The Sociological Tradition of Public Health

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Abstract

Public Health is a field that enables health and healthcare dimensions of social structures—which must provide nurturing, equitable and protective support—through public policy education, applied research, and community service. The primary goal of this field is to advance the overall health and wellness of individuals and populations with a critical focus on the needs and disadvantages of vulnerable populations. In order to achieve this goal, studies that analyze and evaluate the issues of these populations must be performed. Without an understanding of the various social, economic and cultural factors that determine an individual’s holistic well-being, healthcare policy will likely fall short of its larger objectives. Issues involving race, gender, and socioeconomic status (SES) have been proven to be accurate predictors of differential levels of disease, disability, and death in society.[1] As a result, it can be argued that sociology, which can be defined as a study of the structural and institutional development of the social behavior of human society, serves as one of the foundations of public health. This paper evaluates this argument by analyzing the critical role social science research has played in the development of the field of public health by examining the unfamiliar contributions of late 19th century premier sociologists, W. E. B. Du Bois and E. Franklin Frazier.

W. E. B. Du Bois, in many ways the founder of Urban Sociology and one of the most important thinkers and activists of the 20th century, observed and documented prevalent and persistent racial inequities in health in his work, The Philadelphia Negro (1899) and The Health and Physique of the Negro American (1906).

The Philadelphia Negro was a pivotal study that documented the dire racial disparities in the Black urban community by utilizing the available census data coupled with a survey of Philadelphia’s Seventh Ward as analytical evidence. In this study, Du Bois not only addressed the numerous social issues such as alcoholism, crime, inadequate and restricted educational and occupational opportunities, housing conditions, family life, and voting rights; but also concluded that many of these problems among Blacks stem from discrimination and White supremacy and oppression. Moreover, Du Bois coined a new methodology for sociological study. Scholars have recognized the importance of his methodology, which “recognized that the
limited access to economic resources and the social marginalization of some racial groups could have dire social, physical, and psychological consequences for them. Studies today continue to document that [many] racial groups...have markedly poor health outcomes compared to the dominant White population.”[2]

The Health and Physique of the Negro American (1906) was Du Bois’s publication of the Eleventh Atlanta University Conference, in which he discussed and provided statistical evidence based on the 1900 census, the critical racial issues and biases in the insurance industry, fertility and mortality, access to health care services, and the supply of medical personnel. Overall, Du Bois concluded:

“The matter of sickness is an indication of social and economic position...We might continue this argument almost indefinitely going to one conclusion, that the Negro death rate and sickness are largely matters of condition and not due to racial traits and tendencies...With the improved sanitary condition, improved education and better economic opportunities, the mortality of the race may and probably will steadily decrease until it becomes normal...”[3]

As a result, the final resolutions made at the end of the conference reaffirmed Du Bois’s position that health is ultimately determined by social factors. It was stated that “the present differences in mortality seem to be sufficiently explained by conditions of life; and physical measurements prove the Negro a normal human being capable of average human accomplishments.” Hence they called for “a systematic study of Negro problems...because the way to make conditions better is to study the conditions.”[4]

Du Bois’s work provided early evidence of the critical and perpetual role that social class plays in preventing the equitable distribution of quality healthcare. There are other related factors that also serve to inhibit individual well-being. These include: racial discrimination in education and employment, residential segregation by race and socioeconomic level, and the subsequent development of internalized stressors that exacerbate already tenuous physical health among the communities affected by the aforementioned external factors.

E. Franklin Frazier, the prominent sociologist whose studies on African American social structure provided notable insight and awareness to the severity of the numerous issues of the Black community during the 20th century, was greatly influenced by W. E. B. Du Bois. “It was on questions of social reality and social policy that Du Bois had the greatest influence on Frazier.”[5] In fact, Frazier dedicated his work, The Negro in the United States to Du Bois, crediting his efforts in the publication of The Philadelphia Negro as “the first attempt to study in a scientific spirit the problems of the Negro in American life.” It can be argued that he furthered Du Bois’s discussion of the sociological impact of race relations in his own treatise, Race and Culture Contacts in the Modern World (1978).

Frazier’s examination of race relations emphasized his belief that “sociological analysis must include economic and political factors relevant to the analysis of a particular system of social relations being studied.”[6] Hence his methodology for analyzing worldwide race relations included the study of demographic, ecological, economic, and political factors. His argument was that the nature of race and culture contacts is partially determined by the ecological distribution of people, their approach to acquiring and maintaining a livelihood, and the allocation of economic power; the cultural traditions of racially and ethnically diverse people which influence their attitudes toward one another; and the current political organization, the dispersal of political power, and the laws regulating the relations of people with diverse racial and cultural
backgrounds which establish the types of group contacts and interpersonal relationships which take place at every point in history. Frazier’s sociological theory affirms the importance and critical role that the elements of social justice and the social determinants of health play in discipline of public health.

Social justice can simply be defined as the idea in which all persons in question are allotted equal social, economic, and political liberties and opportunities. By ameliorating the frequent disadvantages that contribute to unhealthy communities and advocating for equity in healthcare, this will foster a better general understanding of not only underserved populations but in turn, public health.

The principle foundation of social justice in public health is the promotion of equity in healthcare. “Equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups that have different levels of underlying social advantage or disadvantage—that is, different positions in a social hierarchy.”[7] Social determinants of health are the social, economic, and environmental factors of a population that can positively or negatively influence and impact a person’s holistic well being. Social constructs such as socioeconomic conditions (i.e. regionally fixed poverty), societal inequities (regional differences in quality education and transportation options), social class, racism (institutionalized, internalized, personally-mediated), discrimination (gender or sexual orientation), and societal violence (crime, social disorder), are examples of these social determinants. Information about the existence or nonexistence of these factors in a community is essential to predicting the health status of individuals in that community. Under social justice, all persons are equally entitled to essential entities. “The extent to which social justice and equity exist in a society correlates with the distribution of resources within the population. Equality in distribution of wealth within a society improves population health status and reduces health disparities within that society.”[8] Consider the fact that individuals in communities that are financially secure and economically affluent are healthier than those who live in communities that do not economically thrive. This is because those communities benefit from economic prosperity. Due to the affluence of these communities, these communities most likely possess copious and dependable transportation options, in addition to a safer environment that is more emotionally secure and supportive as a result of possessing quality education systems, and nonetheless generally more access to a variety of relatively affordable healthcare. Although the upper class possess more advantages and resources than those communities that are economically challenged, adverse health conditions are not restricted to the latter. The former however, are more inclined to have a greater array of options and opportunities for treating and preventing illnesses, consequently obviating the occurrence of many preventable chronic conditions. The fair allocation of these advantages and resources should be integral to public health policy and practice. Social justice not only comprises of a fundamental pledge to a fair allocation of resources, but also the advocacy for policies that are coherent with the perpetuation of human life and the display of equal consideration and value for the concerns of all individuals of the community. Frazier’s point of view about the theoretical structure of sociology, in addition to Du Bois’s position that health is ultimately determined by social factors and research should include both qualitative and quantitative methods provide evidence for the vital role sociology has played as the foundation in public health.

To provide optimal healthcare for members of disadvantaged social communities, a synchronized approach to remedying the racial and economic challenges is required. Because these factors are
interrelated, one cannot be addressed without consideration of the others. Where an individual lives, attends school and/or works will often determine their access to healthcare as well as the quality of the care they are able to access. Additionally, their attitude toward healthcare and the choices they make about getting it will also be greatly informed by their circumstances. If a person’s living, educational and work environment is unsafe, unstable, underdeveloped and/or chronically deficient as a consequence of external racialized and/or economic actors, the likelihood is that their health will reflect it.

Scholars have noted that, “regardless of individual or household SES [Social/Economic Status], black and white neighborhoods differ dramatically in the availability of jobs, family structure, opportunities for marriage, and exposure to conventional role models.”[9]

Racial and economic inequality frequently feeds existing stereotypes about disadvantaged groups that affects their access to quality healthcare. While genetic/biological factors are important in predicting health challenges, social stereotypes can cripple preventative healthcare policy. The idea, for example, that Black men are more likely to be engaged in some elements of drug culture, or that Black women are more likely to engage in unsound sexual behavior or to languish in public assistance cul-de-sacs reinforce racial and gender discrimination in healthcare policymaking. In this way, variances in healthcare across racial and ethnic populations are in danger of becoming a self-fulfilling prophecy.

As would be expected, individuals in higher income communities are generally healthier than their less fortunate counterparts. These individuals benefit from safer and more stable living environments (and the measure of emotional well-being that secure living arrangements afford), higher quality education, and consistently reliable infrastructure (e.g. transportation, social and cultural development institutions, etc.). The availability of quality healthcare is also a feature of higher status socioeconomic communities.

The deficiencies in each of the aforementioned areas in lower socioeconomic communities, then, speak to the presence of persistently higher rates of diseases such as diabetes, asthma, or heart disease. The absence of access to preventative healthcare in these communities, and the emotional stressors that come from living, schooling and employment inequalities, feeds the likelihood that each of these diseases will become chronic. Living with a constricted set of choices leads to the likelihood that parents cannot purchase healthy food and children will have to deal with unsafe schools. Many physical ailments, from asthma to diabetes, are exacerbated by these two factors alone, as well as attendant factors such as violence and drugs.

Even those with more economic wherewithal are also beset with diseases. However, they can prevent chronic disease as a consequence of the availability of more healthcare options. Communities should not be sentenced to unsound physical and emotional health because healthcare is not affordable or accessible. There are more than adequate economic resources in the United States (and in the larger world) to provide preventative and therapeutic healthcare for all. The challenge is a question of will.

The complex concept of human health encompasses the full range of physical, mental, emotional and spiritual well-being. Historically, work on racial health disparities has primarily focused around racial ideology, beliefs and their impacts on public health thinking and practice. Discrimination impacts health directly and indirectly. It can contribute to negative health outcomes indirectly, by shaping the health-related behavior of oppressed and/or marginalized groups. As delineated by social science research, racist thought has stigmatized marginalized subjects (specifically those of minority and
vulnerable populations) as disease-ridden threats to broader population health by attributing their health problems to inherent racial characteristics, rather than the institutional inequality that produced the unhealthy environments that hosted harmful, detrimental diseases. The critical use of demographic, cultural, etiological, and ethnographic studies accompanied with quantitative and empirical investigation by sociologists such as W.E.B. Du Bois and E. Franklin Frazier, have illustrated that developing and maintaining the health of individuals in a society requires a public policy commitment that extends far beyond disease prevention. The study of racism as a likely cause of health disparities is essential and should be expanded. This should concentrate on a transdisciplinary framework that highlights the under-studied forms of racism in addition to the etiological role of social inequities on racial and ethnic health disparities and their psychological, historical, biological, and behavioral effects. Ultimately providing the most comprehensive approach in the fight against racial/ethnic disparities in health as well as address interactions among the multiple manifestations and dimensions of discrimination and how they shape determinants of health at ecological levels. ***

REFERENCES


11. Ibid pg. 110


