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Author
Corage Baden, Andrea

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Health Equity at the Intersections:
Exploring the U.S. Public Health Discourse and Implications for Practice

by

Andrea Corage Baden

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ABSTRACT

Health Equity at the Intersections:
Exploring the U.S. Public Health Discourse and Implications for Practice

By: Andrea Corage Baden

This sociological dissertation critically examines the U.S. public health discourse of health equity from an intersectional lens. Intersectionality is a conceptual framework that seeks to understand the simultaneous and varied impacts that multiple social inequalities (e.g. by race, class, sexuality, age) have on health and well-being. I used a qualitative methodology to analyze health equity reports (8) from governmental and non-governmental organizations, key informant interviews (20) with health equity activists and scholars, and related archival materials. I found that health inequalities are theorized, and interventions largely conceived, in ways that do not readily acknowledge the intersecting nature of race, class, and other social formations when considering their contribution to health outcomes. Inattention to these interconnections can compound health inequalities by excluding viable rationales for disparities and health equity. However, conceptualization of the social determinants—such as housing, education, and transportation—within the context of place provided a potent way of thinking relationally about the ways in which various structural conditions come together to affect health across multiple inequalities. Such intersectional framing holds promise in producing more comprehensive and effective interventions to achieve health equity.

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INTRODUCTION, THEORETICAL CONSIDERATIONS, RESEARCH METHODS

The Clean Air Act of 1970 improved the health of this nation's children by eliminating lead in gasoline. Although these environmental protection measures were successful in reducing blood lead levels overall, a disparity grew for a particular group—poor children of color living in the inner city (Cummins and Jackson 2001). The reason? A primary source of lead poisoning for this population remained unaddressed: lead-based paint found in old housing stock. This scenario illustrates how an intervention aimed at improving the health of a vulnerable population can, in fact, *increase* health disparities within that targeted group. On the surface, negative consequences of well-intended interventions are often labeled as unexpected and inadvertent (Frymer, Strolovitch, and Warren 2006). However, closer examination of these actions reveals implicit assumptions about populations and health, which reproduce inequities by overlooking intersectional effects across race, socioeconomic status, geographic location, and/or other stratifications.

My dissertation investigates an emergent health equity framework aimed at tackling multiple health disparities by targeting social conditions. Grounded in precepts of social justice (Whitehead 1992), health equity provides an alternative to a biomedical model long seen as inadequate for addressing the *social* causes of disease. Proponents claim that by pursuing a multi-level (micro, meso, macro), multi-institutional approach, the health equity approach can eliminate health inequalities more effectively than a model focused on individual biology and behavior alone (Iton 2006; Link and Phelan 1995; Williams et al. 2008).

A growing number of scholars and activists are additionally calling for an intersectional framing of inequalities within the health equity debate as a way to better achieve health justice

(Thomas et al. 2011; Weber and Parra-Medina 2003; Östlin et al. 2011). That is, rather than prioritizing a singular dimension of difference, like age in the lead example above, an intersectional approach attends to multiple, overlapping vulnerabilities. As Hankivsky and Christoffersen (2008) explain,

> [I]ntersectionality embraces rather than avoids the complexities that are essential to understanding social inequities, which in turn manifest in health inequities. It therefore has the potential to create more accurate and inclusive knowledge of human lives and health needs which can inform the development of systematically responsive and socially just health systems and policy. (p. 279)

My study examines the discourse of health equity through an intersectional lens. Using qualitative methods to analyze health equity reports (8) from governmental and non-governmental organizations, key informant interviews (20) with health equity activists and scholars, and archival materials, I examine health equity's history, theorizing, and planned action. Specifically, I contextualize the health equity debate within the contemporary dialogue around health differences. I then identify the various etiological stories used within the health equity reports to explicate health inequalities across race, class, and other forms of difference. Further, I articulate and critique the ways that these stories mobilize planned action steps through proposed recommendations to address social determinants of health. While acknowledging health equity as a bold move beyond a biomedical approach to health disparities, I conclude that this new framework remains constrained in its capacity to attend to the complex nature of multiple and co-constitutive inequalities, which limits its potential for achieving health justice.

This dissertation is timely as the first study to characterize U.S. debates on health equity and lay theoretical groundwork for formulating equity policies that incorporates an intersectional perspective. Given the persistence of health disparities across multiple categories of difference, such considerations are especially warranted to address the nature of this complex set of public health issues.

Contemporary efforts to address health inequalities in U.S. Public Health

Since the social movement era of the 1960s and 70s, interest in health inequalities has burgeoned. Often termed “health disparities” in the U.S., these health differences persist across multiple stratifications including race, ethnicity, gender, socioeconomic status, and disability. Thomas and colleagues (Thomas et al. 2011) have demarcated this contemporary resurgence of through three generations of research activities. First generation activities focused on identifying and documenting inequalities in health, as marked by important publications, such as *Report of the Secretary’s Task Force on Black and Minority Health* (U.S. Department of Health and Human Services 1985) and *Women’s Health* (U.S. Public Health Service 1985). Effort pursued during the 1980s successfully demonstrated that stark health inequalities existed within one of the most medically advanced countries in the world. These first generation endeavors legitimized mobilizing resources to address the problem of health differences, including creating federal offices for both minority and women’s health (Auerbach and Figert 1995; Thomas et al. 2006).

By the 1990s, a second generation of research emerged, expanding inquiry into the causes of health inequities. Public health commitments to health inequalities also continued to grow, as evidenced by the prominent federal policy guide *Health People 2000*, which for the first time designated the reduction of health disparities as one of the nation’s two overarching public health goals (Thomas et al. 2006; U.S. Department of Health and Human Services 1991). This goal was upgraded in *Healthy People 2010*, calling for the elimination—not just the reduction—of health disparities (Thomas et al. 2006; U.S. Department of Health and Human Services 2000).

Prioritizing the eradication of health inequalities as a national objective and identifying potential mitigating factors led to a third generation of research. According to Thomas and colleagues, public health activities in the new millennium foreground intervention research into such vital topics as the role of social factors in explaining health inequalities. A barometer for change, the current Healthy People reflects these advances in its 2020 goals promoting health equity and “social and physical environments that promote good health” (U.S. Department of Health and Human Services 2010e). Specifically, *Healthy People 2020* defines health equity as

> [the] attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. (U.S. Department of Health and Human Services 2010b)

Aligning with health equity’s justice emphasis, *Healthy People 2020* refined its health disparities definition to denote not simply any health difference but rather “a particular type…that is closely linked with social, economic, and/or environmental disadvantage”(U.S. Department of Health and Human Services 2010b).

The integration of health equity and social approaches represents important advances in the discourse of health differences. Still, Thomas and colleagues (2011) have argued that third generation research remains limited in its ability to address “more complex linkages to racism and structural determinants of health (e.g., poverty, institutional factors, policy factors)” (p. 404). Moreover, these scholars asserted that understanding the intersectional nature of health inequities is essential to advancing health equity.

Health inequalities as an intersectional problem

Some of the most recalcitrant public health issues of our time traverse multiple inequalities, rather than manifesting solely along any one axis, such as race or socioeconomic status. For instance, African American women have the highest infant mortality among racial/ethnic groups, a disparity that persists across the socioeconomic spectrum (Collins and

David 2009). Transgendered women of color currently have the highest rates of HIV in the U.S. (National Center for HIV/AIDS 2013).

Despite the reality that people live at the intersection of various social locations, public health research and interventions tend to focus on one—or at best two—dimensions of difference. Reasons for such constraints are manifold and include the lack of well-articulated theoretical models addressing multiple inequalities, along with methodological limits in data sources, measures, and quantitative modeling (Hancock 2007b; McCall 2005). Moreover, inequality agendas are often contingency-driven, representing primary affiliations (e.g., race, disability, sexual orientation) that can exclude competing forms of difference that are viewed as "watering down" main concerns (Hancock 2007b; Verloo 2006).

Further, intersectionality requires interdisciplinary thinking about health along social dimensions—yet integration of the social sciences within public health remains the exception, not the rule (Williams and Sternthal 2010). Likewise, although various disciplines have contributed to the study of intersectionality (e.g., sociology (Choo and Ferree 2010; Collins 1990; Glenn 1999), political science (Hancock 2007b; Verloo 2006), and law (Crenshaw 1991)), applications in the areas of health and health disparities have been limited. Efforts to bridging this gap, however, may be seen in the recent scholarship of Weber (Weber and Parra-Medina 2003), Daniels and Schulz (Daniels and Schulz 2006), and Hankivsky and colleagues (Hankivsky and Christoffersen 2008; Hankivsky and Cormier 2009; Hankivsky and Cormier 2011), among others, who have introduced intersectionality into the U.S. conversation about health differences.

Theoretical Considerations

This dissertation adopts a critical, social constructionist approach to investigating health equity discourse. By constructionist, I employ the idea that social realities are created through human interaction and formalized through institutions (Berger and Luckmann 1966), whereas critical theorizing directs analytic attention to relations of power (Collins 2000b; Fairclough 1999). Debates over equity reflect struggles around power. As a discursive study of the U.S. health equity debate engages concerns around both equity and discourse, I draw from two theoretical traditions to inform my analysis. The first, intersectionality, directs attention to the interconnections between race, class, and other inequalities. The second, Foucault's theory on knowledge and power guides my exploration of power as manifested through discourse. These two theoretical orientations share core concerns of my project regarding power and relationality. That is, for both intersectionality and critical discourse theorizing, power is centrally implicated in social relations and equity. Moreover, power is perceived as operating through interactive processes at multiple levels from macro to micro, and between multiple systems of class, race, and other stratifications.

Intersectionality

Health equity discourse is concerned with inequalities across race, class, gender and other forms of difference. Intersectionality presents an integrative framework for understanding and acting on these inequalities along intersecting axes of power (Glenn 1999). Within this context, race, class, gender, and other forms of difference are conceived of as non-reducible categories that cannot be comprehended separately from one another. Rather, intersectionality encourages relational thinking about the *interconnectedness* among and across groups (Collins 2010), as well as between micro identity and macro structure, meaning-making and actions, and privilege and disadvantage (Glenn 1999). As such, intersectionality offers a dynamic approach to addressing complex health inequalities.

While a preoccupation with multiple oppressions has been documented for over a century (Cole 2009; Collins 2000b; King 1988), intersectionality as a theoretical framework emerged more recently in the 1970s as a counter-response among women of color to their homogenization by white women dominating second wave feminism (Mann and Huffman 2005). Its theoretical underpinnings reflect feminist, post-structuralist, critical race theory, and postcolonial influences. Some scholars have pointed to the Combahee River Collective's 1977 black feminist statement as one of the earliest expressions of contemporary intersectionality (Davis 2008; Knapp 2005; Mann and Huffman 2005). These scholars also recognize intersectionality's roots in a cluster of writings that capture women's multiple social locations, with such titles as *Woman, Race, Class* (Davis 1981), *All Women are White, All the Blacks are Men, but Some of Us are Brave* (Hull, Bell-Scott, and Smith 1982), and *Feminist Theory: From Margins to Center* (hooks 1984).

Most intersectional theorists recognize Kimberlé Crenshaw as having coined the term "intersectionality" (Collins 2009; Knapp 2005; McCall 2005; Yuval-Davis 2006). In legal articles addressing employment discrimination and gender violence respectively, the critical race scholar (Crenshaw 1989; 1991) illustrated how black women fell through the cracks in processes that could not accommodate multiple dimensions of inequality simultaneously. For instance, a black woman filing a workplace discrimination grievance had to choose between either her gender or race, but not both. Crenshaw employs the term "structural intersectionality" to describe this identity-centered phenomenon.

Though intersectionality is often characterized in terms of the lived experience of marginalized groups, Crenshaw (1991) also highlighted two additional aspects.

Representationally, intersectionality is concerned with how marginalized groups are culturally constructed through the media, science, and other domains. Politically, intersectionality attends to the ways in which inequalities are strategically taken up by various constituencies to further political aims. For example, in an examination of feminist and anti-racist discourse around women and violence, Crenshaw reported these groups' uni-dimensional focus on gender and race respectively "paradoxically….marginalize the issue of violence against women of color" (1991:1245). Crenshaw warned:

> The failure of feminism to integrate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of anti-racism to interrogate patriarchy means that anti-racism will frequently reproduce the subordination of women. (1991:1252).

Crenshaw's critique remains relevant to the contested field of health equity, where in Chapter 2 I show the various ways diverse constituencies work together—or not—in advancing health justice.

Patricia Hill Collins has also importantly contributed to early intersectionality theorizing. Through her introduction of Black Feminist Thought (Collins 1986; 1989; 1990; 2000a), the sociologist extended and put forward several key concepts including two salient to this project. The first, standpoint theory,[1] recognizes that lived experience can be constitutive of knowledge production; the second, the matrix of domination, refers to the way that race, class, gender, and sexuality intersected to produce complex disadvantages in the lives of women of color.

Combining these two ideas, Collins (1989) asserted that the matrix of domination situates Black women in ways that allowed them to "see" the simultaneity of privilege and inequality as it operates within power structures. This structural positioning enables these women to amass a unique "outsider within" perspective gained from daily negotiating between white and black

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[1] Collins developed her concept of black women's standpoint from feminist standpoint theory (see Hartsock 1983).

worlds (p. 751). As the scholar explained, “[l]iving life as Black women requires wisdom since knowledge about the dynamics of race, gender, and class subordination has been essential to black women’s survival” (p. 758). This situated perspective offers valuable insights into inequitable social relations, claimed Collins, that are not readily accessible to those in more privileged positions.

Collins (2000b) further theorized the matrix of domination as operating through multiple interconnected spheres; these include the structural domain comprising institutional policies and practices; the disciplinary domain of bureaucratic hierarchies and surveillance; the hegemonic domain linking institutional practices to everyday interactions through the promotion of ideological and commonsense ideas; and the interpersonal domain of daily interactions. While intersectional theorists have proposed alternative conceptualizations of power networks, all embrace the vision of intersectional power as necessarily multi-dimensional and interconnected (see for example Dhamoon 2011; Walby 2007; Yuval-Davis 2006).

In studying health equity policies and practices, this research project is oriented toward the structural and hegemonic domains of power. Specifically in Chapter 3, I articulate the ways in which health equity discourse draws on and normalizes commonsense notions of inequality to legitimize certain forms of action around the social conditions of health. In premising situated knowledges from a standpoint perspective, Chapter 4 also explores who is targeted for intervention, as well as the roles these various disadvantaged groups play in determining health equity actions.

My research is also informed by substantive scholarship on health inequalities, in particular Weber & Parra-Medine’s (2003) intersectional framework and critique of the biomedical paradigm, currently the predominant approach in the public health field. These scholars highlighted biomedicine's limits in addressing the complexities of health inequities on multiple grounds. For instance, biomedicine is oriented toward the individual. Yet, health is not located just within individual bodies but also within communities and across larger domains. Also, biomedicine tends to reduces inequalities to a set of static variables, which can obscure the social relations and processes generating these inequalities. Weber & Parra-Medine (2003) wrote:

> By not directly addressing the social processes that generate and sustain inequalities, researchers are unable so "see" beyond the proximate causes…to challenge the fundamental causes that may reside in systematic political, economic, and social inequalities. (p. 215)

These scholars further asserted that a biomedical paradigm lends itself to a distributional formulation that roots the problem of health differences more within the uneven allocation of resources than in the social relations determining these distributions. In this model, group differences are identified along a "more or less" scale, relative to a standardized norm. Yet, the norm itself often remains undertheorized with regard to its privileged status, normalization, and assumptions in maintaining an inequitable hierarchy. Finally, Weber and Parra-Medina claimed that the biomedical paradigm reinforces the status quo by valuing an "expert," objective knowledge as superior and necessarily separate from "lay" knowledge and advocacy, which unduly undermines the perspectives and participation of people most negatively impacted by health inequalities.

I concur with Weber and Parra-Medina (2003) that an intersectional approach more effectively addresses the complex, multi-dimensional nature of health disparities. The scholars explained, "intersectional approaches problematize the processes generating macro structures" of inequalities and their relationship to "individual and collective identities, behaviors and health status" (p. 187). These structures of inequality are seen as dynamic and interactive. Although distributional aspects of inequality are of central concern, intersectionality also importantly recognizes the social relations that determine this distribution. That is, who is making decisions is as relevant as what decisions are made.

Drawing on the scholarship outlined above, I articulate five core premises of intersectionality that guide my research. These include 1) the centrality of power; 2) a focus on intersecting and mutually constitutive systems of inequality; 3) recognition of privilege as well as disadvantage; 4) valuation of situated knowledges; and 5) the interconnections between theorizing and social action.

For the first premise, I adopt Davis's (2008) definition of intersectionality as "the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power" (p. 68). Struggles over equity are struggles around power, with health disparities embodying the conflict at a corporeal level. Power within an intersectional context is understood not only as enacted through force, but also through non-coercive forms of social control (Collins 2000b; Glenn 1999). The latter draws on a Gramcian[2] notion of hegemony, referring to "taken-for-granted practices and assumptions that make domination seem natural and inevitable" (Glenn 1999:13; Gramsci, Hoare, and Nowell-Smith 1971). These processes are notably generated through non-political arenas such as culture, education, and health. Intersectional theorizing also draws upon Michel Foucault's notion of power as constituted within a nexus of knowledge and discourse (Collins 1999; Glenn 1999). As I discuss below, my research follows this Foucaultian conceptualization in studying the operations of power through health equity discourse and practice.

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[2] Sociologist Antonio Gramsci (1971) introduced the term "hegemony" to describe a form of domination pursued through persuasion and consent rather than coercion. Popular media exemplify one hegemonic mechanism of social control, which shapes social norms and ways of thinking.

The second intersectional premise situates race, class, gender, and other forms of inequality as interlocking, interactive, and historically contingent processes reflecting social systems that are co-constructive and mutually reinforcing (Collins 1990; Crenshaw 1991; Glenn 1999). That is, such processes are "positioned and gain meaning in relation to each other" (Glenn 1999:9). This premise holds particular significance in analyzing public health discourse where—as Weber and Parra-Medina explained (2003)—concepts such as race and gender are often reduced to independent variables, unlinked from macro systems of power. Following intersectional scholars (e.g., Glenn 1999; McCall 2005), I primarily interpret group categories as discursive markers for these underlying systems of inequality.

Third, understanding multiple inequalities in a relational context commands attention to the "invisible center" — that often dominant yet unnamed set of norms that privilege white, male, non-poor, and heterosexual statuses (Glenn 1999). Within systems of inequality, privilege is secured through institutional and cultural practices that benefit certain groups while simultaneously disadvantaging others. A regressive tax structure coupled with an under- and unpaid labor force are illustrative of this exploitive dynamic. Scholars have argued that part of privilege's power rests in an invisibility that deflects attention elsewhere, particularly toward marginalized groups as problematized populations (Daniels and Schulz 2006). An intersectional approach encourages analysis of both privileged and disadvantaged positions. In Chapters 3 and 4, I show how the health equity debate is characterized by a pursuit of opportunities for disadvantaged groups. Yet, related mechanisms of privilege remain unacknowledged.

Fourth, the situated knowledges of marginalized groups critically inform an understanding of inequalities. As Collins (1989) has argued, people living at the intersections of multiple inequalities contribute unique and valuable understandings about how complex interconnected systems of inequality work. In Chapter 4, “Mobilizing health equity action,” I consider the degree to which disadvantaged groups are included within health equity planning and action processes.

Fifth, an intersectional critique is only realized “when abstract thought is joined with concrete action” (Collins 2000b:29). Drawing on Foucault and others, Collins (1989) has argued that the linkages between theorizing and practice represent important points of intersectional inquiry. In Chapters 3 and 4 respectively, I trace the interconnections between health equity theory and practice by describing how inequalities are constructed through causal stories that then are translated into action via proposed interventions.

On a final note, my study of health equity discourse follows a new wave of intersectional inquiry specifically aimed at articulating the social processes and systems that generate multiple inequalities (Choo and Ferree 2010; Dhamoon 2011; McCall 2005; Walby 2007). This contrasts with previous intersectional scholarship, which has largely been devoted to capturing the experiences of those living at the intersections of inequalities, most notably women of color (Collins 2009; Knapp 2005; McCall 2005). As Collins (2009) points out, however, this recent structural thrust is not so much a novel direction but rather a circling back to the original commitments of intersectionality to articulate structural mechanisms for social change.

Foucault: Power/knowledge/discourse

Tracing how power operates through health equity discourse is central to this dissertation project. My theoretical approach is heavily influenced by Michel Foucault. The French philosopher and historian has been credited with expanding the concept of discourse beyond language, or even semiotics, to a system of representation embracing practice as well (Hall 1997). Furthermore, Foucault characterized discourse as deeply entwined within a nexus of power and knowledge. The scholar asserted, “discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle, discourse is the power which is to be seized” (Foucault 1981:52-53).

By power, Foucault (1993) referred not to a top down force emanating from the state or elite groups. Rather, this diffuse resource was essentially productive and harnessed to organize human action. Such power came “from below” as “exercised from innumerable points” accessible to all (1993:47). Furthermore, Foucault insisted “where there is power, there is resistance” as resistance is a counterforce inherent within all power relations (1993:477).

This thesis on power is part of a larger post-structuralist critique, in which Foucault described modernity less as an evolutionary advancement than as a contemporary reconfiguration of ongoing dominating practices (Best and Kellner 1991). In a study of punishment, Foucault (1984) traced how power has been reformulated from a feudal sovereign power exercised through deadly force (e.g., execution, war) to a wider social power of the modern state. One manifestation of this modern form is what Foucault termed “biopower” (Foucault 1984). Attending to the administration of human life, biopower exerts social control through both the training of individual bodies (via institutions such as schools and the military), as well as the regulation of human populations (via technologies of surveillance).

Medicine and public health are actively engaged in the production of biopower through the generation of scientific knowledge and health practice. By constructing certain realities while disqualifying others, this disciplinary knowledge serves to maintain “regimes of truth” about health and equity (Hall 1997). As such, knowledge is neither neutral, nor objective but rather as Hall (1997) explained, “always inextricably enmeshed in relations of power because it is always being applied to the regulation of social conduct in practice” (p. 47).

Discourse, according to Foucault, is the medium through which power/knowledge travels. Most broadly, discourse can be thought of as “historically variable ways of specifying knowledges and truths, whereby knowledges are socially constructed and produced by effects of power and spoken in terms of ‘truths’ ” (Carabine 2001:275). Rather than monolithic or unified, Foucault (1972) characterized discourses as comprised of multiple and diverse statements. Where discourses derive coherence is through the patterned regularities and interconnections of these divergent enunciations, particularly with regard to the ways these statements form objects, subjects, and concepts. Foucault (1981) was especially concerned with discontinuities within discourse when “things are no longer perceived, described, expressed, characterized, classified, and known in the same way” (p. 217). This emphasis on discursive ruptures and/or reconfigurations challenged modernist claims of continuity and progress.

In the next section, I discuss how I apply Foucault’s ideas of knowledge, power, and discourse to the contemporary study of health equity.

Research Methodology

This project is a qualitative, sociological investigation of health equity discourse, articulating the ways in which inequalities across race, class, and other stratifications are constructed and potentially intervened upon. A study of equity is a study of power. This research focuses on discursive power as manifested through text. My methodology is primarily informed by Foucault’s theorizing around power/knowledge. This approach is well suited for an intersectional analysis of health equity discourse. Specifically, discourse reflects the constitutive relationship between power and knowledge that is the form and substance of the Collins’s “matrix of domination” which is enacted upon bodies. Engaging Foucault within this intersectional analysis facilitates a deconstruction of discourse to elucidate its constitutive elements and their interrelationship and to tease apart how health equity both promotes and inhibits efforts toward health justice.

Though a comprehensive Foucauldian genealogy tracing grand epochs across time was beyond the scope and intent of this dissertation, I heeded to Carabine's (2001)prescription that investigation "of a particular movement without resorting to tracing its history….will still tell us something about discourse/power/knowledge" (p. 280) . Hence, I focus my inquiry of health equity within contemporary dialogues around health differences in the U.S. and abroad. To study this discourse and its power effects, I trace both the discursive construction of health equity, as well as the ways that these ideas are acted upon through proposed interventions. Further, I take up Foucault's concern for discontinuities in identifying the tensions within the contemporary dialogue around health differences that led to the rebranding of health disparities to health equity (1972; 1981). Finally, in keeping with Foucault's assertion that people's ideas do not exist outside of discourse (Foucault 1972), I direct my inquiry not on the particular individuals or organizations that serve as my sources, but rather on the collective discourse produced by these data.

Research questions

Taking up Foucault's methodological emphasis on history, discourse, and its power effects, my research is guided by the three questions outlined in the following table.

Table 1.0.1: Overview of Research Methods

RESEARCH QUESTION	DATA SOURCES	ANALYTIC STRATEGIES
1. How is health equity discourse situated within the contemporary debate around health differences?	▪ Health equity reports ▪ Key informant interviews ▪ Published historical accounts ▪ Government/NGO documents ▪ Organizational webpages	Content analysis capturing broad historic information

2. How are health inequalities theorized across race, class, and other forms of difference?	▪ Health equity reports ▪ Key informant interviews	In-depth textual analysis with detailed coding scheme
3. How does health equity shape planned action?	▪ Health equity reports ▪ Key informant interviews	In-depth textual analysis with detailed coding scheme

These research questions frame the three findings chapters of this dissertation. Specifically, the first history question is addressed in Chapter 2, “Historicizing health equity in public health discourse and practice.” The second on health equity theorizing is taken up in Chapter 3, “Causal Stories: Theorizing health equity across race, class, and other forms of difference,” and the third question analyzing proposed interventions is covered in Chapter 4, “Mobilizing health equity action: social determinants of health and place.”

Data sources, collection, and management

In order to address the range of concerns posed by my research questions regarding the evolutions, social construction, and proposed actions of health equity, this research project utilized multiple forms of data. Health equity reports and key informant interviews served as the main sources addressing all three queries (RQ1-3). Published historical accounts, organizational documents, and webpages supplemented my inquiry into the history of health equity discourse (RQ1).

Health equity reports were chosen as a main data source because such documents are highly influential in promoting theoretical frames and directing action around health equity at the national, state, and local levels. As Freeman (2006) offered, health equity “[d]ocuments are important for the vocabularies and ways of thinking they generate, reproduce, translate, and set in motion” (p. 52). Produced for wide circulation among various audiences (e.g., organizational staff, policymakers, community constituents), these directives offer a succinct problem definition and proposed set of recommendations aimed at promoting particular types of actions around health equity. As such, the health equity reports provided a discursive format through which to analysis both the constructions of health equity and well as how this discourse shaped planned actions.

Key informant interviews served as the second main data source to gain “insider” knowledge of the health equity debate not readily transparent from the documents. For instance, the health equity reports are highly scripted affairs that typically reveal little about the process and politics behind the documents’ creation. To attain this background information, I interviewed individuals who helped produce the health equity reports, to ascertain the reasons for and challenges in creating the report. As I was interested in understanding the health equity discourse more generally, I also interviewed health equity leaders to gain insight into the field’s evolution, including factors shaping the debate, as well as strategies used to move the dialogue forward.

Constructing a social history of health equity required supplemental resources. I drew on historical accounts to chronicle the early health disparities debate from the late 1970s to the 2000s. Comparable accounts of health equity were limited given the nascent status of this new frame particularly within the U.S. dialogue of health differences. Therefore, I used documents and webpages from health-equity oriented organizations to chronicle this movement.

Finally, I engaged in other research activities to gain additional information about my topic. Specifically, I conducted informational interviews to initially orient my project. I also attended conferences and trainings to keep abreast of advances in the health equity field, and collected and reviewed health equity materials from these venues. Field notes and documents from these sources were used as background materials to contextualize and inform my project, though included in my analysis. Data for this study were collected between August 2009 and April 2013.

Health equity reports

Eight (8) health equity reports were selected for in-depth thematic analysis, with publication dates ranging from 2008 to 2013. As no central health equity database existed,[3] I identified a convenience sample of health equity reports using: (1) referrals from key informants interviewed for this project (see below); (2) public health conferences (e.g., American Public Health Association; Academy of Health Equity); (3) listservs (e.g., Spirit of 1848, EQUIDAD); and (4) Google search engine (search terms include "health equity report", "health equity initiative"). Inclusion criteria specified that the reports include the term "health equity" in the text, provided theoretical explanations of health inequities and recommendations for action, and be publicly available on the Internet. I selected a range of organizations (e.g., public health agencies, foundations, nongovernmental organizations) to maximize institutional variation. Regional variation was also desired. However, I only identified reports produced by East and West coast organizations as meeting my study criteria during the primary data collection period (2009-2011).[4] The following table provides an overview of the eight health equity reports used in my analysis.

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[3] The Institute for Alternative Futures (Han and Haasenritter 2009) published a compendium of health equity initiatives, publications, and events in a memo dated November 24, 2009. While I did not access this document until 2011 after my initial data collection was complete, I reviewed the compendium and confirmed that my sampling did not overlook any key documents identified by this independent source.

[4] In exception, DHHS *Healthy People 2020* did not release detailed recommendations around the social determinants of health until April 2013. As my research focusing on both theorizing and proposed actions, I included the *Healthy People 2020* (U.S. Department of Health and Human Services 2013b) recommendations to complete analysis of this document.

Table 1.0.2: Health Equity Reports

AUTHOR (YEAR)	REPORT	ORG TYPE	*Total pages*	IN-DEPTH ANALYSIS		
				Sections	*Pages*	*Total Pp*
Alameda County Health Department (2008)	*Life & Death from Unnatural Causes*	Local health department	166	Exec Sum Intro	vii-xvi 3-10	18
Bay Area Regional Health Inequalities Initiative (2008)	*Health Inequities in the Bay Area*	Public health organization	42	All	1-36	36
California Pan-Ethnic Health Network (2009)	*Landscape of Opportunity*	Nongovernment organization	44	All	1-40	40
King County (2008)	*King Co Equity & Social Justice*	Regional government	27	All	Front, 1-24	25
Department of Health & Human Services (2010)	*Healthy People 2020*	Federal health organization	63	Select[1]	Web	63
National Partnership for Action to End Health Disparities (2011)	*National Stakeholder Strategy for Achieving Health Equity*	Federal health organization	230	Exec Sum Sec 1 & 3	1-21 109-137	41
Multnomah County Health Department (2009)	*Multnomah HE Initiative*	Local health department	145	Intro+	3-11	8
Robert Wood Johnson Commission to Build a Healthier America (2009)	*Beyond Healthcare*	Foundation	126	Exec Sum & Intro	1-25	25

[1] Includes the following DHHS *Healthy People 2020* webpages and documents: *Healthy People 2020* [brochure] (2010e); “Determinants of Health” (2010d); “Disparities” (2010b); “Foundation Health Measures” (2010c); “Framework” (2010a); “Social Determinants of Health Overview” (2013a); “Social Determinants of Health Summary Objectives” (2013b).

All health equity reports were downloaded from the Internet, catalogued, and uploaded into Atlas.ti 6.0 (2009) qualitative management software program for analysis. Documents were available in full PDF versions, except the *Health People 2020* report (U.S. Department of Health and Human Services 2010e), which primarily existed in webpage format.[5] To achieve a manageable and comparable data set, I limited analysis to report sections summarizing organizational history, etiological theorizing, and proposed actions around health equity. These summaries comprised the full report for shorter directives or executive summaries for longer reports. In exception, the National Partnership for Action's (2011) *National Stakeholder Strategy for Achieving Health Equity* and the DHHS *Healthy People 2020* (U.S. Department of Health and Human Services 2010; 2013) reports did not organize discussions as concisely. Rather, text of interest appeared in non-continuous sections or webpages respectively, which were alternatively downloaded. As indicated in the table above, the number of pages per document selected for analysis ranged from 8 to 63 pages (average 31 pages/document), comprising a total of 256 pages.

Key informant interviews

A total of 20 interviews were conducted for this project. Potential participants were identified using: (1) contributor lists from health equity reports, conferences (e.g., Academy of Health Equity Conference) and publications; and 2) referrals from other informants through a process known as snowball sampling (Patton 1990).Criteria for inclusion specified individuals who either helped produce a health equity report used in this project or were otherwise engaged in health equity activities in a leadership capacity (e.g., published in the area of health disparities/equity, held a leadership position in a health equity organization or project).

Potential participants were contacted by email with regard to participation, except for two individuals who were recruited at conferences. As outlined in the Table 1.3, the informant group varied demographically by race and gender. Professional affiliations included engagement in

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[5] Healthy People "Social Determinants of Health Summary Objectives" (U.S. Department of Health and Human Services 2013b) is available as a PDF document.

governmental and non-governmental health equity programs (n=16), academia (n=3), and the media (n=1), though informants reported multiple organizational affiliations currently and in the past. The key informant sample included individuals who crafted five of the eight reports.

Procedurally, most interviews (n=15) were conducted in-person at worksites or conferences, with the remainder carried out by telephone when a face-to-face opportunity was unavailable. Informed consent following procedures approved by the UCSF Committee on Human Research was obtained at the session start. Interviews ranged from half an hour to two hours (average one hour) and followed a semi-structured interview guide (see Appendix A). Participants were asked about their professional roles, understanding of health equity and related terms (as defined by the informant), organizational efforts regarding health equity, and evolution of the health equity movement in regard to defining moments, trajectories, strategies, successes and challenges. Interviews were audio-recorded (per permission), transcribed, catalogued, and uploaded into Atlas.ti 6.0 (2009) qualitative software analysis.

Table 1.0.3: Participants by Race and Gender

	AFRICAN AMERICAN	LATINA/LATINO	WHITE	TOTAL
WOMEN	4	1	3	8
MEN	7		5	12
TOTAL	11	1	8	20

Supplemental historical materials (historical accounts, organizational documents, webpages)

In addition to the health equity reports and key informant interviews, data from the following three supplemental sources were collected in order to contextualize the health equity debate historically within the larger discussions around of health differences: published historical accounts, organizational documents, and webpages. Published historical accounts were identified through two literature searches conducted in 2009. The first search used the search term “history” combined with “health disparities,” and “health policy” entered into a variety of search engines, including University of California library Melvyl catalogue, PubMed, and Sociological Abstracts. This search produced references primarily related to racial and socioeconomic disparities. As I was interested in a broader intersectional context, I conducted a second literature search adding terms “history” and “women’s health movement” to capture historical accounts related to efforts addressing women’s health disparities. While many social groups experience health inequalities, I chose women as the third disparities population to include in my social history chapter because of a comparable level of institutionalization of women’s health matters, which provided a rich comparison to those around racial and socioeconomic disparities.

The publications gleaned from the literature searches directed me to my second supplemental source, key governmental and non-governmental documents. This collection of health disparities reports, congressional records, and other materials helped benchmark the contemporary debate around health differences chronologically. My third supplemental source comprised webpages from health equity-oriented organizations, describing their organizational and/or program histories. The health equity-oriented organizations were identified either through previously noted archival materials or via procedures detailed above for accessing health equity reports. The specific history webpages were located by following the organizations’ homepage links, such as “about us”, and “history”. All supplemental materials—historical accounts, documents, and webpages—were accessed and downloaded via the internet. Hard copies of these materials were printed for a hand coded content analysis of key historical themes, as described below.

Analytic strategies

For my qualitative analysis of health equity discourse, I adopted an iterative, inductive approach that was informed by Foucaultian discourse analysis (Carabine 2001) and grounded theory techniques (Charmaz 2006; Glaser and Strauss 1967; Strauss and Corbin 1998). Specifically, I followed the main steps and analytic processes outlined by Carabine (2001), then augmented my in-depth textual analysis with several grounded theory techniques (e.g., coding, constant comparative method, memoing) that kept analysis close to or "grounded" in the data.

As Carabine (2001) recommended, I first immersed myself in the health equity field broadly to familiarize myself with my topic. I collected and reviewed numerous documents, attended conferences and webinars, and conducted informational interviews. This exposure to the discourse allowed me to gain a general sense of the kinds of health equity issues discussed and the ways these issues were being talked about. Based on input gleaned from informational interviews, I chose to prioritize health equity reports, key informant interviews, and supplemental archival materials described previously as the data sources for my analysis. All other materials served as background information.

As outlined in Table 1.1, I conducted two types of analysis—a broad content analysis for RQ1 and in-depth textual analysis for RQ2 and 3. These analytic approaches were selected to accommodate the analytic requirements of the different research questions. To develop a social history of the health equity movement (RQ1), I performed a content analysis of historical themes, which involved hand coding a range of materials (e.g., published historical accounts, organizational documents, webpages) to chronicle key actors, events, and debates within the health disparities/equity discourse. This broad level of analysis was suitable for constructing a social history of the field.

To investigate etiological theorizing and proposed actions within health equity discourse. (RQ2 and 3), I conducted an in-depth textual analysis on the health equity reports and key informant interviews described previously. With the aid of Atlas.ti 6.0 (2009) qualitative software, I analyzed these textual sources following qualitative techniques of coding, memoing and constant comparison (Charmaz 2006). I used codes as analytic markers to categorize text according to themes of interest. My coding scheme incorporated both “pre-selected” and “emergent” codes. Pre-selected codes refer to thematic concepts drawn from my research questions and extant literature that are selected prior to analyzing my data. For instance, the health equity literature suggested that the idea of health equity was associated with the concepts of social determinants of health and social justice so I established codes with these terms to capture relevant text (Braveman 2006; Braveman and Gruskin 2003; Whitehead 1992). I also pre-selected codes such as race, racism, gender, and socioeconomic status to analyze discussion of various forms of inequality and potential intersections. Guided by discourse analysis techniques (Carabine 2001), I paid particular attention to absences of relevant information (e.g., focus on racial and ethnic disparities without discussion of racism; gender references that omitted women or men), noting these with the code “silences” in sections of text where the omission was observed. In contrast to preselected codes, emergent codes are those identified during analysis, appearing as patterned, repeating ideas. Examples include the term “opportunity,” which often appeared in report text, or verbatim phrases like “Obama era,” “democratic process,” and “cooptation” repeated by interviewees.

Given this project’s exploratory nature, initial coding was provisional or what Blumer (1954) termed ‘sensitizing,’ that is “merely suggest[ing] directions along which to look” (p. 7). Such coding first serves to orient, rather than commit, highlighting segments of textual material for further examination. For instance, ideas about social determinants were central to my analysis so I begin coding using this pre-selected term. However, multiple types of social determinants were present within my data, so I generated additional codes to capture subcategories (e.g., social, economic, political) and specific types (e.g., housing, education, transportation). This process engaged a comparative method (Charmaz 2006), wherein data was contrasted against other data to identify similarities and differences. Through this comparative effort, codes can be solidified into what Blumer (1954) terms “definitive concepts,” well-defined and distinguished by particular attributes and contextual factors.

Additionally, the comparative process aids in establishing theoretical linkages between codes. For instance, the term “environmental determinants” often referenced concepts of “place” and “community engagement” which expanded understanding of political action in terms of geography site and actors. Linkages also led to the development of larger categories, which comprise a number of associated codes. An example would be the term “conditions of possibilities,” a Foucaultian notion referring to the conditions that allow a discourse to emerge or change (Foucault 1981; Kendall and Wickham 1999). I used this theoretical term to capture various information (e.g., timing, public health knowledge, leadership) referenced by interviewees as contributing to health equity’s emergence as a new frame for health differences

Throughout my analysis, I pursued several forms of “memoing” to record my procedural decisions, reflective thoughts, and analytic development (Strauss and Corbin 1998). Analytic memos that record emerging ideas and interconnections in the data are particularly essential to developing a comprehensive understanding of the phenomena under study. Pursued in tandem with coding and comparison techniques, analytic memoing enabled me to articulate the range of concepts and actions used within health equity discourse and served as the central tools for qualitative analysis.

Dissertation Overview

In Chapter 2, “Historicizing health equity through public health discourse and practice,” I contextualize the health equity debate within the contemporary conversation around health differences both in the U.S. and abroad. Inspired by Foucaultian genealogy, I situate this conversation within overarching frames of biomedicine, social justice, and neoliberalism, which I argue significantly shape what can and cannot be said about health differences and equity. I illustrate how these frames generate frictions between biomedical and social approaches to health inequalities, as well as among various constituencies identified by race, gender, and class divisions who are vying for position within public health agendas aimed at addressing health inequities. I argue these two tensions between approaches and disparity populations generate the momentum for a health equity movement to promote a social determinants approach to health inequalities and inclusion of a range of disadvantaged groups. As interviews with key informants highlight, however, mobilization around health equity is far from uniform. Rather, this movement fuels longtime struggles between race and class perspectives, as well as between liberal and more radical approaches to at achieving equity in health.

Chapter 3, “Causal stories: Theorizing health equity across race, class, and other forms of difference,” describes the ways in which health inequities are theorized across race, class, and other forms of difference, as presented within 8 health equity reports representing a range of governmental and nongovernmental organizations. My analysis demonstrates that these “causal stories” are not particularly intersectional in that tales tend to either reduce multiple inequalities to an autonomous “laundry list” of variables, which combine in an additive rather than intersecting manner; or the tales prioritize one form of inequality (notably socioeconomic status or race) over others.

That is, rather than conceptualized as co-constitutive, socioeconomic status or race were tended to be contentiously juxtapositioned within the discourse, further supporting Chapter 2 interview findings of a divide between race and class perspectives to addressing health inequalities. Furthermore, while race and socioeconomic status receive the most attention within the causal stories, other forms of differences—notably gender, disability, and sexual orientation—remain undertheorized.

Chapter 4, “Mobilizing health equity action: social determinants of health and place,” describes the action steps proposed by the health equity reports to eliminate health disparities. I illustrate that these recommendations primarily cluster around environmental and socioeconomic domains, which correlate with Chapter 3’s causal stories theorizing about the socioeconomic gradient and racialized notions of place. The remainder of this chapter is devoted to articulating the dimensions of place as an organizational construct, registering both its strengths and limitations.

Chapter 5, “Conclusions” provides an overview of key dissertation findings. I follow with implications of this study for sociology and health. Specifically, I discuss theoretical contributions with regard to the social structuring of health inequalities. I then provide several implications of this research for health research and policy. I close with an account of study limitations, as well as future research directions based on findings to date.

CHAPTER 2

HISTORICIZING HEALTH EQUITY IN PUBLIC HEALTH DISCOURSE & PRACTICE

In 1906, W.E.B. DuBois published The Health and Physique of the Negro American, in which he asserted that health differences between Whites and African Americans were not due to inherent racial inferiority, as conservatively ascribed, but to deleterious social and economic conditions plaguing Black communities (Brown and Fee 2003; DuBois 2003; Thomas et al. 2006). Moreover, DuBois' critique was not limited to the "color-line" but in fact recognized an intersectional imperative cutting across class and gender. That is, the African American experience was not only impacted by poverty but affected men and women in unique ways (Hancock 2005). This early twentieth century scholarship demonstrates that the debate around health equity is not new, nor uni-dimensional, but rather reflects ongoing contestations about the meaning and consequences of health differences in modern society.

In the spirit of Dubois's critique, my dissertation assesses the potential of health equity discourse as an intersectional project that pursues justice across multiple, intersecting lines of power that shape both social structures and identities (Collins 1990). To historically contextualize my analysis, I position the health equity debate as part of a resurgence of attention to health inequalities within the post-civil rights era. Following Foucault (Foucault 1994) and others (Collins 2010; Winant 1997; 2001), I approach this re-emergence not simply as a progression of the dialogue around health inequalities but rather a reconfiguration of a perennial struggle, or what Collins (2010) calls a "changing-same" situation (p. 8). For health equity, this has meant reinstating commitments to social justice, while re-articulating the debate around present-day contingencies.

In these pages, I identify neoliberalism, biomedicine and the social justice discourse of civil rights as importantly shaping the debate around health inequalities. These overarching frames shape what can and cannot be said about health differences in this particular era. Against this discursive backdrop, I argue that health equity represents a re-articulation of health disparities as an explicitly social rather than biomedical phenomenon that requires solutions targeting social conditions of health. Moreover, the equity frame invites a re-commitment to health differences as a justice concern, which in the U.S. has meant moving beyond race to include other forms of inequality.

My analysis draws from primary and secondary sources to historicize health equity within the contemporary discursive moment. I open by describing the overarching frameworks influencing the dialogue of health differences from the 1950s to the present. During this period biomedicine and neoliberalism have emerged as discursive forces, accompanied by a sociopolitical explosion of social movements. Drawing on high profile documents and related critiques addressing health inequities, I next illustrate the ways these frameworks generate the overlapping frictions with the health disparities debate between neoliberalism and social justice imperatives; biomedicine and social approaches; and race-, class-, and gender-based perspectives.

In the final chapter section, I trace the emergence of the U.S. movement for health equity. Given its nascent status, few historical accounts capture health equity's development within this country so I supplement my archival sources with primary data from key informant interviews and health equity reports. I outline the movement's early activities to illustrate how this health equity effort is defined by the push for justice and actions around the social determinants of health. In historicizing the health equity debate in this way, I underscore two intersectional themes taken up in the remainder of this dissertation involving inclusion of diverse types of disadvantage and attention to structural forms of inequality.

Overarching Frames: Biomedicine, Social Justice, & Neoliberalism

> [D]iscourses…do not occur in isolation but in dialogue, in relation to or, more often, in contrast and opposition to other groups of utterances. (Mills 2004:10)

As Mills (2004) has stated, discourses cannot be understood separately from other dialogues. Indeed, discourses are a part of larger interactive networks in which ideas and actions collide and coalesce. As a discourse, the health equity debate is no exception. In this section, I consider three overarching socio-political and cultural frames influencing the health equity debate. Deeply political, such frames promote dominant ideas about health and inequalities that are often taken-for-granted in a particular historical moment. My considerations include biomedicine, social justice, and neoliberalism. In selecting these three frames as the discursive backdrop of my discussion, I am not suggesting that these are the only frames intersecting the health equity field. Rather, I ascertain that biomedicine, social justice, and neoliberalism are particularly instrumental in provoking major points of contention within the health equity debate. In this section, I briefly chronicle these discursive conditions. While internally complex and at times conflicting, each framework amasses particular discursive characteristics that provide it distinction, which I attempt to encapsulate below.

The period following WWII has marked an important shift in the conversation around health that continues into the present day. It was during the 1950s that biomedicine gained dominance within the health arena, bringing with it a clinical, individually-oriented, and technical approach to population health (Fee 1994; Krieger 2011). Biomedicine's ascendency over other social and alternative medical approaches can be partly attributed to its success in controlling communicable diseases through biotechnologies, such as vaccines and antibiotics. Some argue, however, that biomedicine's achievements overshadow the important role of social and sanitary reforms in curbing infectious diseases (Fee 1994; McKinlay and McKinlay 1977). Moreover, these critics posit that biomedicine's ascendency was bolstered by an American ethos of individualism and anti-communist sentiment (Fee 1994).

Public health—the field devoted to population health differences—was similarly impacted in the post war years. Founded in the sanitarium movements of the early industrial era, public health redirected efforts away from social reform, gravitating instead toward less controversial health education campaigns in the wake of the so-called Red Scare (Fairchild et al. 2010; Fee 1994; Krieger 2011). Even as public health theorizing evolved from a single to a multivariate disease model, prevailing biomedical logics directed attention to individual-level biological and behavioral factors (e.g., diet, exercise) considered most amenable to change (Krieger 1994; Link and Phelan 1995). As such, critics have contended that biomedical discourse reduces complex social phenomena around race, class, and other social inequalities to discrete, decontextualized characteristics of individuals (Fee and Krieger 1993; Weber and Parra-Medina 2003). Along these lines, Shim (2002) warns, "these disciplinary practices effectively displace and erase the importance of social relations and formations of power in the production of health and illness" (p. 131). This biomedicalization[6] of a social problem reinforces commonplace notions of health disparities as individual biological and behavioral concerns, while diverting attention from the deeper social relations generating these health injustices.

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[6] The concept of biomedicalization expands upon Irving Zola's (2004) idea of medicalization, which describes the extension of medical authority into everyday life, to include new and extended medical domains of risk assessment, computer and information technology, health care corporatization and privatization, and individualized health genetic, among others (Clarke et al. 2003).

As Foucault (1993) has theorized, however, power begets resistance. Social unrest in the 1960s and1970s re-politicized the very health arena through which biomedicine exerts its authority. The civil rights movement helped re-cast health disparities as fundamentally a social concern. In calling for equity and justice across race, gender, and other forms of difference, activists tied struggles around segregated health services and reproductive rights to broader social equalities in employment, education, and political participation (Gamble and Stone 2006). These grassroots efforts led to the institutionalization of civil society demands. Among the more notable U.S. legal actions were the Civil Rights Act of 1964, Medicaid/Medicaid (1965), and abortion rights of Roe v. Wade (1973) (Gamble and Stone 2006; Weisman 1998). A small but growing body of research suggests a positive impact of civil rights reforms on reducing health disparities, supporting the justice argument that social interventions provided successful strategies in improving the well-being of disadvantaged populations (Kaplan, Rnjit, and Burgard 2008; Krieger et al. 2008; Satcher et al. 2005).

The 1970s and 1980s brought broad neo-liberal retrenchments, both in the Reagan administration and governments abroad (e.g., Thatcher in Great Britain, Lalonde in Canada) (Irwin and Scali 2007). Harvey (2005) has characterized the rise of neoliberalism as a restoration of class power and elite governance, disrupted by the welfare and cultural reforms of the preceding decades. As an economic policy, neoliberalism promotes open markets and privatization in tandem with devolution of the welfare state. This economic agenda translates into a “pull yourself up by your bootstraps” ethos of personal responsibility. As a form of governance, Ong (2006) and others (e.g., Steger and Roy 2010) have argued that neoliberalism presents the most recent incarnation of a biopolitics that governs human life through technologies of “market knowledge” (p. 13). As such, health is turned into a Wall Street commodity where patients are constructed as consumers and quality care is monetarily incentivized. While proponents claim neoliberal practices increase economic efficiency and productivity, progressives counter that these economic initiatives redistribute resources and control to powerful elite, vastly intensifying social inequalities (Coburn 2004; Navarro 2009). As a health equity concern, neoliberalism not only increases health disparities but its pro-market ideology also re-enforces individualistic, biotechnological solutions to social problems (Krieger et al. 2008).

Considered together, biomedicine, social justice, and neoliberalism provide the discursive milieu through which health equity currently circulates. Neoliberalism represents the dominant sociopolitical frame advancing market justice and the commodification of health, while social justice calls for a rebalancing power and revitalizing welfare state. Biomedicine provides the dominant health frame, which manages health primarily through biological and behavioral technologies. The micro-level focus aligns biomedicine more closely with neoliberal individualism than with social justice. In the following sections, I illustrate some ways these overarching frames interface within the contemporary debate around health inequalities, creating points of resistance and accommodation.

Discourses of Health Difference, 1970s-2000s

Drawing on key documents and initiatives and related historical accounts, I briefly chronicle the contemporary debates around health difference in the U.S. and overseas. While alternatively framed as a conversation about “health disparities” in the United States and “health inequalities” internationally, both venues express similar concerns around tackling health inequities as a social problem within the current neoliberal biomedicalized context. Yet, the distinguishing features of these lexicons notably represent different orientations to the problem of health differences. Specifically, the U.S. “health disparities” term carries strong racial and ethnic connotations, whereas the international “health inequalities” moniker prioritizes socioeconomic concerns (Braveman 2006; Exworthy et al. 2006). In this section, I highlight these discursive frictions between biomedical and social approaches, as well as between race, class, and gender orientations within the discourse of health difference. As I will illustrate, these two tensions resurface throughout the contemporary U.S. debate around health differences, providing fodder for rebranding the health disparities argument to one of health equity.

U.S. Debate around Health Disparities

The civil rights era marked a critical transition in U.S. history with regard to recognizing the rights of women, people of color, gays, and other marginalized groups (Omi and Winant 1994; Stein 2012; Weisman 1998). This wave of social activism paved the way for renewed attention to health inequalities. Yet these justice efforts did not progress unobstructed. Rather, the examples below show that the debate was marked by repeated challenges as to what constituted health disparities, as well as their solutions. As Foucault (1972) reminds us, discourse exists as a contentious field, defined more through fractures, discontinuities, and morphologies than by unity.

Discursive tensions between biomedical and social approaches

Following health disparities’ discursive fault lines, I first elucidate frictions between biomedical and social framings of health differences. In so doing, I illustrate how neoliberal and biomedical imperatives, which reinforce an individualistic, biological and behavioral framing of health disparities, clash with alternative social constructions around health equity. I begin with The 1985 *Report of the Secretary’s Task Force on Black and Minority Health* (U.S. Department of Health and Human Services 1985), often considered the cornerstone of contemporary U.S.

health disparities discourse (Thomas et al. 2006). Also referred to as the Heckler Report, this ten-volume publication was the most comprehensive in its time for statistically documenting health inequities across racial and ethnic groups. Further, the publication's use of an "excess death" measure[7] dramatically captured the significant impact of inequities as *avoidable* mortality (Gamble and Stone 2006). This rhetorical strategy poignantly fueled moral and action-oriented imperatives, which portrayed health inequities as "an affront to both our ideals and to the ongoing genius of American medicine" (U.S. Department of Health and Human Services 1985:ix).

Though hailed as a foundational document in establishing the contemporary U.S. dialogue around health inequalities, The Heckler Report did not escape criticism. Specifically, the publication received negative appraisal for promoting personal responsibility while offering little commentary on the social forces generating community ill-health (Gamble and Stone 2006). As then president of the National Medical Association[8] Dr. Edith Irby Jones asserted, the report suggested that "[i]f black people would only 'behave' their health problems would be solved…" (Jones 1985, quoted in Gamble and Stone 2006:105). By reinforcing a dominant biomedical discourse fixed on individual behavioral change, the Heckler Report recommendations aligned with neoliberal sentiments emphasizing personal rather than societal responsibility.

Struggles between biomedical and social perspectives continued to play out in the coming decades. In 1999 for example, a high profile study in the *New England Journal of Medicine* reported differential treatment between blacks and whites with cardiovascular disease (Schulman

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[7] In epidemiology, an excess death measure calculates the number of deaths observed beyond those expected in a standardized population, such as comparing blacks to whites of similar age and gender (Dever and Champagne 1984: 99-100).

[8] A U.S. black medical professional organization.

et al. 1999). Following a public outcry of injustice, Congress commissioned the Institute of Medicine to develop a policy report on the topic (Gamble and Stone 2006). However, the congressional charge was narrowly defined to only investigate racial and ethnic differences within the health care setting. The resulting report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, and Nelson 2003), offered compelling evidence and recommendations regarding inequalities involving health provider bias, cultural and geographic barriers to medical care, and the health care regulatory and policy environment. Still, the report authors acknowledged that the constraints of their charge prohibited critique of the underlying social conditions of health disparities, specifically poverty and structural disadvantage resulting from "historic patterns of legalized segregation and discrimination" (Smedley, Stith, and Nelson 2003:6).

Then in December 2003, DDHS released its controversial *National Healthcare Disparities Report* (U.S. Department of Health and Human Services 2003).[9] Internal leaks quickly revealed that the executive summary—the report section most typically read by policymakers—had been significantly altered (Bloche 2004; Steinbrook 2004). Among the modifications was deletion of the word "disparity" 28 times in the "key findings" section (U.S. House of Representatives 2004). Defined in an earlier draft document as "the condition or fact of being unequal, as in age, rank, or degree", the word "disparity" was replaced with the more neutral term "difference" (U.S. House of Representatives 2004, quoted in U.S. House of Representatives 2004:1). As the edited report explained:

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[9] As a result of public concerns, the December 2003 version *National Healthcare Disparities Report* is no longer available from DHHS Agency for Healthcare Research and Quality website. Instead, the controversial end of year report has been replaced with the original unedited July 2003 version (U.S. Department of Health and Human Services 2003).

> Where we find variation among populations, this variation will simply be described as a "difference." By allowing the data to speak for themselves, there is no implication that these differences result in adverse health outcomes or imply prejudice in any way. (U.S. House of Representatives 2004, quoted in U.S. House of Representatives 2004:6).

Neutralizing disparities terminology by deploying terms of mathematical differences was not simply a case of semantics but also had real world consequences, as a special congressional investigation revealed (U.S. House of Representatives 2004). By relegating racial and ethnic health disparities to the level of simple variation, the report downplayed this health crisis of inequality in order to justify program cuts in this area. Indeed, the Republican administration's budget axe was already aimed at several key health equity programs including the Health Careers Opportunity Program for Minorities and the Agency for Healthcare Research and Quality's (AHRQ) Excellence Centers to Eliminate Ethnic/Racial Disparities (U.S. House of Representatives 2004). The congressional investigation concluded that the Bush administration altered the *National Healthcare Disparities Report* "…to promote a narrow political or ideological agenda" (U.S. House of Representatives 2004:9). This agenda reflected a neoliberal imperative to reduce big government, which targeted, among others, social programs aimed at benefiting disadvantaged groups.

Discursive tensions across race, class, and gender perspectives

I now consider the second fault line in the debate around health differences; that which reaches across race, class, and gender to illustrate the roles that diverse constituencies play in advancing the discourse of health inequalities. I begin again with the Heckler Report (U.S. Department of Health and Human Services 1985). As noted, this publication was pivotal in documenting health inequities across racial and ethnic groups. The inclusion of populations of color beyond "Black"—specifically "Hispanic", "Native America", and "Asian/Pacific

Islander"[10]—was relatively novel and of interest from an intersectional perspective in recognizing population diversity. As such, the publication legitimized a particular framing of health differences that established race and ethnicity as the dominant concerns. Substantively, the report helped cultivate a governmental infrastructure to tackle these health differences through the establishment of a minority health office at the Department of Health and Human Services (DHHS) (Gamble and Stone 2006; Thomas et al. 2006). The Centers of Disease Control (CDC) and National Institutes of Health (NIH) shortly followed with offices of their own.

Yet, racial and ethnic health disparities were not the only targets of efforts in the wake of post-civil rights efforts to alleviate health inequalities. For instance the same year as the Heckler Report release, *Women's Health* (U.S. Public Health Service 1985) was published by the Public Health Task Force on Women's Health Issues. This two-volume government document established the need for gender appropriate research at the federal level (Auerbach and Figert 1995). Though receiving minor attention relative to the Heckler Report, the Public Health Task Force publication was important in its own right in placing women's health on the national agenda (Auerbach and Figert 1995).

Following a decade of slowed activities around health inequalities during the Republican 1990s, President Clinton revitalized governmental attention through numerous initiatives. I discuss three initiatives that illustrate cross constituency exchange. The first was the 1993 NIH Revitalization Act Subtitle B–Equity Regarding Women and Minorities (Public Law 103-4) that established an inclusion requirement for women and people of color in NIH sponsored research (Johnson and Fee 1997). The primary driver behind this provision was a coalition of women's health advocates, including the bi-partisan Congressional Caucus of Women's Issues and a NIH

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[10] Racial and ethnic category terminology used in the Heckler report (U.S. Department of Health and Human Services 1985).

insider group, the Society for the Advancement of Women’s Health Research (Epstein 2007; Weisman 1998). Not surprisingly, Subtitle B’s initial emphasis reflected this constituency’s gender focus, though draft provision language was expanded to include people of color once the Congressional Black Caucus expressed interest (Epstein 2007).

The second initiative was *Healthy People 2000* (U.S. Department of Health and Human Services 1991), a DHHS publication that sets national public health guidelines. This decennial report for the first time prioritized the reduction of health disparities as a national goal, underscoring that “…the greatest opportunities for improvement and the greatest threats to the future health status of the Nation reside in population groups that have historically been disadvantaged economically, educationally, and politically” (U.S. Department of Health and Human Services 1991:46). Disadvantaged groups were specified by race/ethnicity, low income, and disability. However, the health objectives for the disenfranchised were unevenly applied across the document. For instance, *Healthy People 2000* set lower benchmarks for racial and ethnic populations relative to their white peers (Thomas et al. 2006). The segregated benchmarking practice was eliminated in the 2010 iteration of *Healthy People*, however, as the government advanced its commitment toward equity (Thomas et al. 2006). Along these lines, *Healthy People 2010* also elevated its national goal from “reducing” to “eliminating” health disparities and expanded disparities categories to include gender, geographic location, and sexual orientation (U.S. Department of Health and Human Services 1991).

A third initiative from the Clinton era was the Minority Health and Health Disparities Research and Education Act of 2000 (42 United States Congress 202), which prioritized research and training across governmental organizations (Thomas et al. 2006). This initiative elevated the NIH Office of Minority Health from “Office” to the higher “Center” status. However, key congressional members demanded inclusion of poor white populations within the Center's mandate before approving the legislation (Gamble and Stone 2006).

In characterizing some of the contours of the contemporary U.S. health disparities debate, I highlighted two important points of intersectional concern. First, this overview captures struggles between biomedical and social approaches to health differences, as illuminated in discursive frictions around both the definition of disparities, as well as its remedies. Are disparities clinical variations in health to be treated biomedically or are these differences manifestations of injustice requiring structural interventions? Such questions point to larger political tensions between an individualistic, pro-market neoliberalism on the one hand and a social justice imperative on the other. Second, the U.S. disparities debate appears to represent separate rather than intersecting dialogues around race, class, and other forms of difference. Aside from brief moments of multi-constituent lobbying, efforts to address specific population health differences often occur in mutual exclusion of, and at times in direct competition with, each other. Furthermore, these endeavors are not pursued in equal tempo, but instead are dominated by racial and ethnic concerns. As I discuss below, such conflicts are not unique to the United States but occur overseas as well.

International Debate around Health Inequalities

While the civil rights movement ignited U.S. attention to racial and ethnic disparities, the international community pursued an agenda around socioeconomic inequalities and social determinants of health. This concentration reflects longtime struggles in Europe, Latin American, and elsewhere around class politics, a conversation muted in the U.S. by neoliberal doctrine and conservative ideas of a "classless" society (Macintyre 1997). Examples of international efforts promoting an alternative socioeconomic determinants framework included the World Health

Organization (WHO) “Health for All by the Year 2000” initiative, proposed in 1976, which pushed for expansion of basic health services in concert with attention to nonmedical conditions impacting population health (Irwin and Scali 2007). The objectives of “Health for All” were embraced within the 1978 International Conference on Primary Health Care’s Alma-Ata Declaration, along with calls for community participation, social development, and intra-governmental action (Baum 2007; Irwin and Scali 2007). The next decade produced the influential British publication, *Inequalities in Health: Report of a Research Working Group*, (Black et al. 1980). Commonly referred to as the Black Report, this document underscored the class gradient in health (Macintyre 1997).

As in the U.S., efforts toward a social framing of health differences met resistance from neoliberal interests. In Britain, the Black Report was suppressed by the incoming conservative Thatcher administration (Oliver and Nutbeam 2003; Whitehead 1998). Likewise, the comprehensive primary health care model promoted at Alma-Ata was transformed by the World Bank into a vertical health program devoid of structural reform (Baum 2007; Irwin and Scali 2007). Neoliberal politics continued to dominate the international health agenda throughout the 1990s, with an informal shift of authority from WHO to the World Bank with its promotion of pro-market structural adjustment initiatives (Baum 2007; Braveman 2006; Irwin and Scali 2007).

In exception, the WHO European office continued to build on WHO’s “Health for All” framework, commissioning a series of publications that conceptualized a new health equity framework (Whitehead 1998). Among these writings was Margaret Whitehead’s (1992) influential paper, “The concepts and principles of equity and health,” which helped define health equity and related concepts. Specifically, Whitehead described equity as the fair opportunity for attaining one’s full health potential, with recognition that “…none should be disadvantaged from achieving this potential, if it can be avoided” (p. 433). Alternatively, inequity referred to not just any health difference but rather those “differences which are *unnecessary*…*avoidable*…*unfair* and *unjust*” (p. 431, emphasis in original). Whitehead also articulated key principles for policy action around health equity that targeted living and working conditions, civic participation, health care access, and intra-governmental action.

These ideas around inclusivity, collaboration, and social conditions of health form the cornerstones of a health equity framework in the international push for social justice, with a particular emphasis on socioeconomic determinants. While the U.S. disparities debate makes reference to socioeconomic status in acknowledging low income groups, as well as connections between race and poverty, racial and ethnic disparities remain its dominant concern. This divergent focus between U.S. and international debates represents varying, and at times conflicting, race and class perspectives. As I discuss shortly, these dissimilarities have exacerbated tensions within the U.S. debate with the recent adoption of the European health equity lexicon within this nation’s conversation around health differences.

U.S. Movement toward Health Equity

In this final section, I describe the transition in the U.S. conversation from health disparities to health equity, drawing on primary and secondary sources, including data from in-depth analysis of health equity reports and key informant interviews. I argue that the move toward health equity was a move toward social justice that advanced two primary concerns: the first regarding the social determinants of health and the second regarding disadvantage and inclusion. By repositioning the disparities conversation within the context of social determinants and equity, advocates pushed the issue of health differences from a biomedical problem back into the sociopolitical arena. And naming health disparities as not just any health variations but rather those differences adversely affecting historically disadvantaged groups bolstered this justice imperative. Moreover, considering disparities within a justice context offered an opportunity to reinforce the idea of health inequality as not only a racial and ethnic concern, but also one affecting other groups. I consider these themes in turn, first discussing the move from a biomedical to a social determinants approach, then from health differences to health inequities.

Moving beyond biomedicine toward the social determinants of health

> [T]he social determinants and the equity frame is a window to a transformative understanding of health and the medical model of health is just - it's a dinosaur. So it's kind of a roundabout way of getting away from this deficit approach to understanding that if you live in the right conditions and you have the right mental and emotional frame, you can be healthy and that the disease and pathology is the exception, it's not the norm. (Interview 04)

By the mid-1990s, U.S. health organizations began laying a foundation for what has become the most recent reframing of the conversation around equity in health. Whereas most organizations neither directly defined health equity nor elevated the term to a core organizing principle during these early years, their efforts provided the discursive groundwork for linking health equity explicitly to justice and the social determinants of health. Below, I feature several governmental and non-governmental entities to briefly overview when and how these groups took up a health equity frame. This chronicle is not intended as a comprehensive history but rather a case study highlighting efforts among a select group of organizations that intentionally adopted a health equity frame to address health disparities.

My discussion begins with three nongovernmental organizations (NGOs): Bay Area Health Inequities Initiative (BARHII), National Organization for County and City Health Officials (NACCHO), and MacArthur Research Network on Socioeconomic Status & Health (MacArthur Network). As public health organizations, BARHII and NACCHO shared an interest in advancing a social approach to health. For instance, Bay Area Health Inequities Initiative aimed to bring together local public health directors and health officers who were "troubled…that preventable illness and death seemed to reflect patterns of social inequalities, but public health programs were not designed to deal with these underlying causes" (Bay Area Regional Health Inequities Initiative N.d.). Staff at the NACCHO was similarly grappling with questions regarding "what health departments can do to better address the causes of these inequalities" (National Association of County and City Health Officials N.d.). Both BARHII and NACCHO galvanized efforts around a similar mission "to transform public health practice for the purpose of eliminating health inequalities using a broad spectrum of approaches that create healthy communities" (Bay Area Regional Health Inequities Initiative N.d.).

The third NGO, the MacArthur Network was comprised of a small multidisciplinary workgroup of psychologists, social scientists, physicians, and public health professionals, who were interested in understanding the biological and psychological mechanisms by which socioeconomic factors influence wellbeing (Adler and Stewart 2010). The catalyzing event for this research focus was a presentation given by social epidemiologists, which demonstrated the strong associations between socioeconomic status and health. As one informant recounted, when the epidemiologists presented the socioeconomic data, the collaborative members "were just stunned….that it was such a powerful predictor" and resolved to understand this association more clearly. "What are the mechanisms, both the psychology and the biological mechanisms, by which the social environment gets under the skin" (Interview 14)? MacArthur Network members went on to contribute significantly to research on the psychological and neurobiological mechanisms of health inequality, particularly with regard to stress (e.g. (Adler et al. 1999).

What NACCHO, BARHII, and the MacArthur Network had in common is that these organizations provided collaborative spaces in which health leaders and researchers could convene to talk about equity and the social conditions of health. Each of these groups also eventually produced influential health equity-oriented reports[11] offering conceptual frameworks and action steps for their membership and others working for health justice. These publications premiered the social determinants of health and called for changes at the level of institutional policy and practices. Although grounding their reports in a U.S. dialect of health disparities that encompassed racial and ethnic concerns, the NGOs were not oblivious to the socioeconomic debates occurring overseas. In fact, one informant revealed that the MacArthur Network modeled its report after the WHO's *Social Determinants of Health: The Solid Facts* (Wilkinson and Marmot 2003), with the WHO report's co-author, Michael Marmot, serving as a core Network member. The WHO document was cited in BARHII and NACCHO reports as well. Incorporating international references in these U.S. publications reflects what Margaret Whitehead (1998) has referred to as a "diffusion of ideas"[12] around health equity. In this case, I refer to ideas flowing from the international community to the U.S. that emphasized the social determinants of health, particularly socioeconomic factors. As I will discuss, the integration of a socioeconomic agenda into the race-oriented U.S. debate has been met with mixed reception.

During these early years, the U.S. government and affiliated agencies were also interested in equity and social determinants of health. For instance, DHHS first employed the term "health equity" in its 2000 release of *Healthy People 2010* (U.S. Department of Health and Human ServicesX 2000). Though the phrase itself was not specifically defined, the social determinants of health were included within health equity's conceptualization:

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[11] These reports included MacArthur Network's, *Reaching for a Healthier America: Facts on Socioeconomic Status and Health in the U.S.* (Adler et al. 2007), NACCHO's *Tackling Health Inequalities through Public Health Practice: A Handbook for Action* (Hofrichter 2006) and BARHII's *Health Inequalities in the Bay Area* (Bay Area Regional Health Inequities Initiative 2008).

[12] Whitehead uses the term to describe the process by which ideas around health inequities gain attentions among policymakers and others (1998:470).

> Healthy People 2010 recognizes that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity – an approach that involves improving health, education, housing, labor, justice transportation, agriculture, and the environment, as well as data collection itself…the greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting communitywide safety, education and access to health care. (U.S. Department of Health and Human ServicesX 2000:16)

To support agency efforts to improve population health and reduce disparities, DHHS established the Task Force on Community Preventive Services in 1996, which was charged with evaluating the efficacy of community-based health promotion and disease prevention programs (Guide to Community Preventive Services 2011). The Task Force adopted an ecological model premised on the idea that people's health and the environment in which they live are fundamentally entwined (Truman et al. 2000). Defined as the "social conditions that affect health and can potentially be altered," the social determinants within the Task Force model were assigned to three broad categories: social institutions, environmental and physical conditions, and social relationships (Anderson et al. 2003:12). During the same period, the Institute of Medicine released *Promoting Health: Intervention and Strategies from Social and Behavioral Research* (Smedley and Syme 2000), which also endorsed a social determinants approach across multiple domains (e.g., education, social support, policies) and multiple levels of influence (e.g., individual, community, nation). The report claimed that such an orientation was necessary because "[b]y itself…biomedical research cannot address the most significant challenges to improving the public's health" (p. 1). By promoting interventions at multiple levels, and not just the most proximal as biomedically prescribed, the ecological model signified an important advance beyond the basic multi-variant approach mentioned in Chapter 2 (Krieger 2011).

Despite growing acceptance of the socially-oriented health equity rubric, advocates remained frustrated with the continued biomedicalization of health disparities, particularly by government agencies. As one interviewee lamented, “NIH [thinks they] can solve health disparities by looking through a microscope and it’s wrong. It’s just simply wrong and you’ve got to turn that microscope around, of course, and understand some of the structures, the economic structures” (Interview 02). Similarly, the Health Policy Institute at the Joint Center for Political and Economic Studies (hereafter Joint Center) reported that despite evidence championing the effectiveness of structural interventions, “the lion’s share of public and private investment in health supports the health care industry with minimal resources committed to understanding the role of communities and environments in shaping health outcomes” (Joint Center Health Policy Institute 2006).

This frustration with the continued biomedicalization of health disparities spurred various NGOs to pursue their own health equity agendas. For instance, the Joint Center created the Place Matters Initiative to build “a national movement, community by community” to “strengthen local efforts while simultaneously provid[ing] a national framework” for equity and the social determinants of health (Interview 02). By the early 2000s, numerous U.S. organizations, including regional health departments, policy centers, community organizations, and foundations, had adopted a health equity frame (Han and Haasenritter 2009).

A goal of both governmental and non-governmental entities during these early years was to garner broad-based support for their burgeoning movement toward health equity. The task was to create what Larry Adelman (2010). termed “a public engagement campaign…to help reframe the national discourse about health and what society can and should do to tackle health inequities” (p. 478). Adelman and his team at California Newsreel contributed to this effort by producing *Unnatural Causes…Is Inequity Making Us Sick?* (hereafter referred to as *Unnatural Causes*), a seven-part documentary series on the social determinants of health (California

Newsreel 2008). A number of interviewees characterized this film as a vital cultural contribution that helped solidify diverse health equity efforts. As one informant expounded, in every justice movement "[t]here was either a breakthrough publication or …report, there was something that catalyzed the movement. So here was this vehicle, this tool that would do just that" (Interview 04). Indeed, *Unnatural Causes* drew together broad constituencies of supporters who assisted in the film's conceptualization and dissemination (Adelman 2010).

Unnatural Causes helped mark 2008 as a "watershed" moment for the U.S. movement toward health equity. That year, the film served as the centerpiece for thousands of public engagement campaigns promoting health equity around the country (Adelman 2010). A number of health organizations created companion reports to accompany the film's release; these included BARHII's (2008) *Health Inequities in the Bay Area*, California's Alameda County Public Health Department's (2008) *Life and Death from Unnatural Causes,* and Washington's *King County Equity and Social Justice Initiative* (King County 2008). Other reports released during this period were the CDC's *Promoting Health Equity* (Brennan Ramirez, Baker, and Metzler 2008), Oregon's *Multnomah County Health Equity Initiative* (Multnomah County Health Department 2009), the California Pan-Ethnic Health Network's (2009) *The Landscape of Opportunity: Cultivating Health Equity in California,* and Robert Wood Johnson Commission to Build a Healthier America's (2009) *Beyond Healthcare: New Directions for a Healthier America.* The recent inclusion of health equity and social determinants of health as overarching goals in *Healthy People 2020* (U.S. Department of Health and Human Services 2010e) indicates that these ideas have gained a foothold in the U.S. conversation around health differences. Many of these reports are among the primary data sources supporting this dissertation research.

Moving beyond difference, expanding beyond race

> A health disparity is "a particular health difference that is closely linked with social or economic disadvantage and/or environmental disadvantage…[based on]… racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location, or other characteristics historically linked to discrimination or exclusion." (U.S. Department of Health and Human Services 2010b)

In addition to promoting a social determinants approach, the move toward health equity aimed to solidify the idea of health disparities as not just any type of health differences but rather those deemed unfair and unjust. Reformulating the disparities conversation within the context of equity also afforded a renewed commitment to a diversity of groups experiencing disadvantage. In this section, I trace several discursive threads that helped refine the meaning of health differences under the equity rubric, including the scholarship of Paula Braveman and colleague and subsequent federal level efforts.

Shortly after Margaret Whitehead (1992) published her decisive article on health equity for the WHO, Braveman began to work with WHO staff in Geneva to develop a global initiative entitled "Equity in Health and Health Care" (Braveman 2006). That program was dismantled in 1999 by incoming neoliberal leadership that challenged the underlying social justice imperative of the initiative. Specifically, these new WHO leaders argued that focusing on health differences among pre-determined social groups—such as by class or race—introduced bias. They proposed that health differences should be measured across individuals identified by health/disease or other non-socially marked groupings (Braveman 2006; Braveman and Gruskin 2003).

Braveman and colleagues pushed back against this de-politicalized approach in a series of publications aimed at rooting the meaning of health differences in social justice terms (Braveman 2006; Braveman and Gruskin 2003). Specifically, Braveman and Gruskin (2003) defined health equity as "the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage" (p. 256). Moreover, the authors asserted that "health inequities systematically put populations who are already socially disadvantaged (for example, by virtue of being poor, female or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health" (p. 256). Through these definitions, the authors decisively reinforced the centrality of social hierarchies across race, class, gender, and other forms of difference in structuring health disparities.

Galvanized by this health equity rubric, U.S. federal agencies began reformulating their definitions of health disparities to underscore a justice element. The following example from the CDC's *Promoting Health Equity* report discursively captures this transition (Brennan Ramirez, Baker, and Metzler 2008) whereby the excerpt's first sentence illustrates the standard epidemiological definition of disparities as simple differences; the second elaborates the social justice aspect of inequities:

> Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as health disparities…Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical [social] conditions. (Brennan Ramirez, Baker, and Metzler 2008:6).

Following suit, in 2010 DHHS (2010b)expanded its *Healthy People* definition of disparities to include justice phrases like "difference that is closely linked with social or economic disadvantage and/or environmental disadvantage" and "characteristics historically linked to discrimination or exclusion." By attenuating the social justice language, these federal reports re-enforced the discursive shift from a somewhat ahistorical rendering of disparities as simple statistical variations to a more political adaptation that explicitly acknowledged past and current injustices.

Rebranding health disparities within the context of equity invited an additional opportunity to realign commitments to a diverse platform of social disadvantage. As discussed earlier, racial and ethnic concerns had dominated the contemporary U.S. conversation around health differences for several decades. A number of interviewees commented that this racial emphasis overshadowed attention to other forms of disadvantage, particularly with regard to socioeconomic status, but also those related to disability and sexual orientation. The health equity frame was seen as a way to move beyond this constraint, as one informant explains:

> There's this space that's been opened up for at least a language that not only brings in social determinants, but by referring to a value, it also broadens it beyond race. Equity means justice. It's one thing to say health disparities and then in parenthesis really what we're saying is racial and ethnic health disparity, because that's really the way it had been. Once you make that leap to say health equity, you've acknowledged the value and then it can't be limited to race. (Interview 14)

By emphasizing equity as a value, the health equity term underscored a universal principle of justice as applicable to multiple forms of disadvantage, rather than to one specific group.

Healthy People 2020 (U.S. Department of Health and Human Services 2010b)echoed this expanded view of disadvantage in stating, "[a]lthough the term "disparities" often is interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States...[r]ace or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health".

Most interviewees with whom I spoke welcomed the re-politicization of health differences based on disadvantage, yet were more circumspect about the expansive list of inclusions. Divisions were particularly evident with regard to racial and socioeconomic concerns. For some, emphasis on the latter was both overdue and critical to advancing efforts to ameliorate health disparities:

> Just trying to understand how we frame the conversation really matters to the outcome. I do think that you need to frame the conversation in a way that actually opens up the full story and the full story is that white lower-middle class men and women in this country have been getting hammered by our economic decisions, by some of our globalization…It's not just about the legacy of slavery. To

> embrace that in a health equity message is to enlist the participation of a broader swatch of the population. I think that's critical to being successful. You'll get the racism in there; it's just not the only thing in there. (Interview 24)

Conversely, others expressed apprehension about a heightened socioeconomic focus. These participants feared that such an orientation would divert attention from racial and ethnic health issues. As the quotation below suggests, such concerns arose out of long-term efforts to elevate and pursue racism as the central contributor to health inequalities in this country:

> [M]any of the people who have been carrying the flag for attention on health disparities and have always seen it as unfair but saw that it was a health disparity that named something about a person of color, about a race/ethnic approach and it doesn't cast a wider net to look at other types of inequities or disparities, whether by disability status or SES. And, yet, they don't want to let the flag come down the pole and put up another one because it just took so long, so much work, and it fits their perception of what the real problem is. (Interview 03)

This second group did not dismiss the importance of socioeconomics in determining health but rather viewed the health equity frame as potentially "whiting-out" race by explaining such differences exclusively in socioeconomic terms. Moreover, as one informant warned, subordination of race within a health equity frame could translate into racial exclusion:

> When you have minority health and health disparities you would never think of an office of minority health that didn't have any minorities in it or a center for minority health that didn't have any minorities in it. But you can sure have a center for health equity with no minorities in it or an office of quality improvement and I've got a real problem with that. Again, that's not affirmative action but that simply means you're missing the whole point and how we came into being. This is not just grantsmanship. This is an issue of justice. (Interview 09)

Such apprehensions often belied deeper unease around white privilege, which remained "a problem with the equity/disparity framework," explained one informant, wherein "privilege was rendered invisible" (Interview 07). Other interviewees concurred, pointing to the current so-called post-racial climate, which has further diminished racial concerns by dismissing racism as a problem of the past.

These opinions exemplify the contested terrain of health equity with regard to which health disparities count, and count most, in the struggle against inequities. For many, deeply held positions touched the core of group survival, and as such, are readily defended. These insights help explain why oppositional, rather than intersectional, politics remain at the fore of the conversation around health difference.

Conclusion

In this chapter, I historicize the health equity debate within the post-civil right era. Though the fight for health justice has stretched a millennium (e.g., DuBois 2003), this contemporary period is distinguished by three important sociocultural frames of biomedicine, neoliberalism, and social justice. These frames have been acknowledged as influential discourses in health by numerous scholars (e.g., Hofrichter 2003; Navarro 2009; Smedley, Stith, and Nelson 2003). Situating the conversation of health differences within these overarching discourses helps contextualize and articulate key tensions within this current debate. I have highlighted two such frictions in this chapter; one between biomedical and social orientations to health and the other across constituencies representing race, class, and gendered groups experiencing health inequalities. With regard to the first point of contention, one can witness the discursive clashes between a social justice frame and that of the individualistic, biotechnical orientation well supported by biomedicine and neoliberalism. The second tension illustrates the struggles for dominance within social justice circles as various contingencies jockey for position in the conversation around health differences.

Additionally, I have shown how such discursive tensions offer potential points of transition. For the movement of health equity, this has meant a push toward a social determinants approach and greater inclusion of diverse health disparities populations. Particularly with the recent call to advance structural-level analyses of intersectional inequalities, these observations fuel other salient questions. For instance, how does health equity discourse theorize various forms of inequality? And what constitutes a social determinants approach aimed at reducing these multiple inequalities? I attempt to answer these queries in the remaining chapters of this dissertation.

CHAPTER 3

CAUSAL STORIES: THEORIZING HEALTH INEQUITIES ACROSS RACE, CLASS, AND OTHER FORMS OF DIFFERENCE

Intersectionality promotes theorizing of social inequalities across multiple, co-constituting systems of power. I utilize this lens in analyzing the causal stories of health disparities in eight health equity reports. By causal stories, I refer to the etiological explanations used to explicate health disparities. Such narratives are important in framing how health inequities are understood and acted upon. I am influenced by Deborah Stone's (1989) idea of a causal story as a rhetorical device employed in policy-making to mobilize action around a particular concern.[13] The political scientist has argued that through these narratives, problems and their causes are purposively constructed to advance particular solutions, fix blame, and assign responsibility for change. In this chapter, I consider etiological explanations of health disparities across race, class, and other forms of difference. I am particularly interested in elucidating how these assorted causal tales function to support, diminish, and otherwise prioritize various forms of social inequalities. In so doing, I highlight the intersectional potentials and limitations in health equity theorizing.

Specifically, I demonstrate how causal narratives variously frame disparities with regard to life chances, socioeconomic gradients, racism, immigration, stress, and the lifecourse. What these stories all share in common is the promotion of a social interpretation of health differences; that is, health disparities are theorized as fundamentally a social, not biomedical, phenomenon. Yet, the causal stories account for health inequalities in distinct ways that are not necessarily compatible or overlapping. Furthermore, despite doing the important work of advancing a social

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[13] The term "causal" is not intended to indicate a scientific claim of causality but rather used to indicate the social constructionist nature of public health theorizing.

approach that is inclusive of a diversity of inequalities, these stories are not particularly intersectional. On the contrary, inequalities by race and socioeconomic status are prioritized over other disparities, such as those by gender, disability, and sexual orientation. In fact, the former at times appear in competition with one another. Moreover, the various inequalities tend to be viewed as discreet social formation processes, which are often combined in an additive rather than multiplicative fashion. Such simplistic representations of inequalities obscure the complex intersecting nature of these systems of power, thereby inhibiting effective interventions.

To support my argument, I present data from eight health equity reports described in Chapter 1 to delineate how each causal story explains health inequalities with regard to etiological pathways and type of social inequalities addressed. In applying an intersectional lens, I adopt Weber and Parra-Medina's (2003) health disparities framework to describe the causal stories along three intersectional dimensions—etiological, relational, and interactional. *Etiologically*, intersectionality requires a systems-level analysis that moves beyond the biomedical focus on proximal influences (e.g., behavioral and health interventions) to instead address root causes of inequalities involving racism, classism, and other forms of oppression. *Relationally*, an intersectional approach attends not only to distributional justice (e.g., shifting material resources and services) but to relational justice as well (e.g., power dynamics between social groups). As Weber and Parra-Medina (2003) explained, "[i]t is the procurement of power over others that enables the accumulation of materials and control over institutions" (p. 194). *Interactionally*, intersectionality conceptualizes inequalities as intersecting and mutually reinforcing processes. Rather than acting as discrete social formations, race, class, gender, and other systems of power are intimately entwined and function in relation to one another.

Applying this intersectional framework, I ask a series of questions of my data. For instance, etiologically, is the story primarily descriptive or explanatory? Are inequalities problematized as solely distributional problems involving material resources, or also as relational ones concerning dynamics of power and privilege? Borrowing from Hancock (Hancock 2007b), what approach does the story adopt for managing diversity: unitary (promotes a primary inequality); multiple (recognizes a range of inequalities that are conceptually independent but additive); or intersectional (inequalities as co-constitutive and multiplicative)? After describing the causal narratives in this manner, I follow with a discussion of muted stories around gender, disability, and sexual orientation. Here I adhere to a critical discourse methodology that interprets power not only through what is present in the discourse, but also what is missing or obscured (Carabine 2001). Specifically, I consider how omissions around certain types of social difference impact understanding of disparities in ways that may reinforce inequalities. Throughout my analysis, I supplement report data with comments from key informants in order to shed light on the organizational strategies selected in crafting the language of the health equity directives. Please note the organizational author names of the health equity reports are abbreviated in this chapter. A list of these abbreviations can be found in Appendix 2.

Causal Stories

Six causal stories form the theoretical foundation explaining inequalities within the health equity reports.[14] These stories are summarized in Table 3.1 below. While the directives referenced a variety of causes for inequalities, many appeared in name only (e.g., classism, gender oppression). In this section, I focus on the etiological tales that provide adequate

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[14] These stories are not unique to the health equity reports. Rather, these directives reflect etiological theorizing that is well established within the U.S. discourse on health differences (see for example LaVeist 2005), with the exception of the "Life Chances" story which draws from sociological theorizing.

explanatory text by which I could examine their intersectional dimensions as described by Weber and Parra-Medina (2003). The six stories meeting this criterion include life chances, the socioeconomic gradient, racism, racial/ethnic health paradox, stress, and the lifecourse. The selected titles reflect the primary etiological theme identified in each tale. As evidenced, these explanations range considerably. For instance, certain narratives—like the socioeconomic gradient and racism stories—explain health differences as manifestations of inequitable structural conditions (e.g., socioeconomic status, racism). Alternatively, the stress story explicates disparities through psychosocial pathways. Whether structural or psychosocial, however, both types of stories reinforce a social framing of inequalities.

The table also shows that the causal stories emphasize different types of inequalities. Some stories accommodate multiple forms; others prioritize singular categories. Notably, narratives attending to racial and socioeconomic inequalities receive the widest attention, with stories primarily highlighting these concerns. Alternatively, other forms of difference, such as gender, sexual orientation, and disability, receive only passing mention nested within a list of differences. Moreover, although narratives acknowledge multiple inequalities, none of these causal stories is particularly intersectional, as I will illustrate.

Table 3.0.1: Overview of Causal Stories

			REPORT							
CAUSAL STORY	SUMMARY	INEQUALITY	Alameda	BARHII	CPEHN	HP2020	King	Multnomah	NPA	RWJ
Life Chances	Social position influences opportunities for health	Multi[1]	▨	▨	▨	▨	▨	▨	▨	▨
Socioeconomic gradient	Stepwise correlation between SES[2] & health	SES	▨	▨			▨	▨		▨
Racism	Past/present biased practices explain racial disparities	Race	▨	▨	▨		▨	▨	▨	▨
Racial/ethnic Health Paradox	Population health differs from expected given SES[2]	Race		▨						
Stress	Physical and social stressors cumulatively impact health	Multi[1]	▨	▨	▨		▨		▨	▨
Lifecourse	Cumulative and age-specific vulnerabilities affect health	Multi[1]	▨		▨	▨	▨		▨	▨

[1] Multiple inequalities include two or more of the following: race, socioeconomic status, gender, disability, sexual orientation, age, geographic location, and religion.

[2] Socioeconomic status

On a theoretical note, I reiterate intentions stated in Chapter 1, namely that my intersectional analysis emphasizes structural-level inequities. While the health equity reports at times conflate racism, classism, and other systems of oppression with categories of difference (e.g., race/ethnicity, socioeconomic position, gender, disability, sexual orientation), I approach group classifications as provisional markers of inequality. In so doing, I orient my analysis less on the categories per se and more around what these classifications mean with regard to systems of power. At the same time, I acknowledge that employing social categories as proxies for inequalities is problematic since these classifications refer to individual and group attributes that do not necessarily represent the structural dynamics from which a given category is derived. Methodologically, I would like to remind readers that I follow Foucault (1972) in foregrounding discourse—not subjects (e.g., authors)—in my analysis. As the philosopher insisted, subjects do not exist outside of discourse, but rather are produced *through* discourse. Hence, I present Table 3.1 not as a comparative tool by which to evaluate individual organizations, but rather as a visual aid to highlight the uneven, patchwork nature of the health equity debate as comprised through the six causal stories.

Life chances

The idea of life chances commonly refers to the likelihood of influencing one's life situation through various economic, political, and social conditions based on social position (Lynch and Kaplan 2000). This notion has been popularized within U.S. social and health sciences as an individual-level construct that associates inequities with the uneven distribution of skills, knowledge, and resources (Lynch and Kaplan 2000; Parkin 1978). However, sociologist Max Weber (1946) originally introduced the life chances idea in the early 1900s as part of a larger critique of Marx's class analysis (Wright 2008). Specifically, Weber countered Marx in arguing that power operates through multiple realms, not just class as Marx posited. Social standing (by race, gender, or other social characteristic) and political position also determine life chances. Critical scholars have maintained that the Americanized interpretation of life chances neutralizes Weber's critique (Wright 2008) into a pluralist tale accommodating multiple differences, yet one directed toward individualism and meritocracy, rather than systems of power (Lynch and Kaplan 2000; Parkin 1978).

The life chances story represents a central narrative within the health equity reports. This idea supports a social determinants frame by promoting opportunities aimed at improving one's probability of reaching "the highest level of health" (U.S. Department of Health and Human Services 2010e). The following excerpts illustrate the life chances concept as presented in the health equity reports.

> People clustered in low-income neighborhoods struggle with public and private disinvestment, fewer job opportunities, lower-quality housing and schools, toxic contamination, higher levels of crime, and more social isolation—all of which take their toll on health. The combined impact of these socio-economic and physical realities limits the quality of life and life chances for residents of such neighborhoods. (Alameda 2008:xi)

> Working on our physical surroundings will go a long way to improving opportunities for health. Ensuring that we can live in healthy homes, breathe clean air, play in safe parks, and access fresh fruits and vegetables at every step during our lives will have a profound effect on health inequities. (CPEHN 2009:33)

> What if all residents of King County had the same opportunities regardless of race, ethnicity, gender, immigration status, sexual orientation or disability? What if all residents of King County had the opportunity to receive the same quality education, the same access to basic health care, the same opportunities to work for a living wage, the same access to affordable housing, the same ability to live in safe neighborhoods, and the same opportunity to enjoy the natural environment? A new, better and very different King County would emerge. We can be the catalyst for this change. (King 2008, Frontmatter)

Although the life chances story notably supports a social orientation to equity, the reports' interpretation reflects the "Americanized" version that focuses on people's ability to access health-promoting resources and less on changing fundamental power structures. As such, this narrative serves as a distributional tale concerned primarily with who receives which social goods and services; little is said about who *determines* the distribution schemes or the processes creating inequalities.

Still, the life chances story remains most inclusive of the various forms of inequality, encompassing not only populations of identity, but also location. Among the former are groups constructed by race/ethnicity, socioeconomic position, gender, age, disability, sexual orientation, immigrant status, and religion. Also considered are populations designated by geographic position (e.g., rural, urban). The following excerpt exemplifies a multi-group listing of disparity populations. This particular text appears in a federal document. The federally sponsored health equity reports (i.e., HP2020 2010; PAR 2011) generally offer the most expansive example of a multiple approach to difference.

> Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” (HP2020 2010)

The majority of health equity reports provide some variation on this multi-group posting. Whereas certain categories are present in some reports, only race and socioeconomic inequalities are considered within all the directives. Despite the life story’s inclusivity, however, theorizing about these social differences remains limited. Often reduced into a decontextualized “laundry list” of social categories, inequalities are undistinguished by particular histories or effects. Rather the focus of the life course tale is on commonality—not difference—around experiences of exclusion. Interactionally, connections between various social categories remain unclear. Most often the reports discursively manage multiple categories as discrete grouping that are combined in an additive manner (e.g., socioeconomic status *and* race). Relationally, privilege is ignored. Rather, dominant groups such as males, Whites, and the non-poor appear within the texts as normative markers against which disadvantaged populations are measured. Meanwhile, privilege itself remains underinterrogated for the particular ways this status contributes to inequity and health.

In summary, the life chances story represents a core narrative within the health equity reports, one supporting a social determinants frame while accommodating multiple inequalities. Consistent with a mainstream Americanized interpretation, the reports’ life chances narrative avoids overt critiques of the underlying systems of power, focusing instead on the correlation between social categories and resource distribution. Moreover, this tale is not particularly intersectional, as most inequalities—or their categorical group proxies—exist in name only without indications of how they interrelate. Likewise, the narrative is not particularly relational in that mechanisms of privilege remain obscured and undertheorized. Still, a strength of life chances story lies in its inclusivity in terms of the various populations experiencing health disparities, which could translate into a comprehensive set of interventions addressing multiple groups.

Socioeconomic gradient

The socioeconomic gradient story promotes the idea of a stepwise association between socioeconomic status and wellbeing (Hertzman 1999); that is, health is enhanced with improvements in socioeconomic standing. The socioeconomic gradient concept was first introduced in British studies of coronary heart disease among male civil servants working in the Whitehall parliamentary district of London (Marmot et al. 1978). Specifically, researchers found that heart disease decreased with each advance in occupational grade. The Whitehall studies are credited with reconceptualizing the demography of disease from a bifurcated model distinguishing illnesses of the rich (e.g., heart disease) and the poor (e.g., tuberculosis) to a gradational model spanning socioeconomic groups, including a middle class (Marmot and Brunner 2005). Discursively, this framing of health disparities offers scientific and political leverage for a socioeconomic argument. Particularly, the gradient idea lends scientific credibility when fashioned as a dose response curve, a biomedical criteria supporting causality (Braveman et al. 2010).[15] Moreover, inclusion of a middle class helps generate broad-based appeal for a socioeconomic approach to health, as I illustrate below.

Of the eight U.S. health equity reports I reviewed, five directly discuss the socioeconomic gradient. This story is presented as a distributional tale, wherein socioeconomic factors primarily explain inequalities in a simple cumulative manner: the better your socioeconomic circumstances, the healthier you will be. This construction suggests a hierarchical relationship between subgroups based on resource accumulation, as suggested by the following excerpts:

> Life expectancy in the Bay Area, as in the nation as a whole, conforms to a pattern called the "social gradient," in which the more income and wealth people have, the more likely they are to live longer, while people with less income and wealth can expect to live comparatively shorter lives. (BARHII 2008, p.7)
>
> Rates of illness and death increase as socioeconomic status decreases. Research shows that individual health is substantially influenced by the social and environmental context. In fact, health and life expectancy increase with every step up the social hierarchy. This means that wealthier people live longer, healthier lives. Even the middle class, as it contends with job stress, accessing health care, lower quality schools, and less healthy living environments, lives shorter and less healthy lives than the wealthy. (King 2008:7)
>
> A nation's health is its most precious asset. Yet there are tremendous gaps between how healthy Americans are and how healthy we could be. At every income and education level, Americans should be healthier. Many people with middle-class incomes and education die prematurely from preventable health problems. And for those with more limited incomes and education, health outcomes are far worse. (RWJ 2009:10)

Notably missing from the socioeconomic gradient story is any reference to power, notably class relations. As discussed in Chapter 2, class remains a politically tenuous term and is often reduced to individualized attributes of income and education within U.S. discourse. Whereas most of the health equity reports recognize a growing gap between the rich and the poor (as well as the middle class), and several even point to institutional policies as contributing to this divide, none

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[15] From an intersectional perspective, the dose response argument is problematic in this social application because it assumes that the same mechanism is responsible for producing each stepwise change across the differing groups.

of the directives explicitly articulates the capitalist nature of these phenomena. The absence of a class analysis helps maintain the socioeconomic gradient as a distributional story, where inequalities are addressed through a shifting of resources rather than attending to underlying power dynamics of class exploitation.

Interactionally, the socioeconomic gradient story is what Hancock (2007b) has characterized as a unitary tale, with its primary emphasis on socioeconomic position. Discursively, this approach accommodates within-group variations in acknowledging both socioeconomically advantaged and disadvantaged subgroups. The socioeconomic gradient is thus an inclusionary tale: everyone can benefit from being healthier—as the second excerpt above by Robert Wood Johnson (2009) suggests—even the affluent and the middle class. The socioeconomic gradient is the only story that accommodates advantaged subgroups in this way. Indeed, such inclusion appears contradictory at first in a debate primarily concerned with populations most burdened by health disparities. From a political perspective, however, advancing a health equity agenda that includes more affluent groups can foster political capital. As one informant explains, "If we were going to engage mainstream America in being interested in the issues…and the changes that need to be made, it could not be framed primarily as a problem that affects the poor, disadvantaged, and racial/ethnic minorities" (Interview 14). Several informants concur that interest in the disadvantaged has waned in this era of post-racial, neoliberal entrenchment.

Yet in an effort to garner broad-based appeal, the socioeconomic gradient story appears to be less tolerant of intersectional differences, in minimizing attention to racial populations that deviate from the gradient scheme.[16] Specifically, low-income immigrant groups of color

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[16] Nonconformities to the socioeconomic gradient pattern were reported back in the concept's founding studies. Specifically, British researchers acknowledged that half of the women participating in Whitehall II occupied low

exhibiting better health than middle-income white counterparts are dismissed as exceptions to the gradient tale in one report (BARHII 2008) rather than promoted as exhibiting the intersectional complexities of race, class, and nativity. I discuss this issue in greater detail in the health paradox section. For now, I illustrate how the socioeconomic gradient functions discursively as a universalizing tale that erases the raced and gendered nature of class as a way of preserving the purity of the dose response curve.

Overall, the socioeconomic gradient narrative shares similar discursive features with the life chances story in its distributional emphasis on social conditions, which curtails any serious discussion of underlying causes. Like life chances, the socioeconomic gradient narrative directs change mainly through a shift in access to material resources rather than in social relations (including who decides which policies and practices would be of most benefit). Yet, the socioeconomic gradient story remains distinct in its prioritizing of socioeconomic realm as the primary system of interest. Such an emphasis is valuable in building acceptance among certain political constituencies for a socioeconomic orientation to inequalities, which must push against the constraints of the predominant biomedical and neoliberal frames.

However, this unitary approach of privileging one form of inequality over others comes at a price, as Hancock (2007b) has asserted. By handling variant socioeconomic patterns as *exceptions*—and not acknowledging their racialized and gendered nature—the socioeconomic gradient story over-represents a phenomenon most regularly found within White male populations. From an intersectional standpoint, this type of universalizing is reminiscent of early White feminist claims of a common sisterhood, which overrode the decisional power and concerns of women of color in the name of unity (Crenshaw 1991; Mann and Huffman 2005).

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clerical employment grades, which suggested interactions between socioeconomic status and gender (Marmot et al. 1991). Similarly, U.S. researchers reported deviations from the socioeconomic gradient pattern, particularly among Hispanics and Mexican Americans (Braveman et al. 2010).

Without serious consideration of multiple intersections, however, the dominant norms (e.g., White, middle class, able-bodied, male) promoted by the socioeconomic gradient story become increasingly problematic in advancing health equity, with women constituting more than half of the U.S. population (U.S. Bureau of the Census 2011), and Latinos predicted to represent 30% of this nation's demographic by 2050 (U.S. Bureau of the Census 2008).

Racism

The racism story posits that institutional and personally-mediated forms of racism explain racial and ethnic health differences. By institutional racism, I refer to what Jones (2000) has characterized as historically-rooted institutional practices that have resulted in "differential access to the goods, services, and opportunities of society by race" (p. 1212). Alternatively, personally-medicated racism indicates individual prejudicial assumptions and discriminatory actions directed toward others according to race (Jones 2000). The racism narrative has been circulating for over a century, promoted by scholars and activists arguing that racism—not group biology and/or class—primarily explain poor health among people of color (e.g., DuBois 2003; Oliver and Shapiro 1997; Williams and Collins 2001). Recent public health scholarship focuses on segregation and discrimination as key determinants in health disparities among populations of color (e.g., Acevedo-Garcia et al. 2003; Gee et al. 2009; Williams and Collins 2001; Williams and Mohammed 2009). Identifying segregation as a social factor in the causal chain helps build a case for a place-based approach to social determinants, as I discuss in Chapter 4. Moreover, segregation bolsters the racism narrative's challenge to economically-oriented arguments, like the socioeconomic gradient, in asserting that socioeconomic factors are not the only nor the primarily social influences of health. Rather, racism remains the fundamental determinant of health and socioeconomic status for people of color.

The racism story appears within seven of the eight health equity reports and is the most developed in terms of articulating etiological and relational attributes. Etiologically, this narrative directly designates racism as responsible for producing racial and ethnic disparities in health and links this claim to the long history in the United States of racial injustices. Several directives point out that even as overt discrimination is no longer legal, racism lives on through the enduring effects of past exclusionary practices, as well as through the de facto discrimination continuing today. The following excerpts illustrate the specific logic employed in the racism story.

> Health inequity is related both to a history of overt discriminatory actions, as well as present-day practices and policies that perpetuate diminished opportunity for certain populations. Inequities in economic, social, physical and service environments continue to create and maintain clear patterns of poor health in Alameda County, statewide, and nationally. Social inequity causes health inequity. (Alameda 2008:viii)
>
> Historical racism in the form of housing segregation, employment discrimination, unequal wages, and other discriminatory practices has created persistent inequalities that limit opportunities for communities of color. (CPEHN 2009:3)
>
> Although racial and ethnic discrimination are illegal, the legacy of such discrimination remains, with many members of some groups more heavily concentrated in resource- and opportunity-poor neighborhoods. Blacks and Hispanics typically live in neighborhoods with higher concentrations of poverty than whites. Poorer neighborhoods have weaker tax bases, which can mean limited support for public schools and community programs; crime and social disorder; and limited access to fresh groceries. Low-income neighborhoods have often served as locations for toxic waste dumps or have bordered freeways, refineries and other sources of pollution. Neighborhood conditions can contribute to disease, such as asthma, as well as limit ability to make healthy choices in daily life. (RWJ 2009:22)

As these texts illustrate, the racism story reinforces the health equity goal of promoting a social determinants approach to health disparities. Segregation plays an important role within this narrative in linking social conditions to a unified racialized system of power that is both historically grounded and systematic in effect. Moreover, racial segregation discursively ties together various social determinants within the context of place. As I discuss in the next chapter, place importantly serves as an intersectional concept that emphasizes the interconnections between diverse social factors and calls for integrated action on those determinants at the community level and beyond.

In addition to naming racism as a fundamental cause of health inequalities, and segregation as a primary mechanism, several directives expose the relational aspects of racism through the process of privileging. This term refers to the social dynamic whereby one group benefits through the exclusion and exploitation of others (Blauner 1972; Harris 1995). The following excerpts explicate the processes of privileging and argue that equity cannot be achieved without disrupting practices that sustain advantages among dominant groups.

> African Americans and Latinos are highly concentrated in these high-poverty areas, a result of racist institutional policies that led to physical separation of races in most of U.S. cities. From racial restrictive covenants to redlining to racial steering, U.S. policies systematically denied people of color from homeownership opportunities while simultaneously expanding them for lower income Whites. (Alameda 2008:11)

> Policy solutions should target root causes of racial and ethnic disparities and be developed with members of the communities most impacted by inequities. A first step to address racial and economic injustices is for the government and community to recognize and dismantle intentional and de facto policies and practices that maintain privilege among historically advantaged groups, such as Whites, males, and the wealthy. With training and self-reflection, decision makers can avoid reinforcing institutional racism, sexism and class privilege through policies. (Multnomah 2009:9)

> The goal must be to transform the privileges that some enjoy into basic rights for everyone to share. Embracing the principles of equity and social justice can lead to a future where all residents of King County have real opportunities for quality education, livable wages, affordable housing, health care, and safe and vibrant neighborhoods. (King 2008:12)

These texts underscore that the mechanisms of disadvantage and privilege are intimately intertwined. To address inequity, it is therefore necessary to attend not only to the processes that create disadvantage but also to those that generate and maintain privilege. Within public health, however, the locus of attention in health disparities debates typically remains fixed on the *disadvantaged* (Daniels and Schulz 2006; Weber and Parra-Medina 2003). Not surprisingly then, discussion of *advantage* is subdued within the health equity reports with these few exceptions. Several interviews identify privilege as a politically risky topic of conversation, even within progressive circles. As one informant contends:

> People are looking at snapshots of present-day injustice and thinking, "Wow, it's messed up but I don't have any responsibility to fix it. I didn't get anything from it." So when you have a conversation about [?], you can't talk about privilege, you can't talk about anything, right? And that was the other problem with the equity/disparity framework - that the privilege was rendered invisible. (Interview 07)

Defensiveness and a lack of awareness among the advantaged are among the reasons given for avoiding such dialogues around privilege. Like class, privileging is often rendered "unspeakable" within health equity discourse.

While the racism tale proves the most etiologically complex narrative in naming racialized systems of power as a fundamental cause of inequality, interactionally, the story's incorporation of other systems into this framework remains limited. The most reported association within the racism tale is with regard to socioeconomic status. This relationship between race and SES is described in two ways: People of color are more likely to be poor because of historical racism, and racial and ethnic groups often experience worse health at each step of the socioeconomic ladder. The following excerpt captures both these positions:

> Racism imposes an added health burden. Past and present discrimination in housing, jobs, and education means that today people of color are more likely to be lower on the class ladder. But even at the same rung, African Americans typically have worse health and die sooner than their White counterparts. In many cases, so do other populations of color. Segregation, social exclusion, encounters with prejudice, one's degree of hope and optimism, differential access, and treatment by the health care system—all of these can affect health. (Alameda 2008:7-8)

Importantly, this text both acknowledges and challenges the social gradient's universalizing effects, indicating that while SES affects the health of people of color, racial status also negatively influences their wellbeing, regardless of socioeconomic standing. This results in a social gradient slope that angles differently for people of color to accommodate both the increased numbers at the lower SES levels and the diminished health of these groups at higher SES levels. Interestingly, the excerpt describes this relationship between race and socioeconomic status as additive rather than intersectional. That is, the impact of socioeconomic status on health is attenuated by racism, but only in a stepwise fashion. As I discuss next in the health paradox story, interactions between race and class are complex and do not always produce a gradient configuration. For now, I highlight how the racism story functions to *diminish* class's theoretical supremacy by inferring that socioeconomic status does not fully explain health differences observed by race and ethnicity. Also of note, intersections of gender and/or other forms of inequality are not well theorized within the racism narrative, though the report's empirical data illustrate such connections.

Overall, the racism story offers intersectional potential along several dimensions. In naming racialized systems of power as a fundamental cause of health inequities, the tale remains the most etiologically developed of the causal tales. Elucidating segregation as a prime mechanism of inequality further strengthens the racism frame. Specifically, segregation is cast within the directives as a key racist process that binds various social determinants within a common environmental milieu. Moreover, in contrast to other tales (e.g., life chances, socioeconomic gradient) that are typically framed as ahistorical problems of distribution, the racism story is presented as a relational one grounded in a history of unfairly disadvantaging people of color relative to Whites. Given the tendency within public health discourse to avoid such overt critique, this historicizing is significant. Attention to both place and privilege promotes interventions toward communities that resists pathologizing these groups, since whiteness and wealth are simultaneously problematizing as part of the inequality equation.

Yet, the racism story promotes toward a racial supremacy in which other forms of inequality tend to remained marginalized. In their pioneering work on racial formation theory, Omi and Winant (1994) document a long theoretical struggle for dominancy between race and class perspectives. I contend that contest continues in these reports as the racism story discursively jostles for recognition in relation to the socioeconomic gradient. Yet, similar to that socioeconomic tale, the racism story also does not well integrate gender, disability, or sexual orientation into its explanatory framework. Hence, the racism tale remains a unitary one in both failing to seriously explicate other inequalities while arguing that race—not class—fundamentally explains health disparities among people of color (Hancock 2007b).

Racial/Ethnic Health Paradox

The racial/ethnic health paradox refers to health outcomes that are unexpected given a particular group’s demographic characteristics, typically in reference to race and socioeconomic status (Acevedo-Garcia and Bates 2008). For instance, low-income Hispanic immigrants exhibit better infant survival rates than whites of higher socioeconomic status (Acevedo-Garcia and Bates 2008; Morales et al. 2002). Several hypotheses have been offered to account for the health paradox phenomenon among these immigrant populations, including acculturation, healthy immigrant and unhealthy outmigration effects, and misclassification (Acevedo-Garcia and Bates 2008; Morales et al. 2002). I focus here on acculturation as most evident in my data. Research suggests that immigrant health advantages diminish across time the longer these groups remain in the receiving country. Scholars argue that acculturation—particularly altered diet and family relations—explain this phenomenon (Lara et al. 2005; Morales et al. 2002).

The acculturation-oriented health paradox tale is not a popular story within the health equity reports. Only one directive (BARHII 2008) mentions this narrative within the sections selected for in-depth analysis.[17] As illustrated in the excerpts below, this story emphasizes the cultural environment as a primary explanation of health differences:

> Asians and Latinos have overall longer life expectancies than both African Americans and whites, and they are less likely to show the influences of poverty. While the issues are complex, a contributing factor is that longer life expectancies for Latinos and Asians are likely a result in part of significant immigrant populations. Many studies have shown that, while the health of immigrants overall is comparatively good, their health status deteriorates the longer they live in the United States, with subsequent generations showing poorer health along a number of public health indicators. (BARHII 2008:13)

> The influence of neighborhood on health is not only a matter of poverty or the physical environment, but also is affected by cultural factors (family, community, diet, etc.) that can help or hinder people's abilities to withstand the effects of poverty and environmental risks. (BARHII 2008:14)

Like the racism causal story, the acculturation health paradox narrative aims to explain racial and ethnic health differences. However, the latter is distinguished by an emphasis on cultural factors, such as diet and family networks, rather than racialized systems of power or interconnections between these macro and micro processes. Without clear linkages to contexts and underlying social conditions, culture could be reduced to a habit of the disadvantaged groups themselves (Viruell-Fuentes, Miranda, and Abdulrahim 2012; Zambrana and Carter-Pokras 2010).

Another limitation of the immigrant health paradox tale is suggested by its very name; that is, the term "paradox" indicates an exception or deviation from a purported norm. In this

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[17] Alameda (2008) also discusses the immigrant paradox, within the social determinants framework. That is, material factors, such as socioeconomic and living conditions, also influence multigenerational health. However, these data was not presented in the executive summary section selected for in-depth analysis, so not included in the discussions above.

case, the immigrant health exceptions represent variations of a dominant demographic pattern, specifically a positive step-wise association between socio-economic status and health. As such, the paradox narrative provides a derivative explanation to the socioeconomic gradient. As noted earlier, the gradient tale normalizes this step-wise socioeconomic pattern with regard to health based on data most commonly representative of white, employed men. If alternatively viewed through an intersectional lens, the immigrant health paradox story underscores the raced, gendered, and nativity-based nature of socioeconomic position. More fully illuminating—rather than dismissing—the interplay of these influences would provide a more accurate and nuanced understanding of the complexities of health disparities. Such considerations are not only important for the intergenerational health of immigrant populations but for nonimmigrants as well, as testament to the United States' poor health profile on key indices of U.S. born groups relative to other nations, both North and South.[18]

Stress

An early contributor to the social determinants debate in the 1990s, the MacArthur Foundation Research Network on Socio-Economic Status and Health aimed to understand how "the social environment gets under the skin" (Interview 14). Stress served as one viable mechanism connecting health to underlying social conditions. Network members and others pursued research demonstrating how social stressors (e.g., employment and financial insecurity, unsafe living and working conditions) adversely impacted physiological and mental wellbeing (e.g., Adler et al. 1999).

Six of the eight health equity reports advance a stress story, thus implicating physiological and psychological pathways connecting social determinants to health status. The

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[18] The U.S. ranks lower than many other nations in important key population health indicators, including infant mortality, homicides, heart disease, and diabetes (National Research Council 2013).

following excepts illustrate the linkage between socioeconomic environment and biology, and underscore the cascading effects of negative conditions on wellbeing.

> Limited economic means can make everyday life a struggle, leaving little time or energy to adopt healthy behaviors and crushing motivation. Chronic stress associated with financial insecurity can seriously damage health, causing wear and tear on the heart and other organs and accelerating aging. (RWJ 2009:22)

> The lack of quality, affordable housing can lead to family stress and related conditions, such as hypertension and poor mental health. It can also lead to less money for essentials such as medical care, transportation, and food. Overcrowding is another symptom of lack of affordable housing. It can adversely impact health by causing stress, respiratory illnesses, and a decrease in overall health. (CPEHN 2009:12)

Whereas the texts above support a social determinants frame in general, several health equity directives enlist the stress story specifically to explain and validate racial and ethnic health differences. The argument is that racism and discrimination are sources of cumulative stress that negatively impacts the health of racially and ethnically marginalized groups:

> There is growing evidence that racism itself is a factor in health, translating into persistent stress and associated illnesses. It has taken its greatest toll over centuries on Native Americans and African Americans, who have the poorest health status. (BARHII 2008:14)

Several reports particularly underscore the deleterious impact of stress on infant mortality and morbidity (e.g., low birth weight) in communities of color, most notably African American. That these negative outcomes persist even among those with high socioeconomic status reinforces the argument that socioeconomic position alone does not account for such racial and ethnic health disparities.

> Studies have shown that many social, medical, and behavioral risk factors increase the risk of low birth weight, including the stress faced by African American mothers. The stress brought on by racism and other social conditions can worsen all health outcomes, particularly birth-related ones. African Americans have by far the highest percentage of low-weight births (12%), twice as many as Latinos and Whites (both 6%). (CPEHN 2009:12)

> The stressors of racism and discrimination may also be contributing to poor health. A highly-educated, professional African-American woman is more than twice as likely to have a child with very low birth weight, compared to a white woman with a high school diploma or less. (King 2008:2)

One report (CPEHN 2009) deploys the stress story in relation to community cohesion, safety, and support within communities of color. Specifically, the directive presents social support as a mediating factor in the stress response, which in turn shapes interactions and behaviors that influence health, which linked back to the social conditions:

> Unfortunately, people of color often tend to be more socially isolated, live in conditions of higher stress with less social support, and lack access to mainstream resources and services. As a result, our communities are less likely to report that people in their neighborhood get along, can be trusted, are willing to help each other, and share common values — attributes of social environments that protect against crime, unhealthy behaviors, and adverse health outcomes. Lower cohesion among residents can also limit the capacity to collectively advocate for resources for their communities. (CPEHN 2009:23)

> Violence in our communities has many different roots, but economic hardship, oppression, and poor mental health are among the most prevalent. The experience of crime can directly affect health through bodily harm, economic hardship, and emotional trauma. Fear of crime can indirectly affect health by increasing stress, promoting social isolation, preventing health-promoting behaviors such as walking for exercise, and preventing access to services for fear of the risks of freely moving about in the community. (CPEHN 2009:25)

The excerpts cited throughout this section illustrate the discursive function of the stress story as support for the social determinants approach. Biomedical discourse often reduces stress to an individualized experience, thus its construction as a mechanism of social determinants within the reports is notable—and intentional—as one past MacArthur Network member explains,

> There was a clear recognition that the kind of more basic science audiences are not going to take this work seriously if you can't identify the plausible biological mechanisms…So I think there was a genuine scientific interest but there was also the recognition that by understanding the biology we will get credibility for the fact of the association itself [between socio-economic status and health], scientific credibility. (Interview 14)

Stone (1989) has argued that scientific "facts" within the causal stories work as the persuasive elements necessary to mobilize certain actors in pursuit of particular agendas. In this case, scientists are a target audience. Despite its biological underpinnings, the stress story remains highly effective in advancing a social determinants argument. This narrative does not provide a systems-level critique, however. Rather, the stress story works as a mechanistic tale explaining how social conditions get "under the skin." As such, the stress story is a complementary tale that accommodates life chances, socioeconomic gradient, and racism arguments.

Lifecourse

The lifecourse perspective asserts that health status is influenced by biological and social factors that have an effect on people across their lifespan (Kuh and Ben-Shlomo 1997). This story brings together ideas of time-specific and cumulative effects of exposure. For instance, Barker (1994) has argued that exposures in utero and during early infancy are especially critical in determining health in adult life. Others have asserted that all life stages present vulnerabilities to health status and that cumulative exposure and their interactions play an important role as well (Davey Smith, Gunnell, and Ben-Shlomo 2001). Though the lifecourse story considers both biological and social determinants, the latter—particularly socioeconomic and psychosocial determinants—have garnered the most attention.

The lifecourse narrative is taken up by six of the eight health equity reports, incorporating both the time-specific and lifespan perspectives described above. Whereas directives underscore the need to address health and health disparities "from birth to death" (NPA 2011:1), the reports target childhood as the most critical period for intervention, as the following excerpts illustrate:

> The developmental needs and transitions of all age groups should be addressed. While infants, children, youth, adults, and elderly require age-appropriate strategies, the largest investments should be in early life because important foundations of adult health are laid in early childhood (Alameda 2008:xi)

> Social disadvantage is damaging at any stage in life but is especially harmful when experienced early in life. (King 2008:21)

Identifying children as a particularly vulnerable population in the health disparities trajectory helps justify actions directed toward this group. Not surprisingly, interventions targeting early childhood, particularly through education, are common recommendations within the health equity reports. In fact, one directive (RWJ 2009) primarily promotes the youth population, arguing that solutions aimed as this age group are the most valuable investment in reducing health inequalities:

> We found the strongest evidence for interventions that can have a lasting effect on the quality of health and life in programs that promote early childhood development and that support children and families. Therefore, many of our recommendations aim to ensure that our children have the best start in life and health. Along with social advantage and disadvantage, health is often passed across generations. Strategies for giving children a healthy start will help ensure future generations of healthy adults. This is indeed a wise long-term investment of scarce resources. (RWJ 2009:5)

In addition to offering a scientific rationale, selecting children as a priority population may bolster political appeal in the fight for equity given that assistance to this group has historically been tolerated across the political spectrum.

Interestingly, although the lifecourse story emphasizes age, ageism is not the focus of this narrative. That is, the health equity directives do not discuss age within the context of power. Instead, the reports configure age as a sociobiological marker influencing health disparities, interceding at points in time, as well as cumulatively across the life span. As such, the lifecourse theory functions as complementary to other tales, specifically the gradient and racism. For instance, one report asserts that “[f]or some families, poverty lasts a lifetime and is perpetuated to next generations, leaving its family members with few opportunities to make healthful decisions” (Alameda 2008:x). Another explains, “A family’s wealth and assets are often built over generations, a fact that contributes to the unequal footing of communities of color" (CPEHN 2009:7).

Like the stress story, the lifecourse story is presented within the health equity reports as a deterministic tale. The main argument is that poor health results from negative exposures encountered at vulnerable points across the lifespan. As such, the lifecourse story is also a complementary narrative that elucidates the pathways to various inequalities, thus accommodating multiple causal tales. Like the stress story, the lifecourse narrative is devoid of a systems-level analysis. Rather, the primary function of age within this story is to justify the distribution of material resources to vulnerable groups, specifically children.

Muted stories

As illustrated by the causal stories, the health equity reports recognize a range of inequities including populations of identity (e.g., race, gender) as well as those designated by spatial location (i.e., geography). Yet, the degree to which the directives theorize these social stratifications differs significantly. Inequalities by race and socioeconomic status are most often articulated, while other forms of inequality—such as those by gender, disability status, and sexual orientation—receive little attention. In discourse analysis, what is silenced is as important as what is said in analyzing dynamics of power (Carabine 2001). By considering the muted stories, I illustrate the ways that the health equity reports can discursively reproduce inequalities through their limiting consideration of particular differences.

I begin with the case of female gender as this form of social difference is commonly recognized within social and health disciplines as part of an inequity trinity with race and class (Knapp 2005; Yuval-Davis 2006). Indeed, equity for girls and women reflects a key concern in the international health equity dialogue. Given its popular consideration abroad, undertheorizing about female gender within these U.S. health equity reports is particularly noteworthy. Though all eight directives recognize gender as a type of inequality within life chances “laundry lists,” none of these documents offer an etiological narrative which integrates gender. When female gender does “show up” within causal stories, its presence serves primarily to support race arguments and is deployed in rather stereotypical ways. For instance, women are characterized almost exclusively in reference to their reproductive and childrearing functions. The stress story excerpts presented earlier on African American women and infant health illustrates this wherein the female child bearer role links stress to a racial story.

In contrast, men are featured as the universal gendered norm and engaged in numerous activities including education, employment, the criminal justice system, and/or violence. Interestingly, the gender emphasis on men and violence within the health equity directives contrasts a longtime intersectional concern about violence against women. Moreover, as universal subjects, men are used throughout the directives to characterize disparities between people of color and Whites. The excerpts below illustrate the common practice of exemplifying a general statement on racial population health using a male gender comparison.

> Rates of college education among people of color are much lower than their white counterparts. Twenty-three percent of African American males have a bachelor’s degree, compared with 50 percent of while males in King County. (King 2008:5)
>
> In California, the life expectancy of African Americans (68 .6 years for men) is almost seven years lower than that of Whites (75 .5 years for men). (CPEHN 2009:10)

My analysis found that gender consistently remains a sidebar to the larger racial story within health equity directives. The lack of etiological elaboration limited understanding of its interconnection to race and/or other forms of inequality. Moreover, the gender stereotyping obscured important variations in the lived experiences of both men and women across a range of social conditions.

Disability and sexual orientation are even more conspicuously absent from the health equity reports. Only four of the eight documents acknowledgment of these forms of inequality, and mainly do so within life chances lists. No further elaboration of these inequalities is provided within the directives, with one exception. The National Partnership for Action (2011) health equity report includes a discussion of disparities in health care access among groups distinguished by disability and sexual orientation. The report even offers a nod to co-occurring inequalities in stating, "LGBT[19] persons who also belong to other historically disadvantaged and other vulnerable populations experience compounded obstacles to care and wellness" (p. 14). Informants familiar with the National Partnership for Action (2011) report indicate that constituencies representing disability and sexual minority populations were vocal contributors during the document's development process, which may explain the more detailed inclusion of these social groups within that report.

Attention to these muted stories reveals the uneven treatment of inequalities within the health equity reports, along with a lack of intersectionality. Such diminished tales can reinforce inequalities by keeping certain types of difference from view. The case of gender well illustrates this effect. Although a universally recognized form of inequality affecting over half the nation's population, female gender is limited to a mere enhancement to other causal stories within the health equity directives. This discursive reductionism echoes a common undervaluation wherein women are seen but not heard while working in the service of others—in this case, other causal stories. As such, the health equity reports do not appear to take gender seriously in its own right as a legitimate inequality. The stories of disability and sexual orientation are even more muted within the directives.

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[19] LGBT is an acronym for lesbian, gay, bisexual, and transgender.

The National Partnership for Action (2011) report experience offers a reminder, however, that the health equity discourse is not static. Rather this constituency-driven debate is continually transforming through the interactions of various inequality groups. How inequities of gender, disability, and sexual orientation will develop within this dialogue remains to be seen. The constituency-driven nature of the health also underscores the importance of recognizing what Crenshaw (1991) has termed “political intersectionality;” that is, the cross-group dynamics of collaboration and contestation in promoting the various agendas around health equity.

Conclusion

In this chapter, I described the causal stories employed within eight health equity reports to explain health disparities along multiple lines of power. Collectively, these stories illustrate a commitment to addressing a diversity of inequalities through a social approach to health. Yet, my findings demonstrate these stories are not particular intersectional. Etiologically, the health equity directives are predominantly limited to mid-level theorizing, which Raphael (2006) has described as directed toward specific social determinants, without illuminating the larger “political, economic, and social processes by which the quality of social determinants of health is shaped” (p. 654). Consistent with this mid-level orientation comes a preoccupation with the distributional aspects of inequalities; less discussed are the relations of power that determine who decides which resources are distributed and whose interests are served (Birn 2009; Navarro 2009; Raphael 2006). As Krieger (2011) alternatively describes, the social determinants perspective “chiefly [focuses] on consumption and its relationship to people’s relative social standing (a.k.a. “the ladder”), with little or no consideration of production” (p. 184).

A closer look at the interrelationships between causal stories reveals that these narratives fit within health equity’s patchwork discourse in both complementary and conflicting ways. For instance, the life chances story provides a unifying tale that links any number of disparity categories to a social determinants approach. The stress and lifecourse narratives are similarly accommodating in that these mechanistic tales can support any causal story in articulating pathways to inequalities. In contrast, the socioeconomic gradient and racism stories act in a degree of opposition or exception to one another. Specifically, the gradient importantly promotes a socioeconomic view, one currently lacking in the U.S. dialogue around health differences. Yet, the tale's universalistic tone implicitly reinforces a dominant White, male norm that mutes other racialized and gendered manifestations. Alternatively, the racism story prioritizes racism as the root cause of inequality but in so doing, minimizes consideration of other inequalities. The contentious juxtaposition of the socioeconomic gradient and racism narratives may reflect underlying tensions between race and class approaches to inequities discussed in Chapter 2.

While certain stories (e.g., life chances, stress) address multiple inequities and others (e.g., socioeconomic gradient, racism) prioritize singular inequalities, collectively these tales illustrate a multiple orientation in constructing social differences as overlapping yet conceptually distinct formation processes (Hancock 2007b). At a glance, this orientation appears potentially compatible with intersectionality, yet I found that the former in fact can work against such relational thinking. As my data illustrates, rarely are social differences combined beyond an additive configuration. Moreover, even within-group differences are downplayed in preference for dominant forms of inequality, as exemplified by race comparisons made primarily between males.

Yet, deconstructing the health equity theorizing into discrete stories also elucidates their intersectional potential. For instance, the life chances story links a number of disparity categories to a social determinants approach. Re-invigorating this tale within a contemporary

Weberian critique that better interconnects and articulates inequalities, including gender, disability, and sexuality, to underlying systems of power can vastly improve life chance’s intersectional etiological power. Though singularly focused, the racism story illustrates the strength of a systems-level analysis in revealing central mechanisms of power around policy actions, both historic and present-day. Likewise, the racial/ethnic health paradox demonstrates how approaching intersectional differences as important points of entry—rather than omission—can enhance theorizing and actions around the complex problem of inequalities. In the next chapter, I discuss how the causal stories shape proposed actions around the social determinants of health.

CHAPTER 4

MOBILIZING HEALTH EQUITY ACTION: SOCIAL DETERMINANTS OF HEALTH & PLACE

In this chapter, I examine how health equity mobilizes actions around the social determinants of health. Defined as the environments in which people live, work, and play, these social influences shape health and quality of life (U.S. Department of Health and Human Services 2013a). As promoted by the causal stories in chapter 3, the social determinants of health are the centerpiece of a health equity framework and serve as the primary sites of planned intervention. Which social determinants count for health equity action and how proposed interventions address multiple inequalities is the focus of this chapter.

Specifically in these pages, I demonstrate that health equity discourse directs actions primarily toward the socioeconomic and environmental determinants of health. These include childhood education, housing, transportation, and other conditions commonly associated with neighborhoods and place. As such, place serves as a powerful organizing principle within health equity discourse, which, I argue, functions intersectionally to connect multiple social determinants to underlying systems of power, as well as to lived experience in terms of both health and collective action. Defined primarily in racial and socioeconomic terms, however, the construct of place essentially excludes gender, sexuality, and disability from discussions of health equity actions. I show that approaching place from an intersectional lens can bring neglected yet important determinants into view. I foreground two highly gendered institutions, the criminal justice and welfare systems, as case examples to illustrate the ways in which experiences of men and women are segregated with the context of place.

My analysis of the health equity action steps draws from more than 300 recommendations presented within the eight health equity reports described in Chapter 1. I begin with an overview of the recommendations to summarize the types of interventions promoted and the ways these proposed interventions relate to the causal stories. This initial analysis revealed that place is the important organizing principle within the directives. Considering this construct in more detail, I describe the ways that a place-based frame enhances health equity actions around the social determinants of health. I follow by addressing limitations of this place-based frame from an intersectional perspective. Please note the organizational author names of the health equity reports are abbreviated in this chapter. A list of these abbreviations can be found in Appendix 2.

Creating the social conditions for health

A primary goal of health equity is to create the social conditions for health. But what counts as a social intervention within this debate? Below, I summarize the recommendations offered by the health equity reports to identify what types of action steps are promoted for equity and in what ways multiple inequalities are addressed. I am also interested in the ways in which the proposed interventions correlate with the etiological stories presented in Chapter 3. Specifically, which interventions are justified because of these stories, and which are not? And what stories remain or become in/visible to support these proposed actions?

Table 4.1 below provides an overview of the social determinants targeted for intervention by the health equity reports. Following the representational schemes presented within the directives, I have arranged these determinants within three structural domains—socioeconomic, environmental, and political. Though the type of determinant identified within each domain—as well as the domains themselves—varies across reports,[20] I found a classification scheme useful in illuminating characteristics associated with each grouping. For this discussion, I categorized

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[20] The health equity reports describe domains variously as social, socioeconomic, physical, environmental, political, and cultural.

socioeconomic determinants as status indicators of income, education, and employment. Environmental determinants include tangible goods and services, such as nutritious foods (consumables), clean air (natural environment), housing, parks and open spaces (recreation), transportation, and health and human services. The political domain captures proposed interventions around capacity building, civic engagement, and law (e.g., criminal justice). I acknowledge that dividing the social determinants into these domains can obscure overlapping and concomitant relationships between these structural influences. The next section addresses the intersectional nature of the various social determinants of health within the context of place.

Table 4.1: Report recommendations by social determinant type

SOCIOECONOMIC (8)	ENVIRONMENTAL (8)	POLITICAL (6)
▪ Education (8) ▪ Employment (6) ▪ Income (5)	▪ Consumables (6) ▪ Natural environment (4) ▪ Housing (7) ▪ Recreation (6) ▪ Transportation (7) ▪ Health Human Services (7)	▪ Capacity Building (4) ▪ Civic Engagement (6) ▪ Criminal Justice (4)

(N) = Number of reports proposing interventions with regards to a corresponding social determinant.

Socioeconomic recommendations: The health equity documents direct action mainly toward the socioeconomic and environmental determinants, with education being the most robust. As a core building block for enhancing life chances, education represents a basic tenet in health equity's discourse of opportunity. Indeed, all eight health equity directives offer recommendations addressing education. A closer look reveals that childhood learning is a clear priority, with twenty-nine (29) of the thirty-one (31) educational recommendations directed toward youth. This near exclusive emphasis on children coincides with the lifecourse narrative's prioritization of this age group.

Education is also central to the social gradient tale. That story underscores the importance of socioeconomic determinants in impacting health at "every step up the social hierarchy" (King

2008:7). Interestingly, I found that proposed socioeconomic interventions primarily target disadvantaged groups, rather than the general population. The absence of the latter supports my earlier assertion that non-poor groups are included within the gradient tale primarily to build broad–based political support for a socioeconomic approach, rather than to direct health equity actions toward advantaged populations.

Environmental recommendations: Also prevalent within the health equity reports are recommendations covering both the built and natural environments. A distinguishing characteristic of proposed interventions within the environmental domain is their connection to place—specifically neighborhoods and communities. The report logic for this place-based approach is that neighborhoods create the infrastructure necessary to maintaining health through access to a network of health-promoting factors (e.g., nutritious foods, clean air, quality housing). The following recommendation exemplifies this geographic emphasis in calling for:

> [i]mprovements in neighborhood living conditions that combine mixed income, mixed use, no displacement, public transportation, affordable housing, open space and removal of blight. (BARHII 2008:18)

The next section introduces place as a key organizing principle within the health equity reports. For now, I revisit the casual stories—most notably the racism narrative, which advances the idea of place as a central feature for acting on disparities particularly as resulting from racial segregation. Surprisingly, race is not referenced within the reports' proposed environmental interventions, except with regard to housing, and health and human services. Rather, "low-income" appears as the favored descriptor for targeted groups within this domain, which contrasts with the socioeconomic arena where race descriptors are most common. Given race's dominance within the causal stories, its absence within the environmental recommendations is remarkable. This omission may reflect an effort to "universalize" recommendations for greater political appeal, as with the social gradient tale discussed previously (Chapter 3), and/or a way to shift blame for poor health away from racial groups onto the social conditions in which they live. Regardless of the rationale, the disappearance of race, like that of non-poor groups discussed above, suggests the strategic use of discursive erasures to advance a particular social determinants agenda.

Political recommendations: Recommendations in the political arena are slightly less common than in the other two domains, with six of eight directives proposing such interventions. As shifting power is a core objective of intersectional praxis, I foreground recommendations addressing two determinants that especially advance political engagement—capacity building and civic participation. By capacity building, the health equity reports refer to the procurement of skills and resources to engage in health equity activities. As indicated in Table 4.1, four directives propose actions around capacity building. Primarily oriented toward disadvantaged communities, these recommendations address data access and interpretation skills, leadership development, and other technical assistance.

Notably, the health equity reports focus less on the proficiency of public health agencies and other institutions to serve disadvantaged populations. Only three directives specifically address institutional capacity building within their recommendations. One document calls for organizational trainings to address community needs and "engage community members as equal partners" (NPA 2011:116), whereas two others encourage anti-racism and social justice in-services for staff and managers. This general lack of attentiveness to institutional capacity overlooks the operationalization of power within the day-to-day workings of these structural entities.

The second political determinant, civic engagement, references participation in governance processes, such as voting and participation on advisory and governing boards. Six reports included calls for civic engagement in their recommendations. One directive (CPEHN 2008) addresses this determinant as a general intervention. Five reports incorporate civil engagement within one or more environmental recommendation, with calls for public input around air pollution, land use policies, neighborhood development, and transportation planning. Interestingly, only one document (NPA 2011) promotes community engagement in a socioeconomic recommendation. Perhaps this absence reflects the more regional/national focus of socioeconomic interventions, which generate activities not seen as readily accessible at a local, community level.

The finding that the environmental recommendations are more likely to incorporate community participation and that these place-based recommendations are linked with the racism causal story suggests that the racism tale particularly promotes community-engaged interventions. To further validate this observation, I re-examined the health equity documents to see whether reports that emphasized the racism story[21] are most likely to call for community participation within their recommendations. Indeed this is the case. Not only does a detailed racism story follow with action steps that involve community engagement, but also these interventions particularly endorse leadership development.

In sum, the health equity reports mobilize planned action around the social conditions of health—most notably socioeconomic and environmental influences—with childhood education, housing, recreational space, and transportation among the favored targets. Such intervention strategies are consistent with the causal stories (Chapter 3), which theorize inequalities through the socioeconomic gradient, racialized conceptions of place, and the lifecourse prioritization of childhood vulnerabilities. Like the causal stories, the report recommendations importantly expand the health disparities conversation beyond the biomedical frame by offering action steps

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[21] I refer to racism stories that include discussions about racialized histories and issues of privilege (see Chapter 3).

that address social conditions of health. Also salient from an intersectional perspective, the proposed interventions recognize community participation as a valid action strategy, particularly with regard to place-based interventions.

Yet, as with the causal stories, the report recommendations illustrate similar constraints. For instance, proposed interventions are directed primarily toward material determinants most amendable to distributional change. Less attention is devoted to shifting power relations through interventions targeting the political realm and other mechanisms of privilege (e.g., regressive tax structures, corporate loopholes, predatory mortgage practices, environmental deregulation). Similarly, the health equity report recommendations foreground inequalities by socioeconomic status, race, and age. If and how action steps around these forms of inequality intersect with those related to gender, sexual orientation, and/or disability remains unclear. As such, the health report recommendations prove to be not particularly intersectional.

My analysis of the health equity report recommendations also reveals interesting discursive twists in the translation between theory and planned actions. In the case of disparities populations, advantaged groups are dropped as the socioeconomic gradient tale is operationalizing within related interventions. Similarly, race nearly disappears in the place-based recommendations. I speculated that these omissions represent strategic efforts to build greater—and less controversial—political appeal for actions around the social determinants of health. Nonetheless, such exclusions obscure core power dynamics that shape social conditions, thereby potentially limiting the effectiveness of currently proposed interventions strategies. Promising from an intersectional perspective, however, is the health equity reports' conceptualization of place to foster relational thinking around the structural complexities of inequalities, as I next discuss.

Place as an intersectional construct

> Neighborhoods are where poverty, race/ethnicity & other social factors converge with the physical environment to produce the overall conditions that affect health. (BARHII 2008:xx)

As the above excerpt illustrates, place serves as the nexus for inequalities, social conditions, and health. The idea of place is central to the health equity reports, with seven directives incorporating this construct within their proposed interventions. As *Healthy People 2020* outlines, "Understanding the relationship between how population groups experience "place" and the impact of "place" on health is fundamental to the social determinants of health" (U.S. Department of Health and Human Services 2013a). This conceptualization of place eclipses Patricia Hill Collins's (2010) intersectional theorizing about community as "constitut[ing] both a principle for actual organization and an idea that people use to make sense of and shape their everyday realities" (p. 8).

Inspired by this scholarship, I elucidate three discursive functions of place as an intersectional construct that the health equity reports use to enhance relational thinking about social inequalities in health. These include: 1) connecting multiple social conditions under the rubric of place, 2) linking these determinants to interlocking systems of power, and 3) mobilizing various constituencies toward health equity action. Following Collins, I assert that deploying place in this way can advance intersectional understandings of the "organizations, dynamics, and social processes associated with contemporary social inequalities" (Collins 2010:10).

Connecting multiple social conditions under the rubric of place:

> People's health cannot be separated from the environment in which they live. *A toxic mixture of conditions* such as poverty, pollution, poor education, substandard housing, a shortage of grocery stores, cheap fast food, violence, unemployment, and racism combine to make people sick. (Alameda 2008:xvi)

All of the health equity reports underscore the multiplicative and interactive nature of social determinants in impacting health. Specifically, these directives maintain that health is shaped not by one primary social factor but rather by the combined and cumulative effects of multiple social conditions. As the excerpt above illustrates, the idea of place is used to conceptually connect these determinants together under one "roof," so to speak. As one informant explains, a strength of a place-based approach is precisely that it is "looking at a geographic area and seeing…the cumulative impact of all these different layers—transportation, education, and housing" (Interview 27). Tying together the various social determinants under the rubric of place promotes a comprehensive—rather than single issue—approach to tackling the structural components of inequity.

Linking social determinants to systems of power: From an intersectionality perspective, however, focusing on social determinants alone does not necessarily ensure equity. As one informant asserts, social determinants are "just things, like housing, education…but getting to the inequity, you have to explain why there is inequity in housing, what do we mean by that" (Interview 05).

Four health directives illustrate this second discursive function of place as an intersectional construct linking social conditions to underlying systems of power. Specifically, these directives draw on the racism story to historicize place with particular regard to racial segregation. In so doing, these documents explicitly name a racialized system of power as a fundamental cause of health disparities. One informant contends,

> Because of this central role that…racism plays, the issues of residential segregation and the local histories of race…and the way our country's structured with county resource…I think the frame of achieving health equity from a social determinants lens requires a place-based approach. (Interview 24)

Although a unitary tale that prioritize race over other forms of difference, the racism story still serves as an example illustrates how place links social conditions to an underlying system of power. Moreover, situating these determinants within a historicized context of place can expose the processes that determine their equitable distribution, as this informant explains,

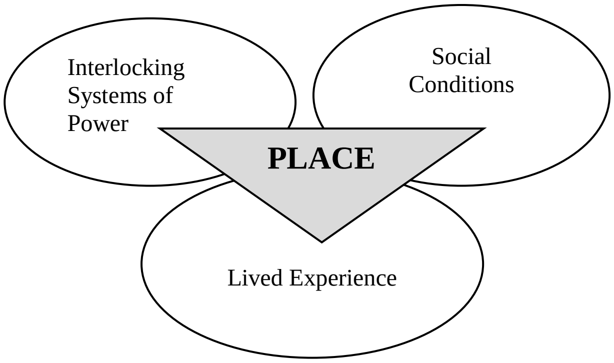
> If the social determinants of health are discussed in the context that takes into account place, power, and history, then they become more examples of the actual mechanisms/pathways of how societal oppression becomes biological outcomes, rather than just an avoidance of the real issues. (Interview27)

Mobilizing various constituencies toward collective action: A third intersectional function of the place construct is mobilizing collective action. As Collins (2010) explained, "[T]he construct of community catalyzes strong, deep feelings that can move people to action" (p. 11). Not only does place direct attention to the site of intervention, but also helps shape collaborations around health equity action. Specifically, several informants explained that a social determinant focus at the neighborhood level legitimizes collaborations among diverse partners, including community members and non-health agencies (e.g., ports, transportation, urban planning). As this informant articulates,

> [B]y focusing on a place…it makes it easier to understand why [the] Housing Authority…Unified School District…health department and…some of these advocacy partners would be at the same table, [which] until now have not ever sat at the same table. (Interview 27)

As previously noted, including groups most negatively impacted by inequalities in decisionmaking processes about their lives is critical to shifting power relations and imperative to an intersectional frame.

Figure 4.1: Place connects multiple levels of power



The conceptual model in Figure 4.1 above depicts the three intersectional functions of place. As a relational framework, intersectionality approaches inequalities by attending to the interrelationships between levels of social interaction, including the macro level concerning interlocking systems of power (e.g., racism, classism, heterosexism); the meso institutional level, addressing policies and practices; and the micro level of lived experience. Linking social dimensions I argue is exactly what place does in the health equity reports. That is, place is used to connect the social conditions of health to underlying systems of power, as well as to lived experiences both in terms of population health outcomes and social action. In this way, place functions intersectionally to elucidate the complex dimensions and mechanisms at which inequalities operate, and therefore need to be ameliorated.

Although a powerful tool in organizing health equity actions, the idea of place as an intersectional construct is not without its limits. Perhaps the most animated concern expressed by informants in this regard is that, like the social determinants of health, the term “place” can “sanitize” the equity conversation by diverting attention from the underlying systems of power at the heart of health inequalities. As one informant recants, “Why don't we just name it what it is? We are not talking about “placism,” we are talking about racism” (Interview 27). Another concurs, adding that talking about health disparities on the Hill (Washington, D.C.) is currently “not considered good politics…[rather]...the preferred language is neighborhoods and communities” (Interview 18). Collins (2010) has defined constructs like community as commonplace but elastic ideas that can serve diverse political projects (p. 12). However, as study informants point out, the malleability in the meaning of place reflects not only the term’s strength in accommodating various political projects but also its vulnerability to cooptation and de-politicization.

Another limitation, according to informants, is that not all inequalities are organized by place, such as gender, disability, or sexuality; or perhaps more to the point, certain types of inequalities are not recognized as part of place. As one informant explains with regard to sexual orientation,

> A group of low-income African-Americans in a geographic area of Detroit may not be inclusive of gay black men who live there. So it's [community] an umbrella term but it can also be exclusive as well as narrow. (Interview 03)

Similarly, the idea of place does not capture certain social determinants that do not fit into notions of local communities and/or benefit from interventions at more regional and national level (e.g., universal health care, national economic policies). A case in point is the criminal justice system, which “remove[s] a whole population from neighborhoods and put[s] them in prison” (Interview 27).

From an intersectional perspective, I welcome these critiques in pointing the way to improve the intersectional potential of place. For instance, rather than promoting place at just the neighborhood level, the idea can be presented as a multi-level construct. This re-articulation expands the power of place in politically leveraging health equity’s argument for social action at local, regional, and national levels. Also, considering the ways that gender intersects with race and socioeconomic position within the context of place can bring certain social determinants into view. Below I discuss the criminal justice and welfare systems as cases in point.

Gendered spaces

The criminal justice and the welfare system together affect the lives of over 13 million people.[22] Highly racialized and classed, these systems are also highly gendered spaces, with men currently comprising over 90% of the prison population and women primarily representing the adult welfare population(Guerino, Harrison, and Sobel 2011; U.S. Department of Health and Human Services 2012). Despite the significant impact of these determinants on lives of people of color, the criminal justice and welfare systems receive limited attention within the health equity reports. In this section, I present the criminal and welfare systems as gendered institutions illustrative of how this dimension of difference intersects race and socioeconomic status in ways that relegate men and women from the same community into different spaces. This is not to say that women do not go to prison, or men are not recipients of welfare. To the contrary, such occurrences represent intersectional concerns in their own right (Davis 2003). My aim here, however, is to foreground the gendered nature of certain social determinants within the context of place. In so doing, I illustrate how an intersectional approach that inserts gender into the race/socioeconomic equation can illuminate institutions currently obscured from view within health equity discourse.

Criminal justice: As illustrated in Table 4.1 above, half (4) of the directives propose interventions directed toward the criminal justice system. In two documents, these recommendations appear in subsections specifically devoted to this social determinant, with a commentary about disproportional representation by race and socioeconomic status either appearing within the section or elsewhere in the document. As one report explicates, addressing “the root causes of disproportionate incarceration rates for African Americans, Latinos, and low-

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[22] Based on 2010 aggregated data for the prison (1.6 million) (Guerino, Harrison, and Sobel 2011), correctional (7.1 million) (Glaze 2011), and TANF (4.7 million) (U.S. Department of Health and Human Services 2012)populations.

income people” is an explicit aim (Alameda 2008:xiv). The following excerpts illustrate proposed interventions along the criminal justice trajectory, including policing, law, and community re-entry.

> Improve neighborhood conditions (e.g., policies that support crime prevention through environmental design, community problem-oriented policing, etc.) to support healthier living environment (NPA 2011:126)
>
> Reform crime laws: Decriminalize addiction and implement community programs for drug offenders in lieu of prison; Eliminate three-strikes laws. (Alameda 2008:xiv)
>
> Support re-entry programs and combine probation with social services, health, and other programs to ensure a support system for probationers. (Alameda 2008:xiv)
>
> We must review and revoke laws that punish individuals returning to their communities—for example, repealing the federal ban on student loans to formerly incarcerated with drug convictions and allowing nonviolent drug offenders the opportunity to expunge their records (CPEHN 2009:35)

Collectively, these recommendations point to inequitable processes both outside and within the criminal justice system itself that lead to disproportionality by race and socioeconomic status. Specifically highlighted are policing practices as well as drug and three-strike laws that have been well-documented with regard to targeting and further disadvantaging low income, communities of color (Chambliss 2003). Linkages with place are evident within the criminal justice-oriented recommendations, including references to community policing and community re-entry programs.

Welfare: Only one directive specifically uses the term “welfare” in its recommendations. However, four other health equity reports employ generic terms (e.g., safety net opportunities, public programs) and/or specify programs by name (e.g., WIC–Special Supplemental Nutrition Program for Women, Infants, and Children, SNAP–Supplemental Nutrition Assistance program). For this discussion, I consider recommendations employing any of these terms under the welfare banner. The following excerpts illustrate report recommendations for welfare programs broadly defined:

> Modernize the Federal Poverty Level: A change in the Federal Poverty Level to reflect the true cost of living today would help those most in need access critical public programs. The Federal Poverty Level needs to reflect current basic needs and geographic differences. (CPEHN 2009:33)
>
> Revise government policies that cause working poor to lose all of their welfare or disability benefits if they take a job to supplement their benefits (Multnomah 2009:21)
>
> Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food. (RWJ 2009:6)

Clustered under the reports' income-related recommendations, proposed welfare interventions appear without commentaries addressing disproportionality. Moreover, these recommendations are oriented toward enhancing public assistance generally (e.g., more lenient eligibility requirements, expanding benefits), rather than addressing inequalities within the system itself, such as differential access to job training and transportation assistance (Jones-Deweever, Dill, and Schram 2009). Like the socioeconomic determinants generally, the welfare recommendations direct attention to state and national interventions rather than those at the community level.

Neither the criminal justice nor welfare systems garner major attention within the reports as sites for potential interventions. From an intersectional perspective, however, recognizing the gendered nature of environments in which people "live, work, and play" certainly elevates these systems within the list of determinants requiring health equity remediation. Also comparisons between criminal justice and welfare systems reveal interesting differences. Particularly, recommendations targeting the criminal justice system are more frequent and more extensive with regard to addressing within-system disparities. In contrast, the proposed welfare system interventions exhibit a universalizing quality, similar to that described in the social gradient story, where racial variations remain obscured. There may be various reasons for these different presentations within the health reports (e.g., severity of system impact). Given the very limited attention to women within these directives generally, however, systems that affect this gendered group may be particularly overlooked.

Conclusion

In this chapter, I characterized the ways in which health equity mobilizes action around the social determinants of health. In so doing, I show how the health equity reports discursively use the idea of place as a central organizing frame for these proposed actions. This place-based frame foregrounds certain determinants for health equity interventions, particularly environmental conditions such as housing, transportation, and recreational spaces. Also, prioritized are socioeconomic determinants, including childhood education, employment, and income. Both socioeconomic and environmental determinants, as well as those targeting youth, are well supported by the reports' causal theorizing around the socioeconomic gradient, racialized notions of place, and childhood vulnerability within the lifecourse.

Like the causal stories, however, the reports' proposed interventions neglect important inequalities—such as those by gender, sexuality and disability—for the ways these differences deferentially manifest across social determinants within the context of place. I consider two institutions—criminal justice and welfare—which significantly impact low income communities of color, yet receive limited attention within the reports. Adopting an intersectional stance, I argue that the criminal justice and welfare systems are also highly gendered spaces, which differently structure the experiences of men and women inhabiting the same community. In so doing, I illustrate the power of intersectionality to elucidate important social determinants for health equity actions, which are currently overlooked within health equity discourse.

CHAPTER 5

CONCLUSION

This dissertation has described the emerging discourse of health equity, a public health approach to eliminating disparities by enhancing social conditions. In analyzing this debate through an intersectional lens, I have illustrated how health equity both promotes and stymies efforts to promote social justice. This "changing-same"[23] pattern of moving forward but remaining unchanged manifests in calls for greater inclusion beyond race, while simultaneously paying to other important inequalities, such as by gender, sexual orientation, and disability. Similarly, proposing action steps around the social determinants of health crucially expands the repertoire of interventions beyond biomedicine, yet health equity discourse leaves the *fundamental* causes of disparities (e.g., class exploitation, gender oppression) essentially neglected. Obfuscating the core processes and interconnected dimensions of inequalities can reinforce current hierarchies of power, thereby hampering efforts to achieve equity.

To account for this changing-same dynamic, I began with a social history in Chapter 2. Specifically, I traced the emergence of the health equity debate from within a larger post-civil rights conversation around health differences, drawing on health equity reports, key informant interviews, and other historical materials. I illustrated how this conversation has been contingency driven, initially by racial and ethnic, socioeconomic, and women's health agendas. Over the years, racial and ethnic concerns have come to dominate the conversation around health differences, while gender has all but disappeared. The recent introduction of health equity has sparked tensions about inequalities are prioritized and subsequently acted upon.

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[23] Inersectionality scholar Patricia Hill Collins (2010) uses this term to describe the ways "social inequalities simultaneously change yet remain the same" (p. 8).

In critical discourse analysis, such discursive frictions mark potential sites of transformation. Following these fault lines enabled me to identify the impetus for health equity as twofold. First, the debate represents a push upstream against a biomedical framing of health disparities to a social one emphasizing the conditions in which people live. Second, the health equity discourse reframes disparities as not simply any health differences but as those specifically affecting disadvantaged populations, including those by race, socioeconomic status, gender, sexual orientation, age, religion, and disability. These two observations provoked additional questions, which I took up in succeeding chapters regarding how various inequalities are construed within health equity discourse and shape subsequent social actions.

Chapter 3 focused on the social construction of health inequalities, drawing on governmental and nongovernmental health equity reports and supplemented by key informant interviews with academics and scholars knowledgeable in the field. Specifically, I highlighted six causal stories deployed to explain health differences. These include explications about life chances, socioeconomic gradients, racism, racial/ethnic health paradoxes, stress, and the lifecourse. I showed how these etiological tales interact in both conflictual and complementary ways. For instance, the socioeconomic gradient and racism narratives relate with some degree of opposition with regard to which form of inequality—by race or class—most fundamentally explains health disparities. Still other stories, such as stress and lifecourse, function as complementary tales delineating pathways from social exposures to ill health, that, in turn, bolster other narratives. Considered collectively, these causal stories reflect midlevel theorizing, which foregrounds a distributional approach to equity that offers only intermittent attention to underlying social relations and systems of power. Moreover, I concluded that the health equity reports are not particularly intersectional in handling multiple social differences in health. That is, the health equity reports typically characterize various inequalities as additive and gradational (e.g., the more forms of disadvantage, the worse the health), while complex social formations that do not fit this dominant pattern are explained away as aberrations—as in the case of the racial ethnic health paradox—or barely noticed at all—as with gender, sexual orientation, and disability.

Chapter 4 described how health equity mobilizes planned action steps, based on analysis of the reports' proposed interventions targeting the social determinants of health. Following the causal stories' concerns with the socioeconomic gradient and racialized conceptions of place, I illustrated how the reports' proposed interventions target socioeconomic and environmental determinants, particularly childhood education, housing, transportation, and recreational spaces. But, like the causal stories, recommendations attending to the intersectional nature of these social determinants across gender, disability, and sexuality are scant.

Still, I found that the health equity reports demonstrate a potential for intersectionality with the idea of place when used to connect multiple social determinants to both macro systems of power (e.g., racism), as well as micro lived experiences around health and wellbeing. I argued that this conception of place helps elucidate the overlapping macro, meso, and micro social dimensions through which inequalities are produced and therefore must be eradicated. I then illustrate how an intersectional approach can enhance this construct's capacity to address multiple inequalities. Specifically, I demonstrate how consideration of gendered spaces, such as the criminal and welfare systems, can bring determinants often overlooked within the discourse into view of health equity action.

Concluding with Chapter 5, I discuss the implications of my dissertation research for the fields of sociology and health. I close with an account of study limitations, as well as future directions for this work.

Implications for the field

This sociological investigation of health equity discourse contributes to studies of health inequalities, social determinants of health, and constructions of knowledge/power through discourse. I first discuss the study's theoretical contributions with regard to the social structuring of health inequalities, then its substantive implications for health research and policy.

Theoretical contributions: Social structuring of health inequalities

This dissertation answers a call among intersectionality scholars to extend inquiry beyond identity politics and consider the "neglected objects of analysis, namely the social structural processes by which inequality is organized, as well as the mechanisms that can be used to change, address, or transform these structures" (Collins 2009:x). Specifically, my study of health equity contributes to intersectional theorizing at the structural level by presenting a multi-institutional approach to achieving health justice. Although numerous intersectional studies have focused on singular institutions—such as education or the welfare system (Dill and Zambrana 2009)—the health equity debate attends to a network of social conditions that produce health inequalities. As the health equity reports adeptly argue, no singular institution can fully account for health disparities. Rather, physical and mental wellbeing is influenced by the combined and cumulative effects of multiple social determinants, including health care and beyond. The reports leverage the idea of place to further elucidate the ways in which various structural determinants—such as education, transportation, and recreational resources—come together under one "roof" to influence well-being. In adopting a wider structural lens that captures the network of interactions *between* institutions, the health equity reports advance a comprehensive multi-structural approach to eliminating health disparities.

In presenting place as a central organizing principle for in/equity, the health equity reports parallel Collins's (2010) notion of community. Specifically, the directives describe place as both a principle of social organization that differentially structures people's lives around health, as well as a symbolic device through which people interpret, communicate, and mobilize around such experiences. Collins has characterized various communities by their distinguishing features, like the *gated* community, primarily concerned with boundary making and surveillance, and the *virtual* community, which articulates new social relations generated through technologically-mediated forums. Borrowing from the Healthy People 2010 tagline "Healthy People in Healthy Communities" (U.S. Department of Health and Human Services 2000), I augment Collins's list of characterizations with the *healthy* community, which offers unique insights into the production of health inequalities through the interconnected social conditions that influence wellbeing.

In examining health equity as an alternative to a biomedical framing of health difference, my dissertation engages Weber and Parra-Medina's (2003) intersectional framework from a new vantage point. Whereas these scholars have argued that a biomedical approach inadequately responds to the complex social nature of health disparities, I introduce health equity as a *corrective* to the biomedical model. Specifically, health equity is importantly distinguished from the former in advancing a social determinants agenda that attends to multiple disadvantaged groups. As such, the health equity dialogue resonates with an intersectional imperative to explicitly address various inequalities at the structural level. Yet, health equity's eclipse with intersectional justice is only partial. Rather, in a changing-same dynamic, I found that the discourse remains constrained by its tendency to reduce social inequalities to autonomous, universalized categories that do not well accommodate intersections of multiple differences. Moreover, health equity keeps certain power relations hidden from view. Not surprisingly, this discourse speaks little of the core mechanisms of social privilege, nor does it linger over political interventions that could explicitly shift these power dynamics. Although health equity advances commitments around social inclusion and structural change, from an intersectional perspective, I have argued, the current strategies do not guarantee equity—at least not in the relational sense that requires shifts in power relations.

Finally, this dissertation research contributes to theorizing about the production of knowledge and power through discourse. Various scholars have undertaken similar scholarship in the contemporary health areas of global health policy (King 2002), sexuality (Mann 2013), and HIV testing (Gagnon and Holmes 2008), to name a few. Unlike projects that interrogate biomedical discourse, however, my study examines a purported progressive alternative of health equity. I showed how this discourse constructs disparity norms—such as the social gradient and additive models—through causal stories that exclude nonconforming types of disadvantage. Currently diminished, exceptionalized, and/or otherwise ignored are important stratifications by nativity, gender, sexuality, and disability in both health equity theorizing and proposed interventions. In highlighting these discursive oversights, I contend that even a justice-oriented discourse aimed at reducing health differences can simultaneously perpetuate these inequalities by obscuring the complex interactions between inequalities, as well as their linkages to underlying systems of power.

Substantive contributions to health research and policy

Scholars and activists have pointed to intersectionality as a way to enhance the justice potential of the health equity frame. Yet intersectionality remains vaguely defined as a "normative and empirical paradigm" (Hancock 2007a:248; see also Davis 2008; Knapp 2005). At its roots, intersectionality represents social justice praxis centered on those living at the intersections of multiple inequalities (Crenshaw 1991; Dill and Zambrana 2009; Glenn 1999). This critical edge can be overshadowed these days with methodological concerns regarding the management of multiple categories (Hancock 2007a; McCall 2005; Walby 2007). I assert that attending to intersecting categories is not the same as committing to an intersectional approach to justice aimed at shifting power relations. Clarity is needed regarding principles of intersectionality and models are needed to guide its application to research and policy. In this dissertation, I outlined five intersectional premises that can guide an intersectional analysis addressing concerns around power, intersecting systems of inequality, privilege, situated knowledges, and the interconnections between theorizing and social action. Others have provided similar conceptual framework of intersectionality (Collins 1999; Glenn 1999; Weber and Parra-Medina 2003), which can importantly inform research and policy.

This study also highlights several discursive strategies that can strengthen the political valence of health equity discourse. One strategy is the use of historicizing. Zambrana & Dill (2009) have maintained, "historical context is essential in revealing how domains of inequality are intermeshed, how those particular arrangements have been produced, and how they affect contemporary policy" (p. 275). In Chapter 3, the racism story particularly engages in historicizing by situating various social determinants such as housing, mortgage banking, education, and so forth within past segregationist and current racially-biased practices. A second strategy is use of place as an intersectional construct. In Chapter 4, I illustrated how place discursively functions to simultaneously connect multiple social determinants to macro systems of power and micro experiences of health. Consistent with intersectional framing, these discursive strategies importantly keep power in view, through the elucidation of its processes and interconnections.

Limitations and future directions

This dissertation examined health equity discourse at—what I argued in Chapter 2— as a watershed moment for new vernacular addressing health differences in this country. Focusing my inquiry on this snapshot of time, and conducting in-depth analysis of select data sources, enabled me to characterize this most recent push toward health justice. Yet, as with most research endeavors, decisions around data sources, methods, theoretical framing, and the research question themselves, precluded viable alternatives. In the discussion that follows, I address several theoretical and methodological limitations of my research, as well as highlight directions for future inquiry.

Theoretically, my analysis centered on a “classic” intersectional triad of race, class, and gender (Knapp 2005), which reflects the primary inequalities considered within both intersectionality and health equity discourse. As I ventured more deeply into my analysis, however, I recognized that foregrounding this trinity replicated the same routinized hierarchies that had become a subject of my critique. That is, by prioritizing race, class, and gender, I too subordinated other forms of inequality, such as related to disability and sexual orientation. A growing body of intersectionality scholarship is engaging sexuality and LGBT studies (e.g. Ferguson 2003; Johnson and Henderson 2005), as well as disabilities (Bell 2011; Fine and Asch 1988). These perspectives have the potential to enhance future intersectional analysis of the health equity field.

Methodologically, I based my in-depth textual analysis on a select group of health equity reports. Although these directives serve as important early U.S. examples of this framing, the discourse of health equity is far broader and nuanced than these texts can capture. Also, with the passage of time, the health equity movement has gained considerable traction, both in this country and internationally. Many more organizations have produced guiding directives than were available when I began this project. Future research targeting more recent reports—particularly publications from community-based and other non-governmental organizations—would likely yield novel insights about health equity discourse. So too would expanding inquiry to other discursive formats, such as peer-reviewed articles, conference proceedings, webinar transcripts, and organizational training manuals.

Historical accounts of the contemporary U.S. health equity movement present another lacuna that demands future study. Although I found the literature replete with international historical accounts and critiques of the health equity debate, analogous U.S. scholarship was severely limited. This paucity revealed itself only with regard to health equity, but also to the larger contemporary health disparities debate. The U.S. provides an important geopolitical site for investigating the debate around health differences, given its particular contextual constellations (e.g., strong racial justice movement, individualist-oriented national ethos). Social histories of this movement would provide critical insights into the mechanisms of its successes and failures to inform future directions.

Finally, my research exposed the various collaborations and conflicts among diverse constituencies working toward health equity. Intersectionality scholars have stressed the value of joint action in building successful justice initiatives (Cole 2008; Crenshaw 1991; Lombardo and Verloo 2009; Verloo 2006; Yuval-Davis 2006). Another future research study could address the multi-constituency collaborative processes around health equity. Lombardo and Verloo (2009) have underscored that policymakers and others working toward institutionalizing multiple equity platforms “need to be especially aware of what the reasons are behind groups’ solidarity or competition, and how institutions could promote intergroup co-operation to address the intersection of multiple inequalities” (p. 81). Key informants have pointed to several rich sites for an intersectional study of institutional collaborations around health equity—among them, the NIH Center for Minority Health and Health Disparities and DHHS Healthy People 2020. Studies of these U.S. venues would provide valuable insights into cross-constituency collaborations, as well as offer worthwhile comparisons with European intersectionality research on this topic.

In conclusion, health equity discourse represents a bold move to extend the health disparities conversation beyond a biomedical frame to address the social conditions impacting health. No longer solely focused bodies and behaviors of disadvantaged groups, health equity discourse foregrounds childhood education, housing, transportation, and recreational spaces, among others, as key structural sites for intervention. Moreover, this debate has re-committed to eliminating inequalities along multiple forms of disadvantage (e.g., by gender, socioeconomic status, disability) in a debate long dominated by racial and ethnic concerns. With regard to addressing both social determinants and multiple inequalities, the health equity movement has made important strides. However, as this study has illustrated, the discourse remains constrained in its efforts to achieve health justice due to its avoidance of macro systems level change, as well as an inability to attend to the intersectional nature of inequalities. An intersectional framing of health equity would enhance its capacity to address the interconnected levels of social interaction across race, sexuality, gender and other inequalities.

APPENDICES

A: Key Informant Interview Guide

As you know, I am interested in learning about how the idea of health equity is being conceptualized and implemented within different organizations.

1) First, please tell me just a bit about yourself and your role here in your organization?

2) Can you tell me a bit about how your organization became focused on health equity?

3) Can you talk about your main activities to date? Are there activities you'd like to pursue but have not yet and why?

4) How did you decide where to start? Who was involved in those decisions?

5) Can you tell me about who is involved in your health equity activities at your organization (e.g., health equity team, other staff)?

6) I am also curious about community involvement. Can you tell me about that?

7) As you know, I'm interested in understanding how people talk about health equity. What does that concept mean to you? What about social determinants of health? Community participation?

8) How does a health equity frame affect how you do your work here?

9) Could you tell me a story about any time so far when you faced a challenge working on health equity or when you learned something you hadn't anticipated? Can you tell me about any situations that really worked well, where you thought 'this is how it should work'?

10) Can you tell me about any organizations or individuals who have shaped how you think about or pursue health equity here in your organization?

Is there anything else you'd like to share that we haven't discussed yet?

B: Health Equity Report Author Abbreviations

ABBREVATION	**AUTHOR (YEAR)**	**REPORT**
ALAMEDA	Alameda County Health Department (2008)	*Life & Death from Unnatural Causes*
BARHII	Bay Area Regional Health Inequalities Initiative (2008)	*Health Inequities in the Bay Area*
CPEHN	California Pan-Ethnic Health Network (2009)	*Landscape of Opportunity*
King	King County (2008)	*King Co Equity & Social Justice*
HP2020	Department of Health & Human Services (2010)	*Healthy People 2020*
NPA	National Partnership for Action to End Health Disparities (2011)	*National Stakeholder Strategy for Achieving Health Equity*
Multnomah	Multnomah County Health Department (2009)	*Multnomah HE Initiative*
RWJ	Robert Wood Johnson Commission to Build a Healthier America (2009)	*Beyond Healthcare*

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