

THE STRANGE DISAPPEARANCE OF HISTORY FROM RACIAL HEALTH DISPARITIES RESEARCH

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Abstract

Although thriving in many respects, racial health disparities research suffers from a lack of historical analysis and may be in danger of reaching a saturation point. This article examines how renewed attention to history can enhance the explanatory power of such research. First, it surveys a body of writing on what history can contribute to contemporary social science and policy debates. Next, it compares current racial health disparities research to the analytical impasse encountered by urban poverty researchers of the late 1980s and early 1990s. It contrasts that work with two classic post-Second World War urban histories, and identifies qualities of the latter lacking in conventional social science. The essay then surveys historically oriented works on race and health, pointing out their usefulness to racial health disparities research while discussing promising future research directions. It concludes with a brief reflection on changes in the academic institutional context necessary for fruitful synergy between public health researchers and historians.

Keywords: Racial/Ethnic Health Disparities, African American History, Urban Poverty, Methodology, Public Health, Social Determinants of Health, Fundamental Causes

RACIAL HEALTH DISPARITIES AND THE ANALYTICAL JUNCTURE

In the past two decades, interest in racial health disparities has surged. Academic journals now regularly publish research that develops the earlier foundational work of Sherman James (1987, 1992), Nancy Krieger (1990, 1993, 2000), David Williams (1995, 1997, 1999), Thomas LaVeist (1992, 1993), and Arline Geronimus (1990, 2000). In the popular press, it is difficult for a regular follower to avoid encountering periodic findings on the racially disproportionate incidence of negative health outcomes, including HIV/AIDS and heart disease among many others. Institutional backing has followed, too, with several universities housing research centers for the study of racial health disparities. Most recently, the National Institutes of Health's Office of Behavioral and Social Sciences Research announced the formation of a cross-disciplinary Network on Inequality, Complexity, and Health to study health disparities (NIH 2010a). If the related calls for funding proposals are any indication, race and health will be a key focus of this endeavor. In short, the study of racial health disparities now appears viable, legitimated, and thriving.

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Aimed at public health researchers but also at policy-oriented historians, my essay argues that this booming research now stands at a crossroads. Fruitful as the disparities scholarship is, we may soon hit an analytical bump where the findings start to become repetitious. We may learn about disease-by-disease, health outcome-by-health outcome, and year-by-year variations in racial health disparities (all of which remain vital data to continue collecting), but the fundamental findings themselves will soon not be very surprising. They consist of two elements: first, the simple (and durable) existence of the disparities themselves, and second, the actual explanations given for them. The latter include poor health-care access, antagonistic racial attitudes of providers, stress caused by everyday discrimination and stereotyping, proximity to environmental health hazards, neighborhood characteristics, and general socioeconomic status (SES)—all of which often vary starkly, the research indicates, by race.¹ Methodologically, the work draws heavily, though not exclusively, on rich quantitative data sets generated from many sources, including public health surveillance, statistical collection efforts, life-course studies, and surveys.

What is missing, however, is a deeper understanding of how and why these social determinants of racial health disparities matter so much, the long-term *process* through which they came into being, and how they might have been avoided. I argue, then, that the major shortcoming in racial health disparities research is an absence of historical perspective that would enable exploration of historically rooted “fundamental causes.” This analytical lacuna, in turn, may become a major pitfall, hampering fuller understanding of causal dynamics at exactly the moment when interest in racial health disparities has reached unprecedented levels. But this need not be, for the current juncture represents, too, an opportunity to expand our analytical horizons through, to borrow the subtitle of a book on history and health policy, “putting the past back in” (Stevens et al., 2006).

WHAT HAPPENED TO HISTORY?

History’s absence from racial health disparities research is conspicuous. The NIH network touts its cross-disciplinarity but lists “economics, biology, ecology, computer science, education, sociology, mathematics and epidemiology”—not history—as examples (NIH 2010b). More than two decades ago, Elizabeth Fee and Daniel Fox (1988) noted that within public health writ large, “historical methods have become subordinate to experimentalism and model building in university curricula for the social sciences and public health and in the priorities of most of the organizations that sponsor research in the hope of ameliorating social problems” (p. 1). Their assessment still holds true.

But history once “was also essential for the study of epidemiology and public health” (Fee and Fox, 1988, p. 1). It seems surprising to remember that a public-health historian, George Rosen, served as the *American Journal of Public Health’s* editor for almost two decades from 1957 to 1973, bringing that perspective to many agenda-setting editorials (Mormon 1993). Although his high optimism toward the progressive properties of the public health state has come under critical scrutiny, Rosen’s writings on fusing history and public health still deserve close rereading. In “Health, History and the Social Sciences,” he declares:

Every social phenomenon is the result of historical process, that is societal factors operating over a period of time through human interaction. . . . As soon as large-scale phenomena are investigated, account must be taken of the histor-

ical facet. This applies as well to the results (theories, models, data et alia) of researches. Clearly, there is a need for historians to understand concepts, methods, terminology, and problems of the social sciences, but conversely this point applies as well to the social scientist (Rosen 1973, p. 55).

Apart from discovering these “societal factors operating over a period of time” that contribute to social problems, Rosen (1973) argues that history also serves as a conceptual locker, offering modes of thinking unconsidered or forgotten by those in the present. At a time when the boundaries of public health analysis have narrowed in some respects, a look backward may uncover heuristics and frames shunted to the side. Modified appropriately, they might prove an enormous intellectual resource for researchers today. And history also identifies red flags, reminding us of many discredited ideas—including ones about race and health—that persist in veiled form into the present.

Rothman and Wheeler (1981) and Stevens (2006) extend such thinking to actual policy-making and institutional action. For Rothman and Wheeler (1981), history undermines an “aura of inevitability” and provides an alternative to “some social science research that appears better able to analyze the forces upholding a system than the forces that might promote change” (p. 7). The historical perspective, Stevens (2006) adds, shows “that choices have been made in the past, and new choices can be made in the future” (p. 8). This insight is important for racial health disparities researchers to register. They frame much of their work by describing the dire revelations in the data, accentuating the tragic dimension to the disparities’ persistence even after the Civil Rights Movement, befuddled by the overall limited effectiveness of so many interventions. History, however, offers accounts that shed light on experiments not fully tested and marginalized, all while uncovering crucial policy decisions that cumulatively resulted in the enduring public health problems of today.

Rothman and Wheeler (1981) carefully emphasize that history does not always provide an “immediate pay-off” (p. 3) or an obviously applicable prescription for the present. Likewise, this essay promises no such payoff but avoids complete insularity from pressing contemporary issues as well. History should constitute a “fundamental policy science” and holds much potential for bolstering racial health disparities research’s analytical depth (Stevens 2006, p. 4).

I begin by surveying two foundational works of urban history, Arnold Hirsch’s (1983) *Making the Second Ghetto* and Thomas Sugrue’s (1996) *The Origins of the Urban Crisis*. These historians provide rich causal accounts to explain the roots of post-Second World War urban decline and racialized poverty. By way of example, their approaches offer much to the world of racial health disparities research, which has yet to adopt similar historically-oriented explanatory approaches. I juxtapose their studies with an account of the intense interest in urban poverty from “big social science” (Katz 1995, p. 60) during the 1980s and 1990s and the latter’s analytical limits. Examining this previous chapter in American social science, one that developed in ways strikingly parallel to current racial health disparities research, helps us avoid an eventual impasse like that which confronted researchers more than twenty years ago.

Next, I review insights that historians (and historically sensitive social scientists) have already contributed to the study of racial health disparities. I have written this section with an eye toward what is most useful for furthering understanding of racial health disparities’ historical roots, interspersing an overview of the historical literature with suggestions for promising areas of future research. I conclude briefly with comments on the institutional context of racial health disparities research and the impediments it presents to my suggestions.

PARALLELS TO EARLIER RESEARCH: URBAN CRISIS AND THE “UNDERCLASS” DEBATE

Although not about health, the now classic studies of Hirsch (1983) and Sugrue (1996) serve as models for how we might go about identifying what exactly in the past contributed to racial health disparities today. They identify roots of the urban conditions that became the subject of much subsequent journalistic and social science research: pervasive residential segregation by race and income; exclusion from the labor market; and economic devastation reflected in a number of indicators. And in many respects, they offer more robust explanations of urban poverty than conventional social science of the time covering the same subjects.

Hirsch's *Making the Second Ghetto* chronicles how Chicago's residential segregation patterns were altered and entrenched over a twenty-year period from the end of the Second World War through the late 1950s. By then, the traditional “Black Belt” of the South Side was “several times larger” and extended much farther southward. Although Blacks had entered new neighborhoods, breaking and “redefining” racial boundaries of “previously all-White areas” (pp. 5, 253–255), they paradoxically remained even more segregated and isolated than before.

Hirsch identifies pre-conditions, policy decisions, and ongoing social phenomena that, over time, accumulated to result in this “second ghetto.” One was the housing crunch during and immediately after the Second World War. Exacerbated by the need to house wartime workers and another wave of Black migration from the South, it resulted in Black entrance into formerly all-White neighborhoods. Another, sparked by the new Black population movement, was a wave of vicious neighborhood violence and intimidation in less affluent White ethnic neighborhoods undergoing potential transition and populated by Whites who had not yet left Chicago. A third was central-city decline, which led concerned city business elites to lobby successfully for state legislation that formed the basis for a new urban redevelopment regime. That legislation enabled the city to seize land for a “public purpose,” via the power of eminent domain, and sell it at reduced rates to private interests for redevelopment projects that displaced thousands of (mostly Black) residents. Due in part to the neighborhood actions of angry and vocal Whites, the Chicago Housing Authority (CHA) made sure to locate the later public housing built for this displaced population in mostly segregated neighborhoods, hardening the city's racial boundaries.

Hirsch examines how these forces played out in two exhaustive accounts of major redevelopment projects, one on the near South Side, the other in the Hyde Park neighborhood around the University of Chicago. Both resulted in massive relocation of Black residents. His work concludes with a detailed account of the CHA's sharp turn away from both racially integrated housing and the construction of relocation housing in scattered sites. In 1949, the state legislature gave the city council the right to veto CHA-proposed sites, thus “establish[ing] a pattern that saw public housing located primarily in existing ghetto areas” (Hirsch 1983, pp. 223–224). After 1955, “more than 99%” of public housing units built “were located in all-Black neighborhoods” (Hirsch 1983, p. 243).

Thomas Sugrue's *Origins of the Urban Crisis* expands upon *Making's* analysis. Sugrue covers not just housing but also the impact of institutionalized job discrimination and the movement of major industry away from Detroit—and how public policy influenced all three phenomena. In Detroit (and Sugrue's account), public housing plays less of a role in residential segregation than does a “homeowners' movement” whose members worked to preserve the racial homogeneity of its members' neighborhoods by intimidating prospective Black residents (Sugrue 1996, p. 214).

Other Whites, however, simply took advantage of generous government lending policies (closed to Blacks) that fueled (racially exclusionary) suburban development.

Sugrue's biggest analytical contribution is an intertwined discussion of job discrimination and capital flight from Detroit. He identifies multiple barriers to employment that midcentury Detroit Blacks encountered, from discrimination "at the hiring gate" to more institutionalized forms within firms and certain union locals that blocked Black workers from apprenticeship programs or seniority-based promotions (Sugrue 1996, pp. 91–123). Although some Blacks surmounted such barriers, they did so at the exact time an increasing number of the city's major industrial employers moved facilities to suburbs, and later, the Sunbelt and outside the country. From 1951 to 1963, Sugrue reports, "the number of shops and factories constructed or modified in Detroit fell tenfold" (Sugrue 1996, p. 149). Between 1947 and 1977, manufacturing employment declined by more than 50%. Over time, this capital flight and the resulting decline in tax revenue reverberated and threatened municipal jobs, a key sector where Blacks had made major entry. Cumulatively, all these developments resulted in unemployment figures that reached double digits by 1980, but Black unemployment had already reached 11.8% as early as 1950 and 18.2% just a decade later in 1960 (Sugrue 1996). *Origins* ties together how the processes of institutional job discrimination, enduring residential segregation, and deindustrialization culminated in the bleak Detroit metropolis we know today.

These overviews of the works' analytical frameworks, of course, leave out much and slight subsequent work that has refined some of their conclusions and extended their stories even closer to the present. I have included just enough detail of the Hirsch and Sugrue studies to emphasize the precision that historical accounts of racial health disparities modeled after them ought to have. Both authors push beyond descriptive statistics, associations between variables, and the quantitative condensation of social processes. They instead identify the historical actors and decisions responsible for those bleak numbers in the first place. As importantly, they identify crucial turning points where "an opportunity for dismantling, instead of expanding, the ghetto" existed (Hirsch 1983, pp. 5–6). Sugrue, likewise, writes that the industrial transformation he documents was not "simply a response to the inexorable demands of the market" (1996, p. 128). Both authors argue persuasively for the *political* dimension of segregated housing and capital flight, highlighting the huge influence of proactive policy decisions: lobbying behind urban renewal legislation, grassroots racism, decisions to locate public housing in segregated areas, lure of lower taxes in suburbs, and employers' desire to undercut labor unions' power via automated and relocated plants. They undercut a deterministic resignation that the contemporary urban landscape simply "had to be." And they challenge dominant but problematic conventional wisdom about urban decline, which points to the riots of the 1960s or places explanatory premium on the supposedly deleterious individual behaviors or "culture" of residents themselves.

Adopting a historical approach can bolster the sophistication of racial health disparities research. It can also help avoid the frustrations of past social science. On this latter point, I turn specifically to the 1980s and 1990s, which saw a revival of scholarly attention devoted to urban poverty similar to that paid to racial health disparities today. Given the juncture at which racial health disparities research now stands, reflecting on this previous social-science episode may help us avoid some of its later pitfalls.

During those years, a raft of articles appeared, initially by journalists, chronicling the emergence of a so-called "underclass," a population alternately (and not always

consistently) defined as economically marginalized, geographically and socially isolated from a “mainstream,” and exhibiting supposedly nonnormative behavioral traits and cultural values. But however elastic and imprecise these initial usages, by the late 1980s, the “underclass” had become a major academic interest for mainstream social scientists, especially with the 1987 publication of liberal sociologist William Julius Wilson’s *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy*. A year later, the Social Science Research Council (SSRC), with support from the Rockefeller Foundation, formally created a \$6 million Committee on the Urban Underclass,² though not without internal debate over whether to use the term (Gans 1995; Katz 1993a).

During its five-year run, the SSRC project funded working groups, data-set construction, conferences, fellowships, and edited volumes, producing much methodologically sophisticated work documenting contemporary urban poverty. Sponsored studies examined the segmented labor market, residential segregation, emerging spatial patterns, family structure, drug use, and crime. But over time (and in retrospect), certain analytical deficits became evident. In 1993, the Rockefeller Foundation declared that the project had reached a point of “saturation,” and shortly afterwards, ended its funding (Gans 1995; O’Connor 2001, p. 282).

Although the SSRC committee initially encouraged a mixed-methods approach, conventional quantitative research soon assumed greater prominence. This is clear from a perusal of articles published by researchers associated with the project and the edited volumes that grew out of it, including the one most widely read, *The Urban Underclass* (Jencks and Peterson, 1991). Several project participants describe the limits of a quantitative thrust in oral histories conducted during and shortly after the project’s existence. In 1992, Martha Gephart, an SSRC staff member, spoke about tension between quantitative and qualitative researchers in one working group:

The quantitative people have done a whole series of analyses within the affected neighborhoods on individual outcomes controlling for family level factors, and developing and testing some mediating models, depending on variables that are in different peoples’ data sets. And the findings are not earthshaking and the conclusion I think that the group is reaching is that there do seem to be some effects of neighborhoods that are discernible from data sets that have been geo-coded with census data, but actually this is not the right way to go about investigating these questions.³

Likewise, a year later, Lawrence Aber, a committee member and leader of that working group, recalled that “quantitative, analytic, ideally economic rational choice models . . . were at the highest point in the order.”⁴ And though not as directly involved in its day-to-day operation, David Featherman, who served as SSRC President during most of the project, spoke of his impression that “the qualitative scholarship on American poverty was perhaps not as widely appreciated as the quantitative scholarship” and that to the degree this was the case, it represented “a great loss” because of the “very, very rich qualitative, historical, ethnographic, and so on, literature” that might have had greater presence.⁵

I review this not to rehash an unproductive debate in social science on the virtues of quantitative versus qualitative research. With research on racial health disparities, the former is obviously necessary to attaining a macrolevel portrait from which to develop a larger agenda. But to the extent quantitative methodology—and its language of variables and associations—becomes predominant, its practitioners can unwittingly narrow the scope of analysis. Questions and their explanations become

constricted by quantitative categories that can reduce complex social processes into variables for models. Moreover, explanation can take on a rather mechanical cause-effect form. Such a form then focuses heavily on individual-level characteristics or behaviors and how much they predict life chances in larger social structure—but far less attention is given to how transformations of the latter can alter the former.

In respective critiques, Michael Katz (1989, 1993b, 1995)—who served as the SSRC’s project archivist—and Alice O’Connor (2001), also a former staffer, note the heavy project focus on family structure, especially the rise in female-headed, single-parent homes and differences in their incidence by race. That focus offers a striking example of how quantitative methodology can obscure as much as it elucidates. “Family,” as Katz (1993b) and others have argued, is a historically fluid construction—a “relative, culture-bound concept, not one fixed and unchanging across time and space” (p. 471). Simply coding it as a variable, concluding that it deviates from some predecided norm, and then assessing its “effects” prevent an alternative analysis of “family” as a historical process. As Katz (1995) argues, social scientists would have benefited less from focusing on “what has happened to the black, Latino, or underclass family” (often in value-laden language) than by analyzing the broader “transformations in social structure” that contribute to such shifts to begin with (pp. 85, 87).

A similar dilemma occurred with race. Although researchers produced much data showing racial differentiation in a number of outcomes, they did so in a way that simultaneously avoided sustained thinking about the complicated ways race operated in the larger political economy. Instead, researchers flattened race into another variable. In a 1994 oral history with him as interviewee, Katz elaborates:

I think that’s a question that has much less to do with the committee per se than the way in which race is dealt with in American social science. Race is a variable in an equation, it’s an independent variable in an equation. To what extent does race affect fertility? To what extent does it affect marriage rates? To what extent does it affect one’s ability to get a job? So one enters race into these various equations that are the basis of quantitative analysis.⁶

He contrasts this tendency with scholarship “thinking about race as a social construct with different meanings, changing over time and as a relationship rather than as a variable. And as a dynamic relationship.”⁷ In the end, what resulted was a body of technically robust research that usefully measured “effects” and racially segmented “outcomes.” But these findings nevertheless felt divorced from a wider context, especially institutions, policies, and long-term economic restructuring—the “dynamic relationship” of which Katz speaks.⁸

Is racial health disparities research headed for the same problems as this social-science predecessor? Many parallels exist with its poverty-research antecedents: a predominantly quantitative methodological orientation, the “big science” institutional context, and increasingly, repetition of the same explanations. In an important critique of now-dominant “risk factor” health research, Robert Aronowitz (1998) notes that the restrictive criteria for potential health risk factors—“they must be quantifiable and properties of the free-standing individual in order to fit into complex risk equations”—can result in the analytical slighting of “social and population-level considerations” equally consequential to health outcomes (p. 134). Much of his critique applies to racial health disparities research, which, boiled down to its essence, explores race as risk factor.

But encouraging signs exist. A growing group of social epidemiologists has encouraged greater attention to multiple layers of context affecting health outcomes (Berkman and Kawachi, 2000). In Nancy Krieger's (2010) words, this "ecosocial" approach requires researchers to "pay heed to context; to life course; to historical generation; to levels of analysis; to the interrelationships between diverse forms of social inequality, including racism, class, and gender, among others—and also to people's relationship to the rest of the ecosystem" (p. 230). In ideal form, such research identifies complex "pathways" and analytically connects health risks themselves to the larger socio-historical context (discrimination, policy decisions, public health interventions, for example) that produces them. For racial health disparities research, this approach exhibits much more dynamism than research of an econometric bent measuring "effects" of variables and factors, "race" among them.

For all its promise, the ecosocial approach's interpretive power remains limited for familiar reasons. Its reliance on aggregate, quantitative data sets limits explanation to the static categories inscribed in those data sets, sophisticated as their construction often is.⁹ As Aronowitz (1998) argues, it is particularly difficult to operationalize power relations between institutions and actors (and their health consequences) in this way. When researchers have attempted to move beyond such confines, their results still lack precision. Some studies, for example, have pointed to reductions in health disparities during the "War on Poverty" and the Civil Rights Movement and reversals after later government retrenchment from those initiatives. But such explanations are stated in a speculative manner. Pointing out reduced health disparities during the "War on Poverty" era begs several questions. Which programs and interventions exactly? What features? How did programs take different form over time? Such questions largely go unanswered in even the best racial health disparities research and require deeper historical exploration.

Contrast this (and the earlier underclass research experience) with Hirsch, Sugrue, and similar works. Their on-the-ground, local focus and deep archival mining allowed them to identify—in ways most poverty research did not—the real estate interests, homeownership associations, urban governance, corporate relocation, and labor market segmentation that cumulatively structure social outcomes along racial lines. That race and racism "matter" are merely starting points. What set these scholars apart was their identifying the constellation of institutions, people, policies, and long-term developments that *make them matter*—and their doing so with a richness and specificity unmatched by their social science colleagues. They demonstrate a fresh historical approach for racial health disparities researchers to emulate.

WHAT HISTORY HAS SHOWN: RACIALISM AND ITS DISCONTENTS

Having discussed the shortcomings of social scientists, I want to shift the spotlight to historians (and historically oriented social scientists), where the bulk of their work on these questions has (and hasn't) focused, and which future directions for research seem promising.

Historical work on racial health disparities has clustered around racial imagery, ideology, and beliefs—and their impacts on public health thinking and practice. The past decade has seen outstanding scholarship in this vein. Urban histories by Nayan Shah (2001), Natalia Molina (2006), and Samuel Roberts (2009) examine, respectively, concerns about epidemics in San Francisco's Chinatown, public health policy towards Mexicans, Japanese, and Chinese in Los Angeles, and tuberculosis control among African Americans in Baltimore. The works span roughly the same period,

from the late nineteenth into the early twentieth century, and thus unfold against multiple strands of popular and scientific racist and nativist thinking during the era. All three authors show how public health and social service workers conceptualized, in terms that alternately invoked the language of biology and culture, non-White subjects as belonging to distinct “races”—a belief historians refer to as “racialism” and the process through which it happens as “racialization.”

Racialist thought fed into three related practices. Racialized subjects became stigmatized as disease-ridden threats to broader (especially White) population health. Their own health problems, meanwhile, were attributed to intrinsic racial characteristics, “rather than,” to borrow Molina’s (2006) words, “the structural inequality that produced the unhealthy environments that hosted virulent diseases” (p. 8). And public health became an instrument for determining membership in the larger polity. Those who conformed to certain behaviors thought to be associated with better health inched closer to civic membership. Those who did not faced exclusion and stigmatization, sometimes with horrific consequences. Roberts’s (2009) book, for instance, ends with the demolition of a Black neighborhood stigmatized as a cauldron of infectious disease.

Though it covers similar ground, Keith Wailoo’s (2001) work on sickle-cell disease and race does not focus on epidemics and the language of racial health menace. Wailoo instead chronicles sickle-cell’s collision with racial ideas: from scientific invisibility to recognition to the center of various ascribed racial meanings and political contestation. To great effect, Wailoo uses the Memphis setting to show how the University of Tennessee–centered academic medical complex’s sickle-cell research center became a midcentury symbol for liberal medical reform, one “asking all the right questions about race, economics, and disease in the heartland of the Black South” (p. 149). Even more valuable, however, is his exploration of how sickle-cell anemia became a “Black disease,” in part due to diagnostic technology that revealed the higher prevalence of the trait among African Americans. That allowed it to become, as Wailoo puts it, “the basis for sweeping academic discussions of ecology, human biology, cultural evolution, and the changing African and African American identity,” much of it laced with racialist assumptions (p. 147), and later, a political symbol during the Civil Rights Movement and afterwards.

Other newer works, which I regret I cannot discuss at length here, have pursued these questions in many contexts including: the Tuskegee Syphilis Study (Reverby 2009), neo-eugenic enterprises (Stern 2005), Native American health (Jones 2004), spirometry (Braun 2005); popular science writing (Spiro 2009), immigrant medical screening and exclusion (Abel 2007; Fairchild 2003), American imperialism (Anderson 2006; Briggs 2003), and psychological thought and practice (Markowitz and Rosner, 1996). If these rich works have one common takeaway, it is that racialism persists in American medical and public health history, and by extension, so does the “naturalization” of racial health disparities. By identifying the historically fluid and constantly changing nature of race as a category—and the meanings, stigmas, and prejudices bound up with it—these authors undercut the notion of race as a fixed entity across time and the pernicious idea that innate, immutable characteristics are linked to it.

These insights come at an important time, as many scholars have identified a resurgence in uncritical uses of race as a category with biological basis (Braun et al., 2007; Duster 2005; Epstein 2007; Goodman 2000; Kaufman and Cooper, 2008; Krieger 2005, 2010; Reed 2005; Reverby 2008). This gives way to tautological explanations of racial health disparities that defer to racial characteristics that are supposedly biologically intrinsic. Less controversial has been the use of race as a

monolithic cultural category in explaining racial health disparities (Jenks 2010). Yet, as many of the above historical works show, the sweeping association of behavioral traits with an entire “racial” population under the banner of “culture”—not just biology—has also been long-standing and frequently destructive. Several of the scholars above argue convincingly that, at various points, public health officials slighted structural explanations and instead referred to racially specific cultural traits and behaviors to explain a higher presence of disease in non-White populations and the failure of interventions targeted at them. By pointing to these disturbing lineages, today’s critics of racialism in its biological and cultural varieties can find much ammunition in the historical literature on race and health that I have cited. On this score, these historians have done an enormous service.

WHAT HISTORY HAS NOT SHOWN: RACIAL HEALTH DISPARITIES AS PROCESS

Historical accounts have not, however, provided a head-on causal account of contemporary racial health disparities in the tradition of Hirsch and Sugrue. This may stem from a long-standing discomfort on historians’ part over using history for explicitly illuminating contemporary social problems. But as Hirsch and Sugrue demonstrate, such engaged history does not require sacrificing complexity. Given the shortcomings of racial health disparities research outlined above, the field needs its *Making the Second Health Ghetto* or *Origins of the Urban Health Crisis*. Historians should pursue the challenge, lest they wish to hyperventilate each time social scientists and policy-makers seem unaware of how past actions give way to present dilemmas.

Six works, only one by an historian, are exceptions that deserve highlighting. David McBride’s (1991) *From TB to AIDS* convincingly argues for the existence, throughout the twentieth century, of competing paradigms for analyzing Black health and identifies key figures and institutions responsible for perpetuating them. One of them, “relationism”/“environmentalism,” looked to the broader social context (especially racial exclusion) as the key determinant in racial health disparities. The other, what McBride (1991) labels “anatomic-genetics,” emphasized on biological racist grounds the allegedly inherent racial characteristics of Blacks that made them more susceptible to disease (pp. 32, 48). He argues that Black medical professional organizations and later community health movements largely upheld relationist/environmentalist views. Using policy discussions of HIV/AIDS as an example, he concludes this paradigm still faces an uphill battle against racist or narrowly biomedical currents that marginalize its more holistic way of thinking about racial health disparities. McBride reminds us that those tensions come from somewhere, stemming from historically differential access to powerful, agenda-setting health institutions. They continue to carry real policy ramifications, influencing the allocation of resources towards certain types of analyses and interventions while marginalizing others.

Cathy Cohen’s (1999) *Boundaries of Blackness* and David Barton Smith’s (1999) *Health Care Divided* center on the decline and lack of policy response to combat racial health disparities. Cohen examines political reactions to the higher prevalence of HIV/AIDS among Blacks during the disease’s early years. She finds that fear of racially tinged political and cultural stigma led to quietism on the part of Black politicians and mainstream civil rights groups. Cohen’s evidence is persuasive. Whether bleak HIV/AIDS racial disparities would have differed that much if these players had acted more proactively is another matter, but Cohen’s work opens up extremely

worthwhile questions on influential political groups' roles in setting (or narrowing) public health agendas. Smith examines the largely under-studied movement to desegregate medical facilities receiving federal Hill-Burton Act hospital construction funds. This foment culminated in a successful federal court decision that, together with the Civil Rights Act, led to federal rule-making and sanctions against noncompliant facilities through the withholding of federal funds. Later real-world enforcement, Smith shows, was more difficult. Through brief case studies in New Orleans, Gary, Philadelphia, and elsewhere, Smith documents how legal quagmires resulted from many activists' and civil rights groups' attempts to use legal instruments, especially after federal retrenchment from vigilant civil rights policing. Alongside tables documenting enduring racial health disparities, Smith questions the efficacy of health facilities' desegregation alone for remedying disparities, particularly when additional consideration is given to factors other than medical care that are harmful to health. His work importantly highlights the legal history of remedies for racial health disparities, the difficulties in implementing them, and their limits in practice.

Except for Smith's glimpses into local desegregation battles, these works lack a sustained regional focus. Such a focus greatly enhances two works by A. J. Schulz et al. (2002) and Deborah Wallace and Rodrick Wallace (1998). The first synthesizes studies examining racial health disparities and neighborhoods with high poverty, noting the poor health outcomes and health environments (lack of fresh grocery stores, fire hazards, waste disposal) within such areas. But the authors make a significant analytical advance by contextualizing their synthesis within Detroit's historical trends, particularly hardening racial segregation and economic decline. They suggest that public health researchers think of these historical developments and their consequences as "fundamental causes" of racial health disparities and that interventions start "addressing fundamental economic and political processes, as well as racial ideologies whose consequences are the spatial separation of African Americans from White Americans and the uneven distribution of resources across racial groups" (Schulz et al., 2002, p. 697). What their work lacks is historical research into more specific features of Detroit public health—its regional health care system or previous interventions, for example—that are largely unmentioned by the studies the authors ably weave together. But their work is a large step in the direction I have urged. That it comes from a distinguished team of racial health disparities researchers is encouraging.

Wallace and Wallace's (1998) *A Plague on Your Houses* is the culmination of a long-term project on the public health effects of New York City fire service reductions and federal and local "benign neglect" urban policies in the 1970s. After a detailed account of the fire policy's ideological influences, they devote most of the book to documenting strong spatial correlations between neighborhoods (mostly racially segregated and poor) devastated by fires and resulting higher concentrations of HIV and TB. Summarizing their findings, they write: "Housing overcrowding, localized population density, and poverty worsened horribly after municipal service cuts created massive housing destruction in New York City's traditional ghettos. It was this destruction of physical and social community that led directly to increased TB reactivation and transmission and to epidemics of substance abuse and AIDS/HIV" (p. 94).

The emphasis on New York City fire policy, though, begs the question of how one might explain similar epidemiological patterns in other municipalities without such policies. There is often a monocausal feel to the argument and an underdeveloped examination of policymakers' motives, beyond indifference towards the urban poor. More historical excavation into New York City social service, municipal politics, and public health policy during this time would add nuance to the analysis. But

A Plague on Your Houses is a substantial achievement. It is the work here that most resembles Hirsch and Sugrue's historical approach to racial inequality, forcing us to consider undeniably important policy decisions with residual effects that disempowered sections of New York City continue to feel.

From my review of these works and some public health debates of the past, let me end by providing five under-explored areas of research that are examples of ways (by no means exhaustive) to inject history into racial health disparities research.

Urban Renewal

Urban historians have written much about urban renewal from federal and local levels, but the health ramifications of such mass displacement have until recently remained unexplored. Three recent works offer enticing starting points. Mindy Fullilove's (2004) *Root Shock* brings attention to urban renewal's traumatic mental health consequences, using local case studies and interviews with the displaced. Russ Lopez (2009) examines the 1948 American Public Health Association's guidelines on "blight" and the organization's role in providing public health rationales for slum clearance. Roberts (2009), in his concluding chapter, pursues this theme as well, but even more impressively at the local level and a couple decades before most scholars date the origins of urban renewal. He identifies an emerging "political calculus of blight" in the 1920s, whereby public health officials declared racially segregated and diseased neighborhoods as irreparable threats to (White) Baltimore safety and marked them for demolition. Via careful historical case studies, we need to follow Roberts's analysis through the 1960s to attain both a fuller picture of the public health enterprise's role in providing ideological rationales for blight politics and the subsequent health experience of dispersed populations.

Academic Medical Centers And Cities

In the 1950s and 1960s, a number of major cities, most famously New York City, subcontracted administrative duties of municipal hospitals to major urban academic medical centers (AMCs). In their early years, these affiliations were wracked by controversy. Several investigations unearthed evidence that AMCs misused subcontracting fees, "dumped" their mostly poor and minority patients at municipal hospitals, or failed to improve municipal hospital conditions in many respects. Historians have barely explored the evolution of AMCs' affiliations since: how they varied in different municipalities, their efficacy, and their impacts on the health of the urban poor who depend on municipal health services. Worthwhile, too, is more general exploration of historical debates around urban AMCs' obligations to their surrounding environs. This was a persistent theme at a major June 1969 conference on "Medicine in the Ghetto," cosponsored by Harvard Medical School, that featured commentaries from figures in academic medicine discussing innovative community health initiatives and health services delivery models launched by their institutions (Deuschle 1969; Doyle 1969; Powell 1969). Given their centrality in planning and providing urban medical care for poor minorities, AMCs are important (and often Janus-faced) institutions to study historically for racial health disparities research.

Environmental Justice

In the 1970s and 1980s, a series of federal government studies examined the location of toxic sites and found they were frequently located in areas with higher

percentages of low-income and minority residents. Together with the scholarship of Robert Bullard (1990), these findings have ignited interest in environmental justice: the systematic study of the ecological burden incurred by the marginalized and the strategies they have deployed to combat it. Bullard has argued, further, that racial composition of an area is generally stronger than class in predicting site location and that the term “environmental racism” thus best captures this state of affairs (Bullard 1990, p. 98). With the exception of Andrew Hurley’s (1995) work, we have insufficient historical accounts of the planning and permit process, business decisions, tax subsidies, land valuation, residential segregation, and uneven environmental regulation that produce the outcomes environmental justice research has documented. Such an approach transcends abstract debates over the relative importance of race or class composition as “predictors” of excess ecological burdens by showing that their importance depends very much on the specific histories of different regions.

Neighborhood Health Centers

One of the most significant investments in primary health care infrastructure was the establishment of the Office of Economic Opportunity’s Neighborhood Health Centers during the War on Poverty. Following the municipal budget crises of the 1970s and the closure of municipal hospitals that resulted, the centers have assumed a greater role in primary care for the poor. Most historical scholarship about them has focused on the centers’ political creation and subsequent travails—but at the level of congressional and agency politics, not the individual centers themselves, where many pitched battles occurred over neighborhood activists’ demands for participation in the centers’ administrative decisions. To date, the best account of the latter is Bonnie Lefkowitz’s (2007) recent work, which covers the struggles of centers in several states, but more are necessary.

The centers raise larger questions, too, concerning ideas about health care targeted at the poor. At the 1969 conference, for example, several participants questioned the conference’s very premise. John Holloman (1969), a Black physician with a long history in New York City health activism, stated: “I continue to dislike the terms ‘ghetto physician’ and ‘ghetto medicine’ because they suggest a duality of practices and standards” (pp. 150–151). How parties have framed the problem of health care (particularly for the minority poor) deserves attention, for it sheds light on the assumptions beneath our current discussions and their historical sources.

Health Activism

Identifying roots of racial health disparities can overshadow possible channels for reducing them. Studies of post-Second World War social movements to combat health inequality (by race or otherwise) are sparse. We have studies on hospital unionization (Fink and Greenberg, 1989), medical student organizing (Rogers 2001), Black women’s health movements (Smith 1995), and medical care in the context of the Civil Rights Movement and its immediate aftermath (Dittmer 2009; Smith 1999). The late health activist Walter Lear (1998) has identified a spectrum of groups and figures ripe for study—what he calls the “Health Left”—that mobilized around many injustices in the American health care system, including its racially segmented nature.

CONCLUSION

One goal here has been to encourage more synergy between racial health disparities researchers and historians. Even the most convincing intellectual brief, however, may be less important than modifying the institutional context that constrains such research across disciplines, departments, and schools—balkanization that sociologists of knowledge have long studied in detail. Financial barriers are common. Schools or departments wishing to facilitate such research often cannot commit funds necessary to support researchers interested in working multiple fields across campus. This will likely require high-level administrative establishment of university-wide independent funds for such work. At the level of training, future curricula, via institutionalized dual degree programs and other mechanisms, would introduce public health and history students to the methods, disciplinary conventions, and foundational literature of the other. For racial health disparities research and many other public-health topics, the intellectual payoffs that would arise from more collaboration, whatever the logistics, are considerable. But this will require proactive academic administration with less risk aversion than is usually the case.

More modestly, we cannot, in the words of Schulz et al. (2002) “simply document” racial health disparities (p. 695). Recently, Adolph Reed (2010) has noted the inadequacy of simply noting the racial disparities in affected populations during Hurricane Katrina. Reed writes that “from this perspective, race may still be in New Orleans a default medium through which ‘fundamental conflicts in the social system’ are expressed but that turns out not to tell us very much about either race, those conflicts, or even the relation between the two” (pp. 266–267). Such a univariate view, he argues, simplifies the political economy of real estate, intraracial power differentials, and political regimes responsible for creating the conditions leading up to the event and its depressing aftermath. Plumbing history is necessary for getting at the wider context to which Schulz et al. and Reed refer. Historicized, race becomes not static variable with “effect” but complicated social process. And given the plethora of dubious narratives—past and present—explaining why racial health disparities exist, tight historical reconstructions of their long-term causes have become doubly important.

Historical sensitivity, I have argued, provides three related insights. It identifies, as Rosen (1973) puts it, “the societal factors operating over a period of time” that create the racial health disparities in the first place (p. 55). By locating such factors and the human agents, decision-making, and the exercise of political power behind them, we are reminded that these disparities are not natural but created and thus undoable, however awesome the task. Finally, history forces us to reflect on the very way we interpret these inequalities, often exposing long, sometimes disturbing, lineages behind current ways of thinking, while also opening promising but less-examined questions that have been sidelined. To help build a socially useful and better health science, we would profit much from reversing the historical perspective’s marginalization within the field.

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NOTES

1. More problematic are studies invoking biologicistic and cultural notions of “race” to explain health disparities, which I discuss at greater length later.

2. See annual report as project historian and archivist from Michael Katz, December 8, 1988, box 1, "Project Historian, (C) 1 of 1" [microfiche], SSRC Urban Underclass Project Records, Social Welfare History Archives, Elmer L. Andersen Library, University of Minnesota, Minneapolis, MN [hereafter referred to as "SSRC Urban Underclass Records"].
3. Oral history with Martha Gephart and Alice O'Connor, September 23, 1992, box 5, folder "Martha Gephart + Alice O'Connor Katz interview 9/23/92 final + draft," Oral History Transcripts A-Gi, SSRC Urban Underclass Records.
4. Oral history with J. Lawrence Aber, December 1, 1993, box 5, folder "Larry Aber/MK/12/93," Oral History Transcripts A-Gi, SSRC Urban Underclass Records.
5. Oral history with David Featherman, box 5, folder "Featherman 10/20/94," Oral History Transcripts A-Gi, SSRC Urban Underclass Records.
6. Oral history with Michael Katz, box 6, folder "Katz, Michael 2/19/94 final + draft," Oral History Transcripts Go-M, SSRC Urban Underclass Records.
7. Op. cit.
8. Although the committee sponsored a history working group that produced an edited volume, its members' work was largely conducted separately, thus limiting the entry of historical perspective into the underclass research.
9. See, especially, the excellent methodological essays in Kawachi and Berkman (Eds.) (2003).

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