “the condition or quality of being diverse, different, or varied; difference, unlikeness”—with the term “unlikeness” harkening back to older meanings, including “difference, oddness, wickedness, perversity.”^{13(p 775)} To be diverse, in other words, originally was to differ or be diverted from some explicit or implicit norm.

But in current usage, the term has taken on new meanings, as words will often do when they concern key aspects

Frameworks for Health Research: Biomedical Model and Ecosocial Theory¹⁸

Biomedical Model

- Central question: How do humans, as biological organisms, become ill?
- Disease is a fundamentally biological phenomenon, to be explained in biologic terms.
- Distributions of individual-level risk factors explain disease distributions in populations.
- Intervening on individuals’ risk factors for, and the treatment of, disease is best accomplished through provision of medical services.
- The scientific method provides an objective and value-free way of obtaining knowledge about causes of disease.

Ecosocial Theory

- Central question: Who and what drives population patterns of health, disease, and well-being?
- Distributions of health, disease, and well-being express how we literally incorporate, biologically, social relations (eg, social class, race/ethnicity, gender) into our bodies.
- Social, economic, and political conditions shape distributions of determinants of health, disease, and well-being. These determinants include:
 - changing ways societies produce, distribute, and consume goods, services, and information;
 - changing ways people interact with and transform their ecologic habitat;
 - the pace of societal and ecologic change;
 - biological susceptibility (acquired and inherited).
- Intervening for the public’s health necessitates policies to reduce social and economic inequalities, to curb environmental degradation, and to increase options for individuals’ action to improve health.
- Scientific knowledge and ignorance are shaped by social positioning, technology, and ideology of people who fund and produce scientific research.

of our societies and cultures.^{14(pp 14-15)} To speak of diversity in the United States now is to talk, in coded language, about inclusion of people long excluded from positions of power and social legitimacy: people of color, women, lesbians, and gay men (in their overlapping combinations). It is to acknowledge, respectfully, their cultures, values, and contributions to the larger society, without deeming any one group “the norm.” And, more narrowly, in public health and medical terminology, a study population or neighborhood, or even a panel at an academic conference, now is described as diverse if it contains people of more than one racial/ethnic group (especially in contrast to a group that is all white) and, sometimes but not always, contains both women and men.

Attention to diversity in public health and medicine is thus an unqualified good. Or is it? Once again, what matters is how diversity is conceptualized—as a way of celebrating human imagination and possibilities or as a way of avoiding direct discussion of racism, sexism, and other forms of discrimination and injustice. Notions of scientific objectivity may make some public health and medical practitioners squeamish about using what is often construed as explicitly political terminology. The larger truth,

however, is that indirect and allegedly apolitical terminology is just as political since, by concealing how politics, economics, and ideology shape people’s lives, it serves to uphold the status quo.^{9,20,28-31}

Incorporating Social Facts: Accounting for Social Inequalities in Health

As these few examples suggest, words we use matter—because language expresses our theories, assumptions, and beliefs about how the world is and can be. Behind our words stand markedly different frameworks for understanding and guiding action to shape the public’s health. Some of these differences are summarized in the sidebar above, which juxtaposes two frameworks for understanding health: the biomedical model and ecosocial theory.^{31,32} The former emphasizes disease processes in humans construed chiefly as biologic organisms, whereas the latter asks how we literally incorporate, biologically, social relations (such as those of social class, race/ethnicity, and gender) into our bodies, thereby focusing on who and what drives population patterns of health, disease, and well-being.

As I write this commentary, Congress is awash with legislation intended to cut back, if not end, many programs that have improved public health and reduced

social disparities in health, such as Aid to Families and Dependent Children (AFDC), Head Start, Medicaid and Medicare, unemployment benefits, regulatory powers of the Environmental Protection Agency and the Occupational Safety and Health Administration, and more. Much of the rhetoric around these political changes is couched in racially coded language that suggests the working poor and unemployed (and especially poor people of color) are solely responsible for their plight. Translated to the realm of health, it is as if we are to believe that political and economic decisions about interest rates, inflation, unemployment, taxes, trade treaties, and capital investment, along with socially sanctioned patterns of racism and sexism have no influence on who gets to live how, and thus on population patterns of disease, violence, and death.

In moments such as ours, it is even more apparent why we need theoretical frameworks and sound studies that illuminate causes of social inequalities in health: how people possessing power, property, and privilege affect social, economic, and ecologic conditions. These frameworks and studies must also illuminate causes of social equalities in health: how people subjected to material and social inequalities organize to improve conditions in which they live, love, work, and play. To identify, measure, and influence these causes requires imagining and working for a just and loving world, treasuring diversity and equality. We have the language to name and methods to measure how inequality and social justice affect health. It is in our professional purview to use this language and these methods to generate knowledge that public health and medical practitioners, policy makers, activists, and others need to guide fruitful action to improve the public's health. ■

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