Article

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Diversions: How the Underrepresentation of Research on Advantaged Groups Leaves Explanations for Health Inequalities Incomplete

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Abstract

We identify a gap in health inequalities research that sociologists are particularly well situated to fill—an underrepresentation of research on the role advantaged groups play in creating inequalities. We name the process that creates the imbalance *health-inequality diversions*. We gathered evidence from awarded grants (349), major health-related data sets (7), research articles (324), and Healthy People policy recommendations. We assess whether the inequality-generating actions of advantaged groups are considered either directly by capturing their behaviors or indirectly by asking disadvantaged people about discrimination or exploitation from advantaged groups. We further assess whether there is a tendency to locate the problem in the person or group experiencing health inequalities. We find that diversions are prevalent across all steps of the research process. The diversion concept suggests new lines of sociological research to understand why diversions occur and how gaps in evidence concerning the role of the advantaged might be filled.

Keywords

diversions, fundamental cause, health inequalities, racism, socioeconomic disadvantage

The fact that health inequalities by race and socioeconomic status have persisted despite decades of research and policy aimed at understanding and addressing them raises the possibility that something has been missing in the consideration of them. The candidate component that we consider here are the health-inequality-generating actions of people propitiously situated in racial and socioeconomic hierarchies. We ask, and then empirically examine, whether and to what extent actions of the advantaged have been incorporated at key steps of the health inequalities research process. The answer is of considerable importance because if attention is directed away from advantaged groups, the understanding of the sources of health inequalities are rendered incomplete, policies designed to address health inequalities are at risk of being misdirected, and health inequalities are in danger of being perpetuated.

We name the process of diverting attention away from the actions of the advantaged *health-inequality diversions* with the aim of providing a concept that allows such tendencies to be recognized and addressed. We propose that health-inequality diversions occur when research ignores, underplays, or excuses the actions of more advantaged

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individuals and groups for the part they play in producing health inequalities. Additionally, by excluding a consideration of advantaged groups, diversions achieve a shift in focus to the circumstances of the disadvantaged, leading to the conclusion that what most needs to be fixed is something about them or their circumstances. When diversions are successful, the actions of more privileged groups are protected from scrutiny, thereby preventing advantaged groups from being held accountable for their health-inequality-generating behaviors.

To develop the diversions concept, we begin with an example that helps indicate what is meant by a diversion. We follow with a brief consideration of three theoretical/conceptual foundations that are useful in developing the diversions concept: (1) literature on race and class inequality that emphasizes the importance of directly studying both the advantaged and disadvantaged in understanding the sources of such inequality, (2) fundamental cause theory as a health inequalities theory that directs attention to the actions of the advantaged, and (3) Bourdieu's ideas about the benefit to the advantaged of rendering self-promoting action invisible. We follow our development of the concept with an investigation of key steps in the research process where diversions may occur. Specifically, we draw evidence from National Institutes of Health (NIH) grants, publicly available data sets for secondary analyses, current published research, and national policy prescriptions. We review each of these important steps in the research process to determine whether the actions of the advantaged are addressed or whether attention is diverted away from them. We conclude with theoretical considerations about potential sources and consequences of diversions, ending with what medical sociologists (or others) might do to address diversionary tendencies.

BACKGROUND

An Example of a Diversion

The "Power of Place: A Tale of Two Twelve Year Olds" is taken from the website of the Interdisciplinary Association for Population Health Science (2020). It highlights the importance of social conditions on health fortunes to show how "where we live and how we live can profoundly affect health." In the depiction, Amara, who comes from a poor neighborhood, and Ella, who comes from a rich one, are reported to live only a few miles from one another in New York City (for descriptions of the neighborhoods, see Supplement in the online version of the article). But, as the description states, if current trends continue, Ella can be expected to live 6 years longer than Amara.

The description of Amara's neighborhood is relatively long, with the summary statement indicating that staying healthy there "isn't easy." Houses are abandoned, stray dogs and "escaped chickens" roam the street, and piles of rubble and trash are strewn about. Babies are born preterm to teen mothers, there are no grocery stores, and it is difficult to find safe places to exercise. The assault rate is high, and the homes have mold and roach infestations. Neighbors are more likely to be obese, to have diabetes, and to be hospitalized for alcohol, drugs, strokes, or mental health problems.

The description of Ella's neighborhood is short and positive. People come from all over the world to visit the shops and restaurants in Ella's neighborhood. Babies are born to stable families, schools are excellent, and attendance in them is good. There are abundant supermarkets, safe streets, and plenty of green spaces and gyms, making it easy to stay healthy in Ella's neighborhood.

Reading these descriptions, it is clear where the "problems" are and where action is needed to ameliorate those problems. It is Amara's neighborhood and the social conditions within it. Ella's neighborhood is good, even exceptional, and we are led to think that nothing there is problematic or of importance for thinking about how to address the six-year gap in mortality outcomes that the two young girls would, on average, be expected to experience.

But potentially important circumstances in Ella's neighborhood are completely missing from the description of the situation. To illustrate, consider these possibilities. Ella's grandfather was a World War II veteran who got educational and loan benefits associated with the GI bill—benefits that did not spread to black and brown people. Partly because of these opportunities, he was able to leave an inheritance of money and property to Ella's family. Ella's dad attended an elite college with the benefit of a legacy admission. The family hires tax lawyers who ensure that the family pays as little as possible in income taxes. Ella's family paid a minimum wage salary to a mother of two children from Amara's neighborhood to clean the house and watch Ella so both of Ella's parents could work. Ella's parents got Ella a tutor so that she could get higher scores on admissions tests than other children competing for spots in elite schools. Finally, the family donates substantial sums to the best local hospital and are well connected with the doctors there, ensuring that if they needed it, they would get the best, most attentive medical care possible.

Although it may not be fair to locate all of these inequality-generating activities in one family, Ella's, it is nevertheless highly likely that these circumstances are as common in Ella's neighborhood as abandoned buildings, assaults, hospitalizations for mental illness, and "escaped chickens" are in Amara's. And the things that occur in Ella's neighborhood are important for understanding the massive inequality between the two neighborhoods, and thus the six-year life-expectancy gap the two young girls can be expected to experience. But these problematic features of Ella's neighborhood are not engaged in the tale of two 12-year olds—attention is diverted away from them.

Theoretical and Conceptual Underpinnings

From literature on race and class inequality. Important strands of research in the areas of race and class have focused on the relational nature of advantage and disadvantage, strongly indicating that to understand inequality, research needs to focus on both those who are advantaged by systems and structures as well as those who are disadvantaged by them. In the area of racial inequality, the idea that the actions and advantages of whites are constitutive of black disadvantage has been observed at least since the work of Du Bois ([1899] 1967:163), who famously observed in his book *The Philadelphia Negro* that, "The most difficult social problem of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have…been few other cases in the history of civilized people where human suffering has been viewed with such peculiar indifference." Following on Du Bois in studying the black population of Pennsylvania, Richard R. Wright (1912) challenged the premise of what was then called the "Negro problem" by focusing on white racism as the source of the problems that blacks experienced. As Wright (1912:186) put it: "The 'Negro Problem'—that condition which is peculiar to Negroes, and common to them—is rather found in the attitudes of the white race toward the Negro; an attitude of a majority which seeks to shut out a minority from the enjoyment of the whole social and economic life."

Similarly, Ida B. Wells-Barnett's (1892) *Southern Horrors: Lynch Law in All Its Phases* challenged white media's focus on the criminality of black men and exposed how criminality was used to obscure the real cause of the lynchings, which was whites' fears of black people's economic progress. The need to focus on the actions and advantages of whites has also been strongly represented in sociological studies of race and ethnicity (Doane and Bonilla-Silva 2003; Lipsitz 2006), postcolonial studies (Bhambra 2016; Go 2018), and more recently on whiteness and health (Malat, Mayorga-Gallo, and Williams 2018). Advantages for whites that contribute to the gap between them and blacks and other minority groups emerge in small groups (Ridgeway 2014), are embedded in organizations (Feagin 2006; Ray 2019) and policies (Katznelson 2005), and have been shown to have long-term consequences for inequality (Faber 2020; Sharkey 2014).

The sociological study of socioeconomic inequality also has a long history of conceptualizing the sources of inequality in terms that include not only the circumstances and characteristics of the disadvantaged but also the power and privilege of the advantaged. Marxist thought famously defined exploitation as the expropriation of the fruits of the labor of others, indicating thereby that the economic well-being of one group depends on the deprivation of another (Wright 1997). Similarly, scholars have pointed to actions of the advantaged that achieve the "hoarding of opportunities" for themselves and those in their circle of caring via actions such as zoning laws, legacy admissions to elite schools, and well-paying jobs (Tilly 1999). Hoarded opportunities can then be perpetuated through segregation, discrimination, and exclusion. Finally, Tomaskovic-Devey and Avent-Holt (2019) have developed what they call a "relational inequality theory." The theory strongly focuses on actions that advantaged groups take in relation to others by exploiting them or hoarding opportunities from them (or in their terms, achieving "social closure").

The main point of this brief excursion into sociological reasoning about relational aspects of racial and socioeconomic inequality is to suggest that a complete understanding of inequality requires a focus not just on the disadvantaged but the advantaged as well. Our claim is that this insight needs to be transported to research on health inequalities. Although several theoretical traditions within medical sociology could host such an importation, we turn to fundamental cause theory (FCT) because its concepts are congenial to an emphasis on the advantaged.

From fundamental cause theory. Diversions move attention away from the actions of the advantaged, whereas fundamental cause theory directs attention to them. FCT was developed to understand the persistence of associations between social conditions and health across places and times (Link and Phelan 1995; Phelan et al. 2004). It is based on the observation that even when diseases and associated risk and protective factors change, associations between social conditions and health are reliably reproduced. Something is happening to make this occur, and in FCT, the focus is directed to the actions of people propitiously situated in hierarchical relationships.

The original statement of the theory addressed socioeconomic status and directed attention to "flexible resources" of knowledge, money, power, prestige, and beneficial social connections that could be used individually or collectively to garner a health advantage no matter what the health conditions are in a particular place or time. Because of this, well-situated people reliably acquire better health circumstances for themselves and those in their circle of caring.

The application of FCT to racism and stigma directed attention to different processes in producing a fundamental relationship (Phelan and Link 2015). The idea was that people with power use stigma to achieve desired ends (Link and Phelan 2014; Phelan, Link, and Dovidio 2008). Stigma facilitates the capacity of those who stigmatize to: (1) "keep people down," so they can dominate or exploit other people to their benefit; (2) "keep people in," so that social norms that they value are followed; or (3) "keep people away," so that people they find undesirable can be excluded from social positions and relationships (Phelan et al. 2008). These motives, combined with the power to act on them, lead to the expectation that people who stigmatize will seek new mechanisms to achieve desired ends should an existing mechanism be blocked. Replacement mechanisms are available at the macro level through structural stigma, at the interpersonal level through direct person-to-person discrimination, or in processes that operate through the individual (Link and Phelan 2001). At each level, there are just so many ways to put people down, slight them, exclude them, avoid them, reject them, and discriminate against them, that when motivation and power are in place, stigma processes offer a handy set of possibilities for keeping people down, in, or away.

What is important for the diversions concept in this recap of fundamental cause theory is that it highlights the theory's support for the idea that advantaged groups (and not just disadvantaged ones) are important in producing health inequalities. Whether the focus in FCT turns to socioeconomic, racial, or stigma hierarchies, the theory consistently points to the actions of powerful groups. Diversions move attention away from the actions of the powerful to yield an active denial of what fundamental cause theory asserts.

From Bourdieu's symbolic power and misrecognition concepts. The diversions concept aims to illuminate something that might otherwise be missed or hidden, as in the example of the two girls from New York City neighborhoods. Bourdieu's concepts of symbolic power and misrecognition are useful underpinnings for a concept that seeks to make apparent something that might otherwise be hidden. According to Bourdieu (1987), symbolic power is the capacity to impose a legitimized conception of the social world and the social divisions within it. The power is actualized in taken-for-granted activities that are not recognized to be in the self-interest of those who exercise the symbolic power. Nevertheless, according to Bourdieu, the exercise of such symbolic power reliably reproduces social hierarchies. The relevance of this to the diversions concept is that diversions can be seen as an exercise of symbolic power in their exclusion of the advantaged from the explanation of why health inequalities exist. Health-inequality diversions powerfully influence what people think the problem of health inequalities consists of, who is responsible for the problem, and what needs to be done to address it. Bourdieu's "misrecognition" is critical because, according to his reasoning, the reproduction of inequality is more successfully achieved and more effectively legitimated when it is hidden (Bourdieu 1990). No one questions what is hidden. Diversions allow such misrecognition because the role that powerful groups play as culprits in creating health inequalities are left unaddressed.

DATA AND METHOD

Research Strategy

Having introduced the concept of health-inequality diversions, we now ask whether evidence aligns with it. The key facts at issue are whether and to what extent actions of advantaged people are represented at key steps in the research process. Grants are the first step because they can be conceptualized as the process that generates data, large secondary data sets are next because they were created by grants (or government investment) and are what are available to scholars seeking to write articles about health inequalities, the literature is next because it results from the data available, and policy comes last because it would respond (hopefully) to the narrative provided by the literature. The diversions concept will be more strongly supported if evidence at each step of the research process steps reveals an underrepresentation of studies focused on advantaged groups.

We used a systematic method to gather and analyze data concerning the research development process starting with NIH R01 grants for the five-year period 2015 to 2019, followed by seven major health-related data sets that were publicly available for secondary data analysis, and on to empirical research published in three major outlets addressing health inequalities—the *American Journal of Public Health* (*AJPH*), the *Journal of Health and Social Behavior* (*JHSB*), and *Social Science and Medicine-Population Health* (*SSM-PH*). We ended our empirical inquiry by examining national policy recommendations as represented by the Healthy People 2000, 2010, 2020, and now 2030 series and by reports of progress toward these goals published in *Morbidity and Mortality Weekly Reports* (*MMWR*; Penman-Aguilar, Bouye, and Liburd 2014, 2016).

Three categories of evidence at each stage of the research-generating process were critical to our review: (1) whether the direct inequality-generating actions of advantaged groups were represented, (2) whether indirect reports of the actions of advantaged groups that are described by disadvantaged groups were considered, and (3) whether instead of a focus on advantaged groups, attention located the problem in disadvantaged groups. Evidence consistent with the diversions concept would show relatively little attention focused on advantaged groups and relatively more attention directed at the characteristics and conditions experienced by the disadvantaged. Our approach to gathering and analyzing this evidence is provided as we proceed through each step. But first, we began by identifying the kinds of research investigations that might fit each one of these three categories.

How Common Are Studies That Focus on Actions of the Advantaged?

With respect to socioeconomic status, FCT proposes that people with power can push to secure beneficial circumstances with respect to a wide range of social determinants of health extending from educational advancement, occupational conditions, neighborhood circumstances, wealth accumulation, environmental exposures, health care circumstances, and many others. Our question, then, was whether we would find studies of advantaged people joining in interest groups to keep noise, toxic environmental exposures, and crime away from their houses and places of work. Or would we find studies of well-resourced people using flexible resources to allow their families privileged access to beneficial health circumstances that others with fewer resources cannot enjoy? In its extension to racism and stigma, FCT draws attention to self-beneficial actions of advantaged groups in dominating, exploiting, controlling, or excluding others. Were there studies of how the social determinants of health are shaped by maintaining race and class residential and school segregation through zoning laws, locked communities, or just plain old harassment and discrimination? Did health studies examine the perpetration of dismissive, disrespecting, or disparaging actions of race- and class-advantaged individuals toward those they perceive to be below them? Our question was whether we found studies that, like these examples, focus directly on the actions of more advantaged groups.

How Common Are Studies of Disadvantaged Groups' Reported Exposures to the Noxious Actions of Advantaged Groups?

An indirect approach to gathering evidence about the inequality-generating role of the advantaged is to ask disadvantaged people about experiences of being harassed, dismissed, exploited, looked down on, and discriminated against. With respect to racial-ethnic background, a growing body of evidence (Priest et al. 2019; Williams 2018; Williams and Sternthal 2010) has brought a relatively robust set of measures forward, including but not limited to measures of major lifetime discrimination (Williams et al. 2008), everyday discrimination (Williams et al. 1997), workplace discrimination (Sternthal, Slopen, and Williams 2011), microaggressions (Sue 2010), vigilance (Hicken, Lee, and Hing 2018), rejection sensitivity (Mendoza-Denton et al. 2002), and efforts to cope or resist through racial socialization (Hughes et al. 2006) or racial-ethnic pride (Phinney 1992). Then in addition to these individually based measures, concepts regarding racially toxic environments as in, for example, Krieger's (2014) ecosocial theory, Ray's (2019) theory of racialized organizations, or Hatzenbuehler and Link's (2014) "structural stigma" could be captured to indicate how advantaged groups construct contexts that advantage them and disadvantage others. How commonly and comprehensively have these domains been considered in health-related research? And in keeping with the goal of learning about the inequality-generating behavior of more advantaged groups, how common were efforts to identify the social position of the perpetrator (doctor, lawyer, judge, police, professor), context in which the behavior was experienced (hospital, court, street, traffic stop, university), and the racial-ethnic status of the perpetrator (white, black, Asian, Latinx, or other group)? A consistent focus on the source of prejudice and discrimination could direct attention to those sources so that efforts to reduce discrimination might be developed.

Despite an expansive literature (Phelan, Link, and Tehranifar 2010) on socioeconomic status and health, there are not, to our knowledge, an established set of measures for class discrimination that parallel those for race-ethnicity. Still, we searched for health research focused on exploitation, discrimination, condescension, disdain, or disrespect. For example, did we find research on worker exploitation around overtime pay or irregular hours or studies that focus on embarrassment or humiliation when applying for food stamps or food-pantry items or on being unemployed, being evicted, or residing in a less desirable part of town? Again, as with studies of racial-ethnic discrimination, we assessed whether the sources of the exploitation or humiliation were considered in the research.

How Common Are Studies of the Characteristics and Conditions of the Disadvantaged: Health Behaviors, Traits, Biomarkers, and Genes?

Research on health inequalities can also focus on racial-ethnic and socioeconomic status differences in health behaviors (smoking, diet, exercise, preventive health care), traits (cognitive ability, conscientiousness, health literacy, self-efficacy), biomarkers (inflammation, A1C, hypertension), or genetic and epigenetic factors (telomeres, methylation, polygenic scores). We were interested in the relative frequency with which these factors are represented in the grants, secondary data sets, published literature, and policy prescriptions we examined.

RESULTS

National Institutes of Health R01 Research Grants 2015 to 2019

We chose R01 NIH grants because these represent large government investments seeking to understand and address health inequalities by race-ethnicity and socioeconomic status. We used NIH RePORTER (NIH 2020), an online reporting system that allows a search of all grants funded by the NIH. We searched the five-year period 2015 to 2019 for R01 grants (new or competing renewal) that included in their title, abstract, or project terms any one of the exact phrases “health disparities,” “health inequalities,” or “health inequities.” RePORTER identified 349 grants fitting these criteria during this period. We then used RePORTER to determine what other topics were highlighted in these health-inequalities grants by searching other terms, like “racism,” “adherence,” “health behavior,” or “biomarker.” Additionally, because the titles, abstracts, and public health relevance statements of each proposal are available, we reviewed this information to provide evidence about other more specific issues.

Studies of the direct inequality-generating behavior of the advantaged. To determine whether any of the grants examined behaviors of powerful or advantaged people in generating health inequalities, we examined each title, abstract, and public health relevance statement of each of the 349 grants. We looked for studies focused directly on the actions of people advantaged by their racial-ethnic or socioeconomic status to determine whether any aspect of their behavior was considered a possible contributor to health inequalities. We found none.

Studies of reports from disadvantaged groups. Remarkably, only 31 of 349 (8.9%) health-disparities-related grants also referred to “discrimination,” 23 (6.6%) to “stigma,” 5 (1.4%) to “segregation,” 5 (1.4%) to “incarceration,” 4 (1.1%) to “implicit bias,” 2 (.6%) to “structural racism,” 1 (.3%) to “prejudice,” 1 (.3%) to “exploitation,” and 0 to “microaggression,” “institutional racism,” “white racism,” “physician bias,” “police violence,” and “stop and frisk.” We also searched for the union of these terms and found that in this pool of disparities grants, only 64 (18.3%) mentioned any one of these terms.

We further reviewed whether the 31 grants that mentioned discrimination in the abstract or project narrative had aims or goals focused on discrimination. In 11 of the 31 reviewed, discrimination was not a study aim, suggesting that grants with a strong focus on discrimination are even more rare than our simple count of them indicated. In 17 of 31, the focus was on black/white inequalities, 3 on Latinx populations, and 8 on people stigmatized by HIV or sexual orientation. None of the studies addressed discrimination based on socioeconomic status.

Concepts and conditions that locate the problem in the disadvantaged group. Based on available search terms, we considered two general types of emphases: (1) health behaviors and (2) biomarkers/genetic/epigenetic factors. Indicators of health behaviors or related conditions were smoking, exercise, diet, sedentary lifestyle, obesity, alcohol, substance use, drug use, adherence, compliance, health behavior(s), coping, resilience, and health literacy. At least one of these terms was mentioned in 201 (57.6%) of the grants. Indicators of biomarkers/genetic/epigenetic factors were epigenetic(s), telomere(s), methylation, gene(s), genetic(s), inflammation, and biomarker(s). At least one of these terms was mentioned in 97 (27.8%) of the grants. When we consider indicators of both health behaviors and biomarkers/genetics/epigenetics, we found that 247 (70.8%) of the grants purporting to address health disparities emphasize at least one of the indicators in these two domains.

In sum, our scan of NIH-funded R01 grants found none that directly address the health-inequality-generating behaviors of advantaged groups. When we turned to the experience of disadvantaged groups, we found that far fewer (18.3%) emphasized exposure to systems of disadvantage, such as institutional racism or to unfair, disrespectful, or discriminatory behavior from others, than emphasized health behaviors or biomarkers/genetics/epigenetics (70.8%). If evidence and understanding follows what is selected for study in the grant application process, the complete lack of attention to inequality-generating behaviors of advantaged groups and the underrepresentation—compared to health behaviors and biological factors—of systemic and interpersonal racism is of concern.

Major Health Data Sets Publicly Available for Secondary Analysis

We selected large nationally representative studies that focus on health and make the collected data publicly available. We further restricted attention to either longitudinal studies with multiple waves of data collection or studies that involve multiple cross-sectional assessments. For each study, we examined the survey instruments and protocols from websites describing the studies to determine what domains were covered. The longitudinal data sets we examined were: (1) the National Longitudinal Study of Adolescent to Adult Health (Add Health), (2) the Midlife in the United States Study (MIDUS), (3) the American Changing Lives Survey (ACLS), and (4) the Health and Retirement Survey (HRS). The multiple cross-sectional studies examined were: (1) the National Health Interview Survey (NHIS), (2) the National Health and Nutrition Examination Survey (NHANES), and (3) the Behavioral Risk Factor Surveillance System (BRFSS).

Actions of the advantaged. None of the studies had a themed focus on the health-inequality-generating actions of advantaged people. There were, for example, no questions about gated communities or people using social connections to get better care for a loved one, no behavior or behavioral intentions about wanting to keep minorities or poor people out of neighborhoods and schools, and no measures of implicit biases toward poor people or racial-ethnic minorities.

Reports from disadvantaged people that reflect on the behavior of advantaged people. None of the seven major studies that we reviewed included a measure of racial-ethnic discrimination as a core set of questions (see Table S1 in the online version of the article). Neither did any of the studies include a measure of microaggressions, ethnic pride, racial socialization, or implicit bias. The government-sponsored repeated cross-sectional studies (BRFSS, NHIS, and NHANES) were particularly sparse in their coverage of discrimination. The range in their minimal coverage was from none (NHANES) to the BRFSS that has included four questions on discrimination and its perceived health consequences in 8 of the last 20 years, but never in more than three states in a given year. The NHIS lies in between. It has no core questions about discrimination but allows sponsored supplements, which over the past 20 years included 1 (“cultural competence”) out of 169 (.6%) that included a single question about whether a participant was treated with respect by his or her health care provider.

The longitudinal studies that we reviewed included somewhat more content about discrimination, although the consistency and extent of coverage varied substantially. MIDUS was the most extensive because it included full versions of Williams et al.’s (1997) everyday and lifetime discrimination measures in all waves of the study in a self-administered questionnaire that between 80% and 89% (depending on wave) of core participants completed. Two other studies, the ACL and the HRS, included shortened versions of everyday and lifetime discrimination measures, with ACL incorporating them in Wave 4 (2001), 15 years after the study began, and HRS in Wave 10 (2006), 14 years after the study’s inception. Each of these studies further truncated the discrimination measures in subsequent waves, with the ACL shortening its measures and HRS dropping its assessment of lifetime discrimination in 2014. Add Health incorporated a single item from Williams et al.'s (1997) everyday discrimination measure in Wave 4 (2008), 14 years after the study began, and then added four more items from the scale in Wave 5.

None of the studies included measures that specifically addressed exploitation or demeaning or disrespectful behavior that people of lower socioeconomic status might experience in contact with people of higher socioeconomic status. Only one of the studies that included Williams et al.' (1997) discrimination measures asked whether the discrimination could have occurred because of socioeconomic reasons (Add Health "financial situation"). Others have noticed this nearly complete lack of emphasis on socioeconomic discrimination in the context of research demonstrating that bias is substantial at both implicit and explicit levels (Kuppens et al. 2018; Phelan et al. 2019).

Concepts and conditions that locate the problem in the disadvantaged group. Compared to the amount of attention devoted to racial-ethnic or socioeconomic discrimination, attention paid to health behaviors, traits, biomarkers, and genes is extensive across the studies reviewed (see Table S1 in the online version of the article and the websites of the studies). Studies include health behaviors like smoking, drinking, exercise, sleep quality, and diet and in some instances extensive assessments of multiple personality traits, future orientation, sense of control, and cognitive skills. NHANES has always included a focus on biomarkers, and extensive effort and considerable cost has been mounted to include biomarkers and genetic assessments in Add Health, MIDUS, and HRS. The diversity of individual attributes that can be ascertained from these studies ranges from polygenic scores for extraversion (MIDUS) to ear piercing (Add health) or owning a recreational vehicle (HRS). However, the breadth and intensity with which individual behaviors, traits, biomarkers, and genes are pursued is not the problem. Instead, we argue that the comparative inattention that has been directed toward the inequality-generating behavior of advantaged people or the perpetration of acts of discrimination toward disadvantaged people is problematic.

Empirical Research on Health Inequalities Research Published in Three Major Journals, 2014 to 2019

We chose *AJPH*, *JHSB*, and *SSM-PH* because of their strong emphasis on health inequalities. We used a systematic literature review methodology to identify U.S.-focused empirical articles published from January 1, 2014, to June 30, 2019, that mentioned the terms "health disparities," "health inequalities," or "health inequities." Our search yielded 549 articles. After removing articles that did not meet our inclusion criteria, we were left with 324 articles. A team of 6 graduate and 14 undergraduate students read and coded articles using a coding tool composed primarily of close-ended questions about many issues, including the ones reported here. All students were trained, and all members of the research team engaged in coding sample articles together. The entire group met biweekly for more than six months to discuss coding experiences, challenges, and interrater reliability.

We learned early on that the student coders were adept at coding some aspects of what we were interested in, such as whether specific terms like "racism," "exploitation," or "domination" were mentioned or whether measurement included an assessment of discrimination. In these instances, we report the rater reliability as the intraclass correlation (ICC; agreement) of the student coders (SC) following facts generated from their coding. Other judgments generated less agreement between the student coders. In these instances, we used the student coders to identify articles requiring further investigation and coding by the authors. We defined such articles as ones in which there was not complete agreement among the student coders. We tested the interrater agreement between the two authors (BGL and SJG) for these codes. We report our interrater agreement for each fact ascertained using this method as an author-coded (AC) κ.

Direct assessment of advantaged groups. Of the 324 articles reviewed, 7 (2.2%, AC $\kappa = .70$) focused directly on the role that advantaged groups play in generating health inequalities. Of the seven, five were in *JHSB*, one in *AJPH*, and one in *SSM-PH*. They were roughly evenly split between qualitative (four) and quantitative (three) studies. One of the seven received funding from the NIH. Five of the seven were solo-authored, and all were produced by relatively junior scholars who were graduate students (four) or assistant professors (three) when the study was conducted. Collectively, they not only provide excellent examples of ways in which sociologists can study the health-inequality-generating behaviors of advantaged groups, they further underscore the importance of doing so. They include a qualitative study of differential decision-making processes of obstetricians in deciding whether to provide an abortion (Kimport, Weitz, and Freedman 2016) and an audit study of callbacks from psychotherapists to potential clients who varied by race and class (Kugelmass 2016). Two studies examined what was called "care captaining" (Gengler 2014) or "vigilant advocacy" (Gage-Bouchard 2017) to reveal how higher socioeconomic status parents sought the best health circumstances for their children. In the remaining three studies, Rodriguez (2019) examined how political regimes and associated ideologies impacted inequalities in infant mortality, Olsen (2019) revealed a pattern in which medical educators shifted the stressful responsibility of talking and teaching about race to minority students, and Feldman et al. (2019) focused on the dramatically unequal epidemiology of police killings by race and neighborhood. However, what is most striking to us is how rare such studies are—the vast majority of studies were not directly focused on what advantaged individuals or groups do to create health inequalities.

We also examined how commonly concepts were used that locate the source of health inequalities in the actions of advantaged people. We found that racism was mentioned in 10.8% (35 of 324, SC ICC = .90), institutionalized racism in 2.8% (9 of 324, SC ICC = .85), and specifically white racism or white supremacy not at all (0 of 324). Colonialism was mentioned in .6% (2 of 324, SC ICC = .66), domination in .9% (3 of 328, SC ICC = .80), and exploitation in .3% (1 of 324—students identified two different possible articles and authors' consensus identified one).

Reports from disadvantaged groups. Of the articles reviewed, 4.9% (16 of 324, SC ICC = .70) included a measure of interpersonal discrimination. Measures used in the 16 studies ranged from a single question to comprehensive multidomain assessments (Kwate and Goodman 2015). All 16 incorporated racial-ethnic discrimination as a potential reason for discrimination, whereas a few also included other reasons such as gender, age, and sexual orientation. Only 2 of the 16 included an assessment of discrimination based on socioeconomic status. We were also interested in whether articles identified the source of the discrimination so that efforts to reduce discrimination might be directed to those sources. We found just four papers. Two from the same study considered the actions of the police (McFarland, Taylor, and McFarland 2018; McFarland, Taylor, McFarland, and Friedman 2018), another focused on "doctors and hospitals" (Nguyen et al. 2018), and the fourth involved the behavior of psychotherapists (Kugelmass 2016).

Characteristics and conditions of the disadvantaged group. We also separately coded whether articles included assessments of traits (AC kappa = .78), health behaviors (AC kappa = .60), attitudes (AC kappa = 1.00), genes (AC kappa = .65), biomarkers (AC kappa = .91), or neighborhood/contextual conditions (AC kappa = 1.00) of disadvantaged people. Health behaviors were most common, being included in 144 of 324 (44.4%), followed by neighborhood/contextual conditions, 88 of 324 (26.9%); biomarkers, 40 of 324 (12.4%); attitudes, 32 of 324 (9.8%); and genetic factors, 6 of 324 (1.9%). An assessment of the union of these characteristics and conditions shows that at least one of them was present in 202 of 324 (62.3%) of the articles. What is striking about these figures, however, is not so much their absolute magnitude in isolation but rather how much more common they are than studies that focus on advantaged groups (2.2%) or on discrimination experiences by race-ethnicity (4.9%) or socioeconomic status (.6%).

Policy Initiatives

Every 10 years since 1990, the U.S. Office of Disease Prevention and Health Promotion has produced a set of health goals for the coming decade. The most recent rendition, Healthy People 2030, aims to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all" (Healthy People 2020), making it the fourth such document to set a goal designed to reduce or eliminate health inequalities. The emphasis in these decennial documents is focused on the creation of healthy lifestyles in the American people and the call for action to reduce health disparities with emphases on changing such behaviors (Dorsey, Petersen, and Schottenfeld 2016). Specifically, the plan calls for local programs to address chronic illnesses through strategies such as "establishing smoke- and tobacco-free policies, increasing the availability of healthy food and beverage options for children and families, home visiting programs, and influenza vaccination campaigns" (Dorsey et al. 2016:2). The Centers for Disease Control (CDC) periodically highlights efforts that coincide with this call to action. An examination of the two latest editions of *MMWR* that have spotlighted successful programs indicates that they overwhelmingly focus on health behaviors of disadvantaged groups (Penman-Aguilar et al. 2014, 2016). A page of the CDC (2016) website concerning these efforts provides an infographic to depict the plan of action that shows, like many similar infographics regarding health equity, two men reaching for an apple that is identified as "best health possible." One man is much smaller than the other and would not be able reach the apple under ordinary circumstances. Health equity is achieved, however, by boxes or "programs" that boost the small-statured man up so that he is able to reach the apple of good health. The boxes or programs target health behaviors in stigmatized, minority, or poor populations, thereby efficiently capturing the plan to address health disparities and achieve health equity (see Figure S1 in the online version of the article).

In addition to underscoring our claim that the standard approach to addressing health inequalities involves a focus on characteristics of the disadvantaged, the infographic also captures a diversion. The shorter man cannot reach the apple of good health because of a characteristic he possesses—his stature—he is too short. Moreover, what is needed to allow him to measure up are programs that address his health behaviors. But most importantly from a diversions point of view, the infographic depicts the taller man's advantage as natural—he is bigger—nothing about his behavior is influencing his capacity to reach the apple of good health. He is, for example, not depicted to be the same height as his counterpart but in possession of a box that lifts him up—a box he is unwilling to give up or share.

DISCUSSION

We set out to introduce the concept of health-inequality diversions. We defined health-inequality diversions as a shifting away of the focus from the actions and behaviors of individuals and groups propitiously situated with respect to racial and socioeconomic hierarchies to the characteristics of individuals and groups who are disadvantaged in these ways. Although studies of disadvantaged groups are critically important for revealing the health consequences of exposure to inequality, diversions occur when there is no concomitant scrutiny of the activities of advantaged groups and the part that they play in producing health inequalities. All too often when diversions occur, the source of the health inequality and what needs to be done about it is located in the traits, behaviors, communities, biomarkers, genes, or other characteristics of disadvantaged groups. Advantaged groups are left unexamined, and any role they might play in generating health inequalities is obscured.

We examined four critical steps in the research process: funding of NIH R01 grants, availability of high-quality secondary data, published literature, and Healthy People policy pronouncements regarding health inequalities. First, with respect to a direct focus on the inequality-generating actions of more advantaged individuals and groups, we found that if such a focus existed at all, it was extremely rare across all steps. Although the published literature provided important examples as to what a direct focus on the advantaged might yield, their frequency (2.2%) was remarkably small. Second, we examined research concerning indirect indicators of the behavior of advantaged groups by examining whether steps in the research process included self-reports of the recipients of discriminatory behavior. Even this indirect emphasis was relatively rare for racial-ethnic discrimination and almost entirely absent for socioeconomic status discrimination.

Additionally, the research generally focuses on the consequences of discrimination as it is expressed in the bodies or brains of those affected but not on the who, what, when, where, how, and why associated with the occurrence of the discrimination itself. Someone perpetrated the discrimination, but without investigating its source and context, attention is diverted from the perpetrators. Third, we found evidence at each step of the research process indicating a strong tendency to focus on the traits, behaviors, genes, biomarkers, neighborhoods, or other characteristics or contexts of disadvantaged groups.

Limitations

We selected NIH R01 grants for recent years and not all grants from all sources for all years. We examined major publicly available longitudinal and multiple cross-sectional data sets that are broadly used as secondary data sources but not all data sets that could be relevant to health inequalities. We selected three prominent journals where researchers interested in health inequalities publish their research and not all published research on the topic. Finally, we selected for scrutiny the Healthy People policy recommendations and not all policy recommendations. Our results need to be interpreted in terms of these decisions and any limitations in generalization they might entail. At the same time, our selections were strategic in their identification of *major sources* of knowledge about health inequalities. Even if the facts presented only applied to the sources from which we derived them, they would still matter greatly.

We presented facts consistent with the diversions concept, but we have not investigated or revealed the processes that may have created those facts. Given this limitation, we specify our contribution as having provided a conceptual lens that draws attention to these facts and further provides a rationale for studies that might seek to explain them.

Toward a Theory of Diversions

Having provided a concept and numerous facts consistent with that concept, we now propose some components of a theory of health-inequality diversions by specifying some potential sources and consequences of diversions. Our goal is to explain why such diversions exist, and consequently, we consider both general societal factors that might push for diversions as well as specific conditions that might impinge on health researchers.

Discomfort. An intense focus on the inequality-generating behavior of advantaged groups could be discomfiting to people who benefit from their advantage. If explanations that focus on the advantaged are discomfiting, we would expect such explanations to either never be conceived or, if they are put forward, defensively resisted. In either case, the discomfort would push toward a diversion.

Indifference. Recall that *indifference* is the word that Du Bois ([1899] 1967) used to identify the attitude of the nation toward the health inequalities experienced by black people in the latter part of the nineteenth century. Following on his suggestion, we consider two types of indifference. The first is a relatively direct, even if unspoken, type of indifference in which racial-ethnic minorities and people of lower socioeconomic status simply do not matter that much and are viewed as disposable. A second type emerges when advantaged groups use their power to pursue what most concerns or interests them. Although this could apply broadly to all manner of policy issues, it might apply as well when people decide what to write grants about, what issues to include prominently in large health-related surveys, and what questions to take up in research articles. The decisions made could focus attention on important issues but could also end up, collectively, lacking a focus on key determinants of health inequalities by socioeconomic status and race.

Protecting extant privileges. If attention is focused on the actions of advantaged groups, it exposes the approaches they use to gain a health advantage to scrutiny and thus to potential challenge. If, for example, in the health care sector, advantaged people pay more, demand more, use the social connections of their high-status social networks more, or promise more in future charitable donations, they may enable themselves to obtain more attentive and more comfortable hospital stays. If research exposes circumstances like these, they might be challenged as unfair or unethical, thereby jeopardizing the ability to comfortably maintain and enjoy such privileges.

Anticipation of resistance. If explanations that focus on advantaged groups cause discomfort for members of those groups, call out a self-centered indifference, or challenge self-interests, others, particularly powerful others, may strongly resist such explanations. If so, any individual researcher must consider how their research or research proposal will be viewed by those who might evaluate it, review it, fund it, or convey its value to others. For example, concerned with the potential response, an investigator might choose to steer away from proposals that directly challenge the racist behavior of white people or direct attention to unfair privileges that higher socioeconomic status people extract from the health system.

System-generated constraints. The canon of existing research influences what people "know" about a topic. It poses issues raised in prior research, provides "established" measures of key constructs, and suggests approaches to addressing new, as yet unresolved questions. In keeping with this idea, we argue that central questions posed for health-inequality researchers by the extant canon are some rendition of the following: "We know there are racial and socioeconomic status health inequalities, but what are the pathways through which these emerge?" and "How does inequality get under the skin?" We do not dispute that these are fascinating and important scientific questions that should continue to be pursued. But if we imagine fully answering these questions, it strikes us as highly unlikely that the knowledge created would make the inequalities go away. Answers to these questions are better framed as an indication of "how inequalities are manifest in the body" rather than "what causes the health inequalities to emerge." The latter question is, in our view, the central question that needs to be answered to effectively understand and address health inequalities. But as our review of major public access data sets revealed, enormous research funds have been invested in assessing traits, behaviors, biomarkers, and genetic material while very few resources are deployed to directly or indirectly study the inequality-generating behavior of more powerful groups.

Consequences. Having posed some possible sources of diversions, a more complete theory might include propositions about potential consequences. First, we expect the canon of extant research to affect what people think should be done about health inequalities. Consistent with this expectation, our exploration of policy recommendations identified a distinct focus on characteristics, behaviors, and circumstances of disadvantaged people with the way forward identified as programs to improve these circumstances. Second, we expect that the canon of research will influence the explanation people construct about why health inequalities exist, directing such an explanation to traits, behaviors, genes, and social conditions experienced by disadvantaged people and away from the inequality-generating behavior of advantaged people. From a social-scientific point of view, the consequence is an incomplete scientific explanation. Third, although there are many reasons why health inequalities have been so persistently with us, we expect that diverting attention from a potential source could be a contributing cause of that persistence.

What Can Be Done

Although pursuing and testing a theory of diversions will boost understanding, further testing may not be necessary for action. If the facts we have presented are accepted, an inclination to change them might be deemed desirable even if a fully tested explanation for why those facts emerged has not been fully developed. Instead of, or better, in our view, in addition to a theory of diversions, we need to incorporate theory, concepts, and measures into research focused on the role of advantaged actors in the production of health inequalities. Medical sociologists are well poised to contribute by more thoroughly incorporating relevant theory, concepts, and measures from the broader discipline of sociology by using our methodological diversity and by bringing strong traditions within medical sociology to bear in focusing on the role of advantaged people.

The broader discipline of sociology includes important concepts and theory that could be useful in developing theory and measures about the role advantaged people play in health inequalities. For example, Feagin's concepts of systemic racism (2006) and the white racial frame (2013) point directly to the current and past actions white people have taken to maintain their privileged place in the racial hierarchy. Add the social determinants of health concept, and everything that is included in the system of systemic racism—jobs, housing, education, the justice system—pushes for better health for whites (Malat et al. 2018; Phelan and Link 2015). Similarly, in articulating the concept of color-blind racism, Bonilla-Silva (2017) points to strategies white people use to deny racism and push away calls for equity. The enactment of these strategies buffers white people but is a persistent and powerful stressor in the lives of people of color (Bonilla-Silva 2019). Add the stress process, and, other things equal, stress-related physical and mental health consequences can be predicted to ensue.

Similarly, in the area of class analysis, Wright's (1997) concepts and theories bring forward the relational nature of class categories and the exploitation and domination that might be involved in those relations. Additionally, the concepts of "opportunity hoarding" (Tilly 1999) and "social closure" (Tomaskovic-Devey and Avent-Holt 2019) could be useful. For example, Murphy (1988:88) defines social closure as a "process of subordination whereby one group monopolizes advantages by closing off opportunities to another group of outsiders beneath it which it defines as inferior and ineligible." Finally, Lareau (2011) points to the "concerted cultivation" that higher class parents use to advance their children and the importance of cultural knowledge, knowing the "rules of the game," that young adults from higher socioceconomic status circumstances bring to dealing with bureaucracies. Again, either with respect to positioning in terms of the social determinants of health or with respect to the stress of being exploited, excluded, or looked down on, we would expect health inequalities to emerge. Of course, there are many other examples, and particularly with respect to racism, some valuable theoretical/conceptual models have been developed to inform research on health inequalities that could be drawn on in refocusing efforts toward the actions of advantaged groups (Ford and Airhihenbuwa 2010; Gee and Ford 2011; Hicken et al. 2018; Krieger 2014).

Bringing the advantaged into explanations for health inequalities will open a large, relatively uncharted domain of inquiry for medical sociologists to pursue. An additional strength that sociologists bring is our methodological diversity. For example, we were impressed by how effectively the qualitative researchers Gage-Bouchard (2017) and Gengler (2014) not only revealed what higher socioeconomic status people did to push for the best medical treatment for their sick children but also observed how these efforts were responded to in the medical context. Experimental approaches could also be used to study the behavior of relatively advantaged groups, whether in the field, like Kugelmass's (2016) study of race and class bias in callbacks regarding a potential psychotherapeutic relationship, or lab-based experiments in which race- and class-related interactions might be randomized and stress responses examined.

In the area of survey research, there is an enormous need for not only expanded use of existing measures but also for the development of new measures regarding issues where few, if any, exist. In our review of grants, data sets, published research, and policy recommendations, we found little direct measurement attention focused on what advantaged people do to keep their relative advantage intact. When we turned to indirect measures of the behavior of advantaged groups as reported by the people who experience them, we found little concerning bias, disrespecting, demeaning, discrimination, or exploiting associated with class or socioeconomic status.

Regarding racism, a much more robust compendium of measures is available in the broader social science literature that has not been thoroughly brought to bear in studies of health inequalities. As we discovered, even the most widely used of these measures, the major and daily discrimination scales (Williams et al. 1997), were only sporadically included in the major, publicly available, repeated cross-sectional or longitudinal health studies. A more complete assessment with measures of racial-ethnic pride, racial socialization, microaggressions, implicit bias, or vicarious experiences does not exist in these major ongoing studies.

Beyond coverage in major surveys, a strong response to our claim that advantaged people are removed from consideration would involve building on to existing measures by including questions about the source and context of the discriminatory behavior. This would be important for measures in both the domains of racism and class discrimination. Specifically, we suggest development of assessments that capture who was involved by position, race-ethnicity, age, and gender; what happened; why it happened; when it took place; where it occured; and how it affected the recipient's life circumstances and the way they felt. This kind of assessment would help bring the perpetrators into view so that we see that reports of discrimination are about someone doing something to someone else rather than being an "exposure" that is traced through for any potential behavioral or biological consequences. Additionally, attention could usefully be directed to the contextual level to examine the creation and consequences of racially toxic environments (Krieger 2014), racialized organizations (Ray 2019), and structural stigma (Hatzenbuehler and Link 2014).

CONCLUSION

The concept of diversions draws attention to the possibility of a distinct shifting away of explanatory focus from the health-inequality-generating actions of advantaged groups to the traits, behaviors, communities, biomarkers, genes, or other characteristics of disadvantaged groups. In doing so, diversions contribute to an inadequate scientific explanation of the origins of health inequalities that misguides policy formation and provides a false narrative to those who experience health inequalities about why they do so. In turning attention away from advantaged groups, diversions protect such groups from scrutiny and contribute to the perpetuation of their health-inequality-generating actions. By conceptualizing diversions and providing some evidence of their continued existence, we hope to encourage a focus shift in health-inequalities research that does a more complete job of identifying the sources of health inequalities. As we have argued, medical sociologists are well situated to enact such a shift and to fill the large gap in evidence that currently exists. Our hope is that such a refocusing will be successful and that in the culmination of that success, our diversions concept will be rendered an anachronism. We will see what happens.

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SUPPLEMENTAL MATERIAL

The Supplement, Table S1, and Figure S1 are available in the online version of the article.

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