

In This Issue

- 2** Why Sociologists Are Good for Our Health
Christine Bachrach
- 4** Structural Racism and Inequalities in Health
Taylor W. Hargrove
- 6** “All in This Together?”: Inequalities and Hesitancy Surrounding the COVID-19 Vaccine
Jennifer A. Reich
- 8** How the Vaccine Rollout Reveals Another Failure of U.S. Public Health Infrastructure and Implications for Marginalized Populations
Tiffany D. Joseph
- 9** The Rise of U.S. States and the Fall of U.S. Health
Jennifer Karas Montez
- 10** Understanding the Pandemic’s Impact on Black Americans’ Health from a Life Course Perspective
Latrica E. Best
- 12** COVID-19 and Sociology’s Mental Health Moment
Bernice A. Pescosolido and Byungkyu Lee
- 14** ASA News
- 19** Announcements

What If We Thought of Societies as Patients?

In this issue on health and health care, sociologists discuss how a careful consideration of relationships among individuals, medical and political systems, and social environments can create healthier societies.

Margaret Weigers Vitullo, Deputy Director, American Sociological Association

The baby was born healthy. The woman who had a stroke had a long history of high blood pressure. The man suffered from depression. Statements like these reflect the fact that in the U.S., health is generally thought of as an individual characteristic. Likewise, medicine and medical treatment are usually framed in individual terms. The field of public health is the domain that generally studies population-level health, considering the factors that impact communities and societies. Interventions in public health usually occur at the policy level and may include things such as regulations and programs and the administration of services. The distinction between medicine and public health has long provided a convenient delineation of areas of expertise. Clinical professionals, including doctors and nurses, focus on treating individuals. Public health researchers focus on communities and promoting conditions that will improve the health of the individuals within them.

This issue of *Footnotes* challenges this distinction. The authors here use the methods and insights of sociology to demonstrate the tightly bound relationships between individual health and social conditions across multiple outcomes, including COVID-19 deaths and vaccination rates. They call for a far more nuanced, multi-level and interactive consideration of the factors behind health and well-being.

Jennifer Karas Montez (“The Rise of U.S. States and the Fall of U.S. Health”) demonstrates the impact of state policies regarding labor, the environment, tobacco taxes, civil rights, and immigration on health and longevity. Tiffany Joseph (“How the Vaccine Rollout Reveals Another Failure of U.S.

Public Health Infrastructure and Implications for Marginalized Populations”) brings a similar analytic lens to the pandemic, explaining that it is only through consideration of the interactions between individuals and their environments that we can understand why Black individuals comprise 14.7 percent of all COVID-19 deaths while only 4.6 percent of vaccines have gone to Black people. Christine Bachrach (“Why Sociologists Are Good For Our Health”) points out that even when environmental factors, like neighborhood violence or poverty, are taken into account, they are generally conceptualized as “exposures” suffered by individuals, instead of taking the entire interactive system into account. Jennifer Reich (“All in This Together?”) demonstrates the ways those interactive feedback loops produce vaccine hesitancy and serve to perpetuate it.

Taylor Hargrove (“Structural Racism and Inequalities in Health”) and Latrica Best (“Understanding the Pandemic’s Impact on Black Americans’ Health from a Life Course Perspective”) help us understand that it is not enough to examine the point-in-time relationships between people and places when considering health. Rather, we need nuanced and intersectional analyses that consider how those factors will interact and accumulate across the life course.

Bernice Pescosolido and Byungkyu Lee (“COVID-19 and the Sociology’s Mental Health Moment”) consider the possibility that widely experienced social isolation during the pandemic, and the concomitant increases in depression, anxiety, and other mental health problems, may lead to a broader understanding of the relationship between environment and mental health and perhaps even a reduction in social stigma around mental illness and its treatment.

However, the articles in this issue do not just reveal the fault lines and failings that have led to systemic

inequality in health outcomes across individuals and communities. They also provide guidance on how we can move toward solutions. Producing healthier societies will require careful consideration of the on-going and structured relationships

between individuals, medical and political systems, and social environments. It will require us to think and work in interdisciplinary ways that draw on the expertise of sociologists, public health professionals, and state- and national-level policy makers, as well as the expertise of medical practitioners. In short, it may help if we begin to think of societies and communities as “patients” and not just the individuals within them. “Treatment” then takes on a far broader meaning and, as these articles demonstrate, may result in far better health outcomes. ■

“In the articles that follow, authors use the methods and insights of sociology to demonstrate the tightly bound relationships between individual health and social conditions across multiple outcomes, and call for a far more nuanced, multi-level and interactive consideration of the factors behind health and well-being.”

Why Sociologists Are Good for Our Health

Christine Bachrach, Research Professor,
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- Contact with the **criminal justice system** impairs mental health.
- **Welfare programs** improve health for all; anti-discrimination policies reduce health inequalities.
- Women affected by **structural sexism** are less healthy.
- **Wealth** improves health, but liquid assets and homeownership improve it in different ways.
- **Organizations** can improve mental health by giving employees more control.



Christine Bachrach

health and health equity, but the imperative to advocate for integrating sociological knowledge into our country's health agenda.

Why Sociology Is So Important to Health

For decades now, health scientists have pointed to the **multiple layers of causal factors** involved in the pro-

duction of health, ranging from genetics and physiological systems, to individual behavior and cognition, and to the social, physical, and chemical environments in which people's lives unfold.

Elements of the social environment that research has firmly linked to health and health disparities include the full range of what sociologists study. The World Health Organization's 2008 *Closing the Gap in a Generation* report highlights families, preschool programs and services, urban and rural development, housing, employment, living wages, working conditions, social protection systems—and health care. Studies have shown that social determinants, including neighborhood crime, policing practices, social stratification, institutional norms, government policies, and much more, play foundational roles in the pathways that produce health and health inequities.

These social determinants of health are now well recognized, but in many quarters, health experts have oversimplified them. Much of the social epidemiology literature characterizes things like neighborhood violence or poverty as “exposures.” The focus is on the individual—a receptacle of social environmental causes that exogenously operate on the body—and not on the broader system in which these causes originate and interact.

Welcome efforts to address the social determinants of health have recently arisen within health care systems, but these typically focus on meeting patients' social needs by providing a social worker to help access services. This may help individual patients ameliorate the

effects of their “exposures,” but does nothing to address the root causes of the exposures themselves—racism, stratification systems, and institutional policies and practices.

Sociologists understand that social systems are complex and historically contingent, and that there is often more than one path to an outcome. For example, Bruce Link and Jo Phelan's seminal **fundamental causes theory** underscores how important this is to understanding health disparities. Those higher up the social ladder will always have better health because they have more resources with which to secure it; but how they secure their health advantage will change over time in response to new technologies, new policies, or other changes in the social environment.

Why Have Social Determinants Received Less Attention?

Parsing out the relative importance of medical care, health behaviors, and the conditions of people's lives in contributing to poor health and premature mortality is fraught with difficulty, but efforts to do so have been revealing. The **most recent attempt**, based on county-level data, suggests that socioeconomic factors account for nearly half of all cross-county variation in health outcomes. Health behaviors account for 34 percent, the physical environment 3 percent, and clinical care, 16 percent. Yet, for every article listed in on social determinants of health, there are 10 on health behaviors, and 28 on health care. Why?

It's not just the power and money of the **medical-industrial complex** that has sidelined awareness of sociological contributions to health, although the \$4.45 billion the pharmaceutical industry has spent **lobbying** over the past 22 years to resist government-run health care and protect its profits speaks for itself. Second only to big pharma in lobbying expenditures is insurance companies, with Blue Cross Blue Shield in the lead.

In the United States we have a culture of health that reflects and reinforces a conflation of health

and health care, making the social determinants of health invisible. Health policy, and our discourse around it, is still strongly focused on health care and access to health insurance. Even the World Health Organization, which champions social determinants of health, defines health policy as the “decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.”

Reflecting U.S. cultural values of individualism and personal responsibility, health behaviors are the other major component of our cultural understanding of health. Even the ASA titles its health journal *Health and Social Behavior*. I conducted a search for “health” on the website **This I Believe**, which features contributed essays on the values people hold. Of the 78 essays that characterized health in some substantive way, the majority focused on personal behavior, about a third on medical treatment, and a fifth on the need to be strong to deal with health problems.

Only four connected some aspect of the environment to health. Two of the four were high school students writing that stressful school environments affected their mental health—one focused on chemical toxins in the environment, and the other one on occupational risks to health.

The centrality of personal responsibility in our pantheon of values offers narratives that can be used to deflect attention away from social determinants. If people smoke, it's a poor choice. If people live in unsafe housing, they have failed to raise themselves up. The issue often boils down to a political argument about the role of government; the infringement on liberty of **limiting the size** of sugary beverages. A focus on individual behavior respects autonomy, while blaming the victim and allowing us to accept the deep inequalities in our society.

It's possible that social determinants of health have been less recognized because they are not tied to health in easily visible ways. On the other hand, neither were bacteria, environmental toxins, or behavioral

Continued on Page 3

Feature

Sociologists

From Page 2

risks such as smoking. We needed the contributions of science to understand and address these health hazards, just as we need them in the domain of social determinants.

Moving Forward

What sociologists study has a massive impact on health and mortality, yet the potential for applying sociological knowledge to improve health is just beginning to be tapped. How do we move forward?

(1) **Advance the science.** There is still much to learn about how the structuring of human society works in tandem with individual agency and biology to affect health and longevity. Getting specific about mechanisms is one of the most important unmet challenges. What is it about education that prolongs life? Why is housing so important for health? How exactly do environmental conditions change the way genes affect biological pathways? What contingencies affect which mechanisms are most important under a given set of circumstances. Harnessing systems approaches to model change in social determinants of health, the pathways through which they affect health, and the potential impact of structural interventions, could also be highly fruitful.

(2) **Advocate for social science.** The social sciences need

effective advocacy to raise their stature and increase funding streams. In my interactions with health leaders, I have found too many who hold to misperceptions of “soft” science and believe that “common sense” is all that’s required to address social determinants of health. Advocacy requires that sociologists reach beyond their own academic circles and develop communication strategies that speak to values and interests they may not share. Recent efforts by the National Academies of Science, Engineering, and Medicine to communicate the value of the social sciences for meeting national priorities provide an excellent starting point: a report on work funded by the National Science Foundation and a Roundtable on the Communication and Use of Social and Behavioral Sciences. The Consortium of Social Science Associations holds an Advocacy Day every spring to educate Capitol Hill staffers about our science. ASA is an active member of COSSA and any ASA member can participate.

(3) **Join a team.** If health is the product of the interaction of environments, individual action, and biology, then leveraging sociology to improve health can’t be achieved by sociologists alone. Scientific teamwork across the many disciplines that address

these elements is essential to moving forward. Population health science is responding to this need. **Population health** is a collaborative field, not a new discipline. It pursues a goal articulated for public health in 1988, “fulfilling society’s interest in assuring conditions in which people can be healthy,” but with a broader, less medicalized, understanding of what it takes to foster health. Population health has grown rapidly over the past few decades. In 2015, it acquired its own scientific organization, the **Interdisciplinary Association for Population Health Science**, which engages scientists from schools of public health, medicine, and other health profes-

sions, along with social scientists of all stripes. Population health also promotes engagement across sectors, drawing in actors in government, business, community development, and public health practice who seek to improve health and health equity. While confusion sometimes arises because many **health care providers** use the term more narrowly (for the management of patient populations), even this complements and contributes to the larger vision of population health.

Many talented sociologists are already participating in this field, but there is still much room to grow. Especially needed are sociologists who are willing to take on the challenges of interdisciplinary collaboration and synthesis. This is not a big stretch: sociologists tend to be more interdisciplinary than many other disciplines already. Even sociologists who don’t focus on health as an outcome can provide valuable insight for interdisciplinary teams who might otherwise reinvent the wheel, oversimplify, or misconstrue theory in addressing

social determinants. We will, of course, need universities who are willing to reward interdisciplinary and, ideally, applied work, in their promotion and tenure decisions.

A Great Time to Get Involved

It’s well known that the U.S.—despite its massive expenditures on health care—performs near the bottom of wealthy nations on population health. Its record on health equity is equally poor: recent data on declines in **life expectancy** in 2020 estimate that Black and Latino populations lost three to four times more years of life during the COVID-19 pandemic compared with Whites. And we know why: it’s not just access to health care or quality of care,

“Even sociologists who don’t focus on health as an outcome can provide valuable insight for interdisciplinary teams who might otherwise reinvent the wheel, oversimplify, or misconstrue theory in addressing social determinants.”

though that undoubtedly played some role. People of color died more often because their conditions of life—jobs, income, housing, and more—made them more vulnerable, both to the virus itself

and to developing underlying conditions that increase the risk of death once infected.

These numbers shine a glaring light on the need to reallocate resources to the “fundamental” social causes of health, the causes that sociologists know so well. Recognition of this need is gaining momentum, reflected in provisions of the Affordable Care Act, “**Health in all Policies**”, and evolution of the federal **Healthy People 2030** program. It has been supported by the growth of progressive causes and intensified concern with racial justice issues.

Powerful actors in the medical community recognize the importance of social causes for health outcomes; sociologists have the expertise to put their power and money to work on addressing them. Collaborate! The need has never been greater. ■



Photo: Zack Vessels on Unsplash

Structural Racism and Inequalities in Health

Taylor W. Hargrove, Assistant Professor of Sociology, Faculty Fellow, Carolina Population Center, University of North Carolina at Chapel Hill

The year 2020 was unprecedented. As of March 2021, COVID-19 has claimed the lives of more than 500,000 Americans—a disproportionate number of whom were Black, Latino, and Native American (NCHS 2021). Alongside this global pandemic, the killings of several Black women and men at the hands of police in the United States, including Atiatiana Jefferson, Breonna Taylor, and George Floyd, catalyzed an expansion of ongoing social movements seeking to combat systemic racism in general, and police brutality in particular. Together, these tragic events have brought racialized inequalities, particularly in health, to the forefront of American discourse.

Racialized health inequalities, however, are not new. While life expectancy has generally increased for all groups, Black Americans continue to have lower life expectancies than White Americans and spend a greater portion of their lives in poor health (Beltrán-Sánchez et al. 2015; Freedman and Spillman 2016; NCHS 2019). As of the first half of 2020, the gap in life expectancy at birth between Black and White Americans was six years—an increase of 46 percent since 2019 and the largest gap in life expectancy since 1998 (Arias et al. 2021). Moreover, recent work suggests that racial inequalities in health may be as deadly as COVID-19. Wrigley-Field (2020) found that 700,000 to 1 million excess White deaths would have needed to occur for life expectancy among Whites in 2020 to fall to the highest life expectancy of Black Americans.

Structural racism is an undoubted driver of these persistent inequalities. Structural racism refers to the interconnection of institutions, laws, practices, and ideologies based on historically rooted relations of domination and subordination that organize racialized groups in a hierarchal structure. Those in superior posi-

tions receive economic, political, civic, and social rights and advantages while those in subordinate positions experience barriers to such rights and advantages. Because racism is structural in nature and does not require individual beliefs, intentions, or actions, the conditions needed in order to maintain these hierarchies are reproduced over time (Bonilla-Silva 1997). To reduce inequalities in health produced by this pervasive system, one must have a sense of what we know and what we need to know. Below I briefly outline the relationship between racism and health, and then discuss how some of my work seeks to illuminate racialized health inequalities.

Racial Inequalities across the Life Course

As many other scholars have eloquently addressed, racism affects every aspect of life via a multitude of mechanisms (see, for example, Bailey et al. 2020; Du Bois 1899 [1967]; Gee and Ford 2011; Sewell 2016; Williams et al. 2019). While I will not go into these mechanisms in detail, it is important to note for this essay that structural racism produces consequences at every ecological level, including institutional (e.g., race-based segregation; redlining), interpersonal (e.g., experiences of discrimination), and internalized levels (e.g., adherence to negative beliefs about one's racial group). These various domains of racism shape health via access to socioeconomic opportunities and resources, exposure to stressors, accelerated physiological aging, and residence in neighborhoods that experience social and economic disadvantages and political disenfranchisement.

Racism also influences health at every stage of the life course. Black women, for example, have the highest rates of preterm birth in the U.S. (Martin et al. 2019). Such inequalities stem from social exposures experienced by Black women throughout the life course



Taylor W. Hargrove

that influence maternal health (Geronimus 1996; Geronimus et al. 2006). Given that preterm birth is linked to depressed neurological development, increased cognitive deficiencies, lower academic achievement, and increased

morbidity in childhood and adulthood (Beauregard et al. 2018; Johnson and Marlow 2011; Saigal and Doyle 2008), children born to Black mothers are more likely to begin life in poorer health and follow trajectories of disadvantage across the life course.

Relative to Whites, Black Americans are also at an increased risk of developing high blood pressure, heart disease, diabetes, stroke, and high body mass index at every age beginning in young adulthood (Cunningham et al. 2017; Hargrove 2018); thus, Black young adults already have diseases that manifest later in life for other racial groups. Moreover, Black older adults are more likely than their White counterparts to experience functional limitations, chronic health conditions, and cognitive declines (NCHS 2019; Quiñones et al. 2019; Weuve et al. 2018; Zhang et al. 2016). These patterns result from the types of contexts (e.g., disadvantaged neighborhoods; underfunded schools; hostile workplace environments; negative interactions with health care providers) Black people are likely to experience across the life course.

Knowledge of the health consequences of racism abounds. Given data availability, many investigations focus on the role of downstream factors, such as socioeconomic status, exposure to stressors, and health behaviors. While these factors are important determinants of health, racial disparities often persist even after controlling for their influences in statistical models. My work has focused on three strategies aimed toward providing a more nuanced understanding of these remaining health inequalities: (1) applying an intersectionality perspective; (2)

examining intragroup heterogeneity in pathways to health; and (3) investigating the role of socio-geographic and historical contexts.

Intersectionality

While extremely important, racism is not the only system of inequality that structures life in the United States. Sexism, capitalism, heteronormativity, and ableism, to name a few, substantially affect opportunities for good health and well-being.

Intersectionality theory highlights the interlocking nature of these systems of inequality. Intersectionality posits that the consequences of simultaneous social statuses (e.g., race, gender, class) are multiplicative and mutually constructive. That is, positions at a given intersection of racial, gender, and class hierarchies produce unique social experiences and contexts that characterize one's social reality. Such experiences and contexts are distinct from those of individuals who may share a similar status (e.g., those who are members of the same racial group but a different gender group). The application of an intersectionality approach to the study of health inequality fills a crucial gap, as studies generally examine the individual or additive consequences of social statuses. These approaches assume that systems of inequality (and their effects) are independent of one another. Studies relying on additive approaches may overlook groups that are particularly vulnerable in terms of health.

For example, in a study published in 2020, I led the investigation of the joint consequences of race/ethnicity and gender on age-trajectories of depressive symptoms across adolescence, young adulthood, and the beginning of mid-life. Using data from the National Longitudinal Study of Adolescent to Adult Health (Add Health) and growth curve modeling, findings indicated that Black and Asian American women consistently reported the highest levels of depressive symptoms throughout adolescence and young adulthood. Age trends in depressive

Continued on Page 5

Feature

Inequalities in Health

From Page 4

symptoms were also found to be more dynamic for women than for men, who showed flatter patterns of change overall. This study demonstrated heterogeneity in trajectories of poor mental health within and between racial/ethnic-gender groups across a longer period of the life span than was previously known—with Black and Asian women being particularly disadvantaged. Such disadvantages may have been overlooked in studies examining either race or gender disparities.

Intragroup Heterogeneity

Oftentimes, researchers compare health between race groups, with Whites generally serving as the comparison group. While such approaches are necessary and provide critical information, also needed are within-group approaches aimed toward understanding intragroup heterogeneity. These types of approaches identify unique risk and protective factors that distinguish pathways to health among individuals within social groups that are often erroneously treated as homogenous. Within-group approaches also challenge the notion that established pathways to health (e.g., the relationship between SES and health) are invariant across race groups. Understanding intragroup heterogeneity provides information necessary to increase opportunities for good health among vulnerable populations.

In a study published in 2018, for example, I examined whether skin color intersected with gender to shape trajectories of BMI across early adulthood and midlife among African Americans. Results showed that dark-skinned women had the highest BMI levels across early adulthood and midlife compared to all other skin color-gender groups. BMI disparities between dark-skinned women and their lighter-skinned counterparts remained stable from ages 32-55, while a BMI disadvantage emerged and widened among men with light or dark skin and their medium-skinned counterparts.

Socioeconomic resources, stressors, and health behaviors did not explain the associations between skin color and BMI. These results suggested that skin color and gender-specific experiences likely play a large role in generating health inequality among African Americans. The sources of intragroup heterogeneity should be considered when developing interventions and policies for improving the health of Black Americans.

2001; Uzogara and Jackson 2016). These meanings influence experiences of discrimination from in-group and out-group members, which may ultimately influence health (e.g., Monk 2015).

Social and geographic contexts experienced across the life course also shape the ability of groups to translate resources into health benefits. A series of papers have found that the health consequences

leading to the (over)activation of physiological stress responses during socioeconomic achievement.

With support from the National Institutes of Health, Gaydos and I are working on a set of papers that evaluate the sociocontextual mechanisms linking race, mobility, and health. To aid in these investigations, we led the effort to merge several new sources of contextual data to Add Health, including information from Opportunity Insights, the Institute for Health Metrics and Evaluation, and RWJF County Health Rankings. These data characterize the demographic, socioeconomic, health, and mobility characteristics of the environments of Add Health respondents in early life, young adulthood, and the beginning of midlife. A better understanding of the linkages between life course social environments and health will help identify the precursors of complex patterns of racial inequality in health as well as address their consequences across the life course.

Toward the Future

Racism continues to be a deadly crisis in the United States. We need multilevel, innovative solutions to combat the racialized inequalities it produces. Protesters and community leaders have already put forth some options, such as “defunding the police” in order to reallocate funds used to support police departments to social programs that invest in and improve communities experiencing concentrated disadvantages. However, more is needed. Sociologists are well-positioned to help take on this fight, lest we forget that the genesis of our modern scientific discipline is rooted in studying and alleviating social ills. As stated by Du Bois in 1899 and often reiterated by a prominent scholar in this area, David Williams, “The most difficult social problem in the matter 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 peoples where human suffering has been viewed with such peculiar indifference” (Du Bois 1899 [1967], p.163).

We must not continue this peculiar indifference. ■

“A better understanding of the linkages between life course social environments and health will help identify the precursors of complex patterns of racial inequality in health as well as address their consequences across the life course.”



Social and Geographic Contexts

Prior work on racialized health inequalities has tended to treat the experience and consequences of race as static across social and geographic contexts. A long tradition of sociological scholarship, however, indicates that individuals are social actors embedded within larger social contexts and institutions (Du Bois 1899 [1967]; Durkheim 1897), which can shape interpretations and treatments of race. For example, prior work suggests that for Black Americans, race and skin tone have different meanings in settings that are exclusively in-group (e.g., Black Americans navigating predominantly Black settings) than race and skin tone do in out-group settings (e.g., Black Americans navigating interracial or predominantly White settings) (Celious and Oyserman

of upward social mobility are conditional on one’s early life context. For example, Gaydos et al. (2018) found that Blacks and U.S.-born Latinos who were upwardly mobile (defined as coming from a disadvantaged background in adolescence and achieving a college degree or higher) experienced an increased risk of high metabolic syndrome in young adulthood. Differences across environmental contexts may help explain these patterns. Individuals living in disadvantaged neighborhoods during their early life who achieve upward mobility during adulthood may experience a discordance between the types of capital that exist or are cultivated within their childhood environments and those that are needed to be most successful in racialized organizations like educational institutions. This discordance may produce stressful experiences,

“All in This Together?": Inequalities and Hesitancy Surrounding the COVID-19 Vaccine

Jennifer A. Reich, Professor of Sociology, and Director of the University Honors and Leadership Program, University of Colorado-Denver

Vaccines often face two seemingly contradictory problems: (1) they are at times in high demand and are, thus, distributed inequitably, and (2) people may not want to get vaccinated, undermining efforts to create herd immunity. In the first year of the polio vaccine, for example, it was clear that children from wealthy families with private physicians had better access to it. Yet in subsequent years as supply increased and demand dropped, public health agencies had to work hard to convince people to get the vaccine.

Despite evidence that vaccines work best when used broadly as a community strategy, my research shows that vaccine refusal emerges logically from cultural norms that view individual consumption choices as the key to good health. Vaccines, I found, were seen as one tool among many that could optimize or undermine individual health but were seldom seen as a collective solution. More than a year into a pandemic that has killed more than 500,000 people in the U.S., it appears the rollout of the vaccine against SARS-CoV-2, the virus causing the COVID-19 pandemic, faces these same perceptions and challenges. And despite public health messaging that insists “we are all in this together,” it remains clear that when it comes to vaccines, many are on their own.

Vaccine Distribution and Social Inequality

As background, in December 2020, the FDA authorized two vaccines, along with a third in late February 2021. These vaccines were not licensed. Rather, using a mechanism created after 9/11 to allow the FDA to respond quickly to an imagined bioterrorist attack, the FDA granted an emergency use authorization that allows an unlicensed product to be distributed if it is reasonable to believe that it “may

be effective,” that the known and potential benefits outweigh the known and potential risks, and no formally approved alternatives are available at the time.

Alongside these authorizations, the Advisory Committee on Immunization Practices (ACIP), a committee of vaccine researchers and medical experts that has, since 1964, advised the CDC on how to set federal recommendations for vaccine use, convened to decide how COVID-19 vaccines should be distributed and to whom. Typically, ACIP members examine data to determine which vaccines are most important, how they work in combination with other vaccines, and which subgroups should not use them. ACIP sets the recommended childhood vaccine schedule and examines the safety and efficacy of licensed vaccines. At times, ACIP rescinds a recommendation, as it did in 2016 when data showed that the nasal spray flu vaccine was ineffective, or changes recommendations, as it did with the vaccine against HPV when evidence showed that fewer shots created a strong immune response in younger adolescents.

States interpret ACIP recommendations to enact vaccine requirements for school attendance, college dorm residence, or targeted work forces like healthcare. States thus have different rules requiring different vaccines in different contexts, with some allowing for religious, philosophical, or medical exemptions to be documented through a range of processes.

ACIP’s task for a COVID-19 vaccine was different. Knowing there would not be enough vaccine to meet initial demand, ACIP members—virtually all physicians and scientists—set priorities that were more social considerations than medical ones. Their goals for the vaccine were two-fold: “prevention of morbidity and mortality” and “preservation



Jennifer A. Reich

of societal functioning.” These seemingly complementary goals in many ways work against each other as they identify entirely different populations. To prevent sickness and death, ACIP prioritized those at greatest risk of the worst outcome of infection—defined as those over 75 years of age. Although they were aware of the racial disparities in illness and death, they insisted that their recommendations would be color blind.

The second goal, “preservation of societal functioning,” led ACIP to prioritize “healthcare workers, front-line essential workers, other essential workers.” The CDC published a list of industries in which essential workers are employed, but made clear they could not specify which workers in those industries should get the vaccine first. CDC guidance notes that “jurisdictions should, where feasible, make efforts to prioritize workers in occupations characterized by the inability to work remotely and the need to work in close proximity to others...,” but it was left to local agencies to work out the details of implementation and distribution.

The results were unsurprisingly inequitable. Although 30 states initially followed ACIP recommendations, all but three quickly moved to set their own priorities. Some lowered the age ranges. Others added or removed categories of essential workers. Treatment of people who are unhoused, incarcerated, smoke, or living with underlying health conditions vary across states and even counties.

Equally unsurprising, vaccine prioritization worked best for those for whom social institutions already work best. Seniors in large residential care facilities or insured by hospital systems gained access to vaccines more easily than did seniors who are aging in place, have family caregivers, or seek medical care from community providers. Similarly, healthcare workers employed by large systems or medical groups gained access easily. Workers in home healthcare, hospice, or small practices found access

challenging, even as they undoubtedly qualified under prioritization strategies that placed healthcare workers at the front of the line.

Defining which workers are essential has not gone better. Questions of whether priority should be given to those whose work puts them at greatest risk of infection or whose jobs are essential to the functioning of communities remained unresolved. Without open dialogue, states interpreted this in myriad ways. One only needs to look around the country to see the prolonged disagreements about whether teachers are “essential,” and if so, should priority go to those who are teaching in-person because their work places them at risk, or to all teachers because their work is essential and we will all struggle should they become sick, even when teaching remotely?

The lack of clarity between worker and industry has led to further inequality. For example, the CDC identified “food and agriculture” as an essential industry, but local agencies defined who qualified. So while food and agriculture workers in California experienced a 39 percent increase in mortality during the pandemic, many early vaccines appear to have gone to people working in wineries, which are part of food and agriculture, but whose workers do not all face equal risk.

This bricolage of prioritization strategies has led to huge inequities in distribution. In virtually every state, Black and Latino people are underrepresented among groups receiving a vaccine but are overrepresented in COVID-19 cases and deaths. Building distribution systems on top of existing inequalities, vaccine sites were often set up away from BIPOC neighborhoods, used electronic booking systems that magnify digital divides, or failed to acknowledge pharmacy deserts.

The opacity in these processes has potentially increased among people the distrust of public health systems and possibly vaccines. A majority of Americans say that the

Continued on Page 7

Feature

Inequalities and Hesitancy

From Page 6

vaccine rollout has been **unfair**. About 60 percent of respondents in a January **Kaiser Family Foundation** poll said federal and state governments were doing a fair or poor job with vaccine distribution. Efforts to **rationalize inequalities with algorithms** haven't helped. Most people perceive that individuals are on their own to get access—whether by incessantly reloading webpages, having tech-savvy family members to help, or using connections. One only needs to read comments on social media below any vaccine selfie to see how quickly others want to know why the person proudly sharing their good luck is eligible when they are not.

Vaccine Hesitancy and Wanting to “Wait and See”

Perhaps counterintuitively, inequities in meeting high demand may bolster hesitancy. Despite initial scarcity, the coming months will likely reach a point where anyone who wants a vaccine can get one. Yet, a sizable number of Americans may not want one.

Since early in the pandemic, opinion polls have asked Americans whether they want a COVID-19 vaccine. **Early polls** asked about the idea of a vaccine, since none were actually available. In May 2020, only 27 percent of Americans said they definitely or most likely would not get it. That number grew in the fall to almost 50 percent as the race for a vaccine became politicized. Interest in the vaccine rebounded in December as companies applied for authorization while infections surged. Although the number of people reporting they want a vaccine as soon as possible has risen, many continue to indicate they do not or, more commonly, say they are uncertain and would prefer to “wait and see.”

For those who see the vaccine as the key to ending the pandemic, hesitancy or outright refusal by others is perplexing. Rejecting a technology that promises 65 to 95 percent success to prevent severe illness and death seems irrational. As such, efforts to address hesi-

tancy often presume those who reject vaccines are ignorant or ill-informed and aim to provide information. However, my research shows that vaccine hesitancy is not the result of lack of information, but rather represents processes in which individuals weigh the perceived risks of the vaccine and the disease it prevents against the perceived benefits. Despite messaging that insists vaccines are a community-level solution, people make decisions based on personal experiences, values, and

a vaccine said they were worried about the vaccine’s side effects, including those that would require them to miss work (58 percent and 66 percent, respectively). As individuals perceive themselves as on their own to manage their health, they make vaccine decisions that feel relevant to their individual needs and concerns.

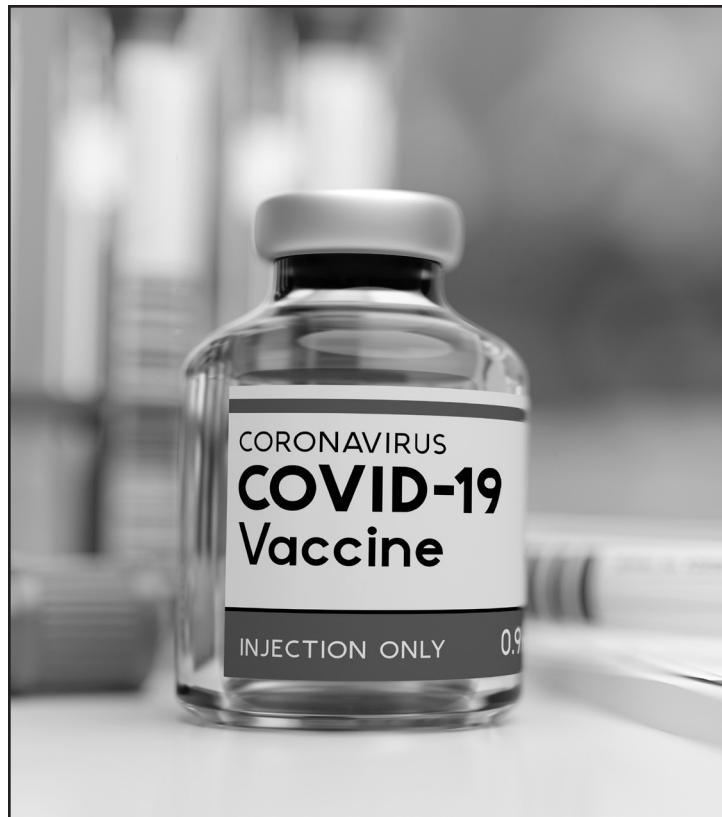
Individual perceptions are shaped by peers and social networks, which can be seen in the ways childhood vaccine refusal **clusters**. For COVID-19 vaccines,

the same. In these ways, individual perceptions and strategies are powerfully informed by structural inequality.

Political identity and affiliation appear to matter, with those who identify as Republican consistently expressing the lowest desire for a vaccine. Those in rural communities also express low interest. Young people who have been told they are unlikely to be seriously affected by the virus show low levels of interest, making many essential workers unwilling to be among the first to be inoculated, despite the measurable risk they face. Throughout, individuals are drawing on cultural information to make a decision that feels personally relevant.

Looking Ahead

The coming months will bring these contradictory problems of lack of access and hesitancy together in complicated, albeit unknown ways. These experimental vaccines may become fully licensed, which could increase confidence in their safety. How well these vaccines work against different variants, how long immunity lasts, and how successfully they prevent asymptomatic transmission may become clearer. Workplaces could address concerns about lost work from side effects and provide support to make these decisions easier. Alternatively, and sadly more likely, private sector employers could instead adopt policies requiring workers to be immunized as a condition of employment, raising new questions of health privacy and worker autonomy. Airlines or restaurants could imaginably ask for **evidence of immunization** as a condition of service, as is being discussed outside of the United States. The tragedy of COVID-19 and the public funding of science that led to these vaccines offered an opportunity to underscore how we are “in this together.” Instead, it seems clear that vaccines will likely remain an individual choice for personal benefit that will inevitably reflect the systems of inequality in which they have been created and distributed. ■



goals, believing at core that they are on their own when it comes to their health.

Notably, people of color appear most likely to say they want to “wait and see.” Media accounts are quick to blame misinformation or conspiracy theories or to attribute distrust to historical racism like the **Tuskegee experiment**. Few acknowledge ongoing experiences with racism in healthcare or recognize the reasons waiting feels safer. In a recent **survey**, 80 to 85 percent of Black and Hispanic respondents who indicated that they want to wait before getting

it appears that knowing someone who has been vaccinated predicts wanting a vaccine. Here, inequities in distribution are magnified and reproduced. As of **late February**, among people making over \$90,000 a year, 7 percent did not know anyone who had received a vaccine. In contrast, among those making under \$40,000, 32 percent did not. Racial disparities in distribution matter too. About 36 percent of Hispanics said they did not know anyone who had received a COVID-19 vaccine, as did 29 percent of Black people, but only 14 percent of white people said

How the Vaccine Rollout Reveals Another Failure of U.S. Public Health Infrastructure and Implications for Marginalized Populations

Tiffany D. Joseph, Associate Professor of Sociology, Northeastern University



Tiffany D. Joseph

To date, the U.S. has the highest number of COVID cases and deaths globally. In late February, it reached another grim milestone when the number of Americans who succumbed to the virus surpassed 500,000. President Biden marked the somber day with a memorial at the White House, where 500 candles were lit, each symbolizing 1,000 of those deaths.

To combat the pandemic, Biden has implemented an aggressive plan, part of which is to vaccinate 200 million Americans in the first 100 days of his presidency. However, three important factors will pose a significant challenge to attain that goal and achieve the necessary herd immunity: (1) lack of centralized infrastructure for the vaccination rollout; (2) complex processes that have been set up for making and keeping appointments; and (3) disparities in vaccinations that reflect deep-seated structural inequalities. Each of these factors further reveal the impact of the disinvestment in U.S. public health infrastructure that have exacerbated the pandemic and may prevent the U.S. from reaching to its “new normal.”

A Rocky Start

First, the lack of a centralized infrastructure has led to a rocky vaccination rollout. Rather, we have a “patchwork” rollout in place that differs across each state and resembles the patchwork response early in the pandemic that allowed COVID-19 to spiral out of control. Further complicating this process are the different eligibility requirements in each state and that some states allow residents to make appointments for the first dose without being able to guarantee a second dose three weeks later.

Both have been issues in states with more robust healthcare resources and state-funded infrastructure such as Massachusetts, my

current state of residence, and in those like my home state of Tennessee, which lack resources and infrastructure. Globally, the U.S. ranks sixth in vaccination rollout. Despite having the advantage of being able to manufacture the vaccines

domestically, other countries with more centralized public health infrastructures have fared better in administering vaccines. This is another indication of how disinvestment in U.S. public health has worsened the impact of COVID-19.

Complicated Processes

Next, those who are eligible to get vaccinated must undergo complex processes for making and keeping vaccination appointments.

Around the country, people have to navigate complicated websites that often crash from over-capacity and struggle to find phone numbers to call for assistance. These processes have created what Herd and Moynihan (2018) call

“administrative burdens”—in signing up for vaccines. These burdens extend beyond vaccines and are imposed on individuals when they navigate government bureaucracy to seek public services. Sometimes these burdens are so cumbersome that they deter individuals from obtaining services for which they are eligible.

Administrative burden affected the initial Obamacare rollout, which prevented individuals from signing up for health coverage in 2013.

Typically, administrative burdens are most burdensome for those who are elderly, lower-income, people of color, immigrants; lack access to computers and/or computer literacy; and have limited English proficiency. For individuals who fit in intersecting categories, inability to navigate the “system” puts them at even more of a structural disadvantage. When you add these burdens to systemic racism, a distrust of the medical system, and concerns about detention/deportation, communities of color—citizens and immigrants—continue to be left behind despite being the hardest hit by the pandemic.

Racial Inequities

Finally, long-standing racial disparities have shaped who has received the vaccine so far. Given how systemic racial privilege and power function in the U.S., it is not surprising that White Americans have been disproportionately more likely to obtain the

Thus, the structural inequalities that made Blacks, Latinxs, and other communities of color more likely to contract and die from COVID-19 also are hindering their ability to get the vaccine. And despite the summer 2020 calls for racial justice after the deaths of George Floyd, Breonna Taylor, and other Black Americans, racial equity efforts in vaccine administration have been few and far between. In some states, activist coalitions have formed to push local and state governments to make more aggressive efforts to get Black and Latinx residents vaccinated. Without more specific and targeted efforts to increase access to and reduce administrative burdens for getting the vaccines to communities devastated by COVID-19, efforts to end the pandemic will be stalled.

Public Policy Plays a Critical Role

Unless these three factors are addressed, it will be difficult for the Biden Administration to have the nation achieve herd immunity by summer. These factors should be a reminder of the importance of public health infrastructure for combatting this pandemic and other public health issues, and simplifying processes for vaccination appointments and engagement with government services more generally.

With sufficient political will, public policy can ameliorate these challenges in the short and long term. Implementing policies to reinvest in public health infrastructure using a racial equity lens; tackling systemic racism in the healthcare system and broader society; coordinating federal-subnational efforts; and simplifying vaccination and healthcare navigation procedures will go a long way in addressing the structural inequalities that have led us to this moment. We will then be better prepared when the next health crisis hits. ■

“Three important factors will pose a significant challenge to attain the goal of vaccinating 200 million Americans in the first 100 days of the Biden administration and achieve the necessary herd immunity: (1) lack of centralized infrastructure for the vaccination rollout; (2) complex processes that have been set up for making and keeping appointments; and (3) disparities in vaccinations that reflect deep-seated structural inequalities.”

vaccine than people of color. This is the case even at vaccination sites in Black and Latinx communities. Currently, a paltry 4.6 percent of COVID-19 vaccines have been administered to Black Americans and 5.7 percent to Latinxs. There has been no data collected on vaccines administered by documentation status to assess how many immigrants, many of whom work in essential jobs, have had vaccine access.

The Rise of U.S. States and the Fall of U.S. Health

Jennifer Karas Montez, Professor of Sociology, Gerald B. Cramer Faculty Scholar in Aging Studies, and Director of the Center for Aging and Policy Studies, Syracuse University

The chances of living a long and healthy life differ markedly across U.S. states. Residents of Minnesota, for example, live



Jennifer Karas Montez

81 years on average and experience 70 of those years in good health. Residents of Mississippi, on the other hand, live 75 years on average, with 65 years spent in good health. Mississippi residents also develop physical limitations at younger ages than do residents of Minnesota. By middle-age (45-54 years), 21 percent of Mississippians have a limitation. It is not until the retirement age (65-74 years) that the same percentage of Minnesotans develop a limitation.

Differences in health and longevity across U.S. states have widened since the mid-1980s. By 2017, the difference in life expectancy between the highest and lowest life expectancy states was seven years—the largest gap ever recorded in the [United States Mortality Database](#), which became operational in 1959. This difference is substantial. To put it in perspective, the life expectancy gap between men and women in 2017 was five years and the gap between Blacks and whites was 3.5 years. Since the mid-1980s, some states have made sizable gains in life expectancy, while many others have made relatively small gains and recently experienced declines. This latter group of states has greatly weighed down overall U.S. life expectancy.

Roles of People and Places

Why is the gap in life expectancy among the states large and growing? Speculations often pit two explanations against each other: people versus place. In other words, is life expectancy lower in Mississippi than Minnesota because of the characteristics of the people or the states themselves?

However, distinguishing the effects of people and place on population health is challenging. It may also be unwise because people and places are interrelated. Importantly, places shape the characteristics of people as well as the health consequences of those characteristics. For these reasons, some researchers assert that attempts to distinguish the effects of people and place on health may have underestimated the effect of place.

Take educational attainment as an example. It is often considered a “people explanation” in this area of research. However, U.S. states can shape overall levels of education through K–12 school funding as well as the health risks associated with low levels of education through policies like minimum wage, Earned Income Tax Credits, and Medicaid. Returning to the Mississippi and Minnesota comparison, having a low level of education is much riskier for health in Mississippi than Minnesota.

With those complexities in mind, this article focuses on U.S. states and how their policy contexts can affect life expectancy. The next section describes how states became major “institutional actors,” defining the social, economic, and policy contexts in which Americans live.

Policy, Power, and Politics

Policymaking authority in the U.S. is split across levels of government, but states do the bulk of routine governing. State laws regulate birth and death, marriage and divorce, crime and punishment, and commercial law, such as the purchase and sale of property. States manage education, prisons, highways, welfare, environmental protection, corporate law, and the professions. In other words, decisions of state legislators touch nearly every aspect of our lives.

States have acquired more policymaking authority over the last 40 years or so, partly due to two policy movements. The devolution movement transferred certain authorities from the federal to state governments. Devolution is often linked to the Reagan administration

and later when Newt Gingrich was the House speaker. A central strategy of devolution was to replace categorical grants to the states with less generous and more flexible block grants. As an illustration: instead of providing each state \$10 to fund education and \$10 to fund roads, the federal government gave each state \$15 along with discretion on how to spend it. One outcome of devolution is that states devised vastly different social service programs.

The second movement is the rise of state preemption laws. These laws prohibit cities and counties from legislating on certain issues. For example, states preempt them from setting a minimum wage below the states’ wage. Preemption laws are not new. What is new is why they are being enacted and who is lobbying for them. Historically, they were used to harmonize state and local laws and provide a regulatory floor (as in the minimum wage example above). However, they are increasingly used by some states to set a regulatory ceiling. Now, half of states prohibit localities from raising the minimum wage. This new type of preemption is occurring across many policy domains. Some states have preempted local authorities to mandate paid leave, ban plastic bags, tax soda-sweetened beverages, and much more. Another characteristic of the new type of preemption is that corporations and their lobbyists have been a driving force.

One consequence of those two movements is that states’ policy contexts have hyperpolarized during the last 40 years. States like New York created a more liberal policy environment, while states like Mississippi created a more conservative one. New Yorkers experience a dramatically different policy context than do Mississippians. For example, the state of New York spends \$22,231 per pupil on K12 education (Mississippi spends \$8,692); has a \$12.50 minimum wage outside of NYC (Mississippi defaults to the federal level of \$7.25); sets its Medicaid income eligibility limit for children at 405 percent of the federal poverty level (Mississippi

sets it at 214 percent); levies a \$4.35 tax on a pack of cigarettes (Mississippi has a \$0.68 tax); has 104 firearm-related laws intended to reduce injury (Mississippi has five); and does not preempt localities from raising the minimum wage (Mississippi does).

How have those tectonic shifts in states’ policy contexts affected life expectancy? Have those shifts widened inequalities between states? Have they contributed to the troubling trends in U.S. life expectancy? Emerging evidence indicates that those policy shifts have, indeed, had an important impact, as highlighted in the following section.

State Policies Affect Life and Death

States’ policies can affect how long people live. But how large are the consequences of state policies on life expectancy? Which policies matter the most? And by how much could we change U.S. life expectancy if we changed state policies? This section sheds light on these questions. It highlights findings from two studies that my collaborators and I recently conducted.

In one study, we examined how 18 policy domains, such as civil rights and labor, predicted life expectancy from 1970 to 2014. The policy data were collected by Jacob Grumbach, a political scientist, who assigned scores to each domain. The scores reflect how liberal or conservative a state’s policies were in each domain in each year. We analyzed the relationship between the policy domains and life expectancy during the 1970–2014 period. Our analysis accounted for several other factors that differ among states, such as the size of their immigrant populations and the unemployment rate.

We found that several state policies strongly predict life expectancy. Policies on labor (e.g., minimum wage), the environment, tobacco taxes, civil rights, and immigration (e.g., driver’s licenses for undocumented persons) were especially important. More liberal versions of those policies predicted longer life expectancy for women

Continued on Page 10

Understanding the Pandemic's Impact on Black Americans' Health from a Life Course Perspective

Latrica E. Best, Associate Professor of Sociology, University of Louisville

As the coronavirus took hold of almost every aspect of our daily lives since its rapid spread last year, researchers quickly highlighted the manner in which COVID-19 disproportionately affected Black Americans and other communities of color. According to the [most recent CDC estimates](#), Black communities experience higher infection, hospitalization, and death rates than their white counterparts. These statistics are disheartening, as these inequities further exacerbate the existing disparities in health outcomes and mortality.

Social science research has shown that, given the 2020 data on COVID-19-related deaths, whites' mortality from the pandemic would still be lower than the lowest mortality of Blacks in [history](#), a statistic that also holds true for whites' mortality during the 1918 flu pandemic. Early [reports](#) also suggest that mental health issues stemming from the pandemic are a growing concern for Black communities, particularly Black women. Blacks' mental health risks related to the pandemic are not surprising, as historically, minoritized groups



Latrica E. Best

have often felt the greatest impact—financially, emotionally, and physically—both during and after public health and environmental crises. In fact, the sociological and environmental causes that underscore COVID-

19-related health inequities mirror and reflect the well-documented social determinants of health that have framed our understanding of and research on health disparities.

Children and adolescents, for the most part, have largely been spared from the physical consequences of COVID-19. Although the infection and death

rates from COVID-19 have remained low over the past year, early [findings](#) suggested that Black, Brown and Indigenous children and young adults represented an overwhelming number of the COVID-19-related deaths for those under the age of 21. Much attention, however, has been given to the mental and developmental concerns and risks related to the significant disruption to everyday lives of youth. Pediatric emergency room-related visits for mental health concerns [increased and remained high](#) for the better part of 2020. The abrupt closing of in-person instruction has, for many

Continued on Page 11

U.S. Health

From Page 9

and men. Marijuana policy was somewhat related to life expectancy, with a more conservative version predicting longer lives.

We found that several policies could potentially increase life expectancy by a sizable amount. Take labor policies: Suppose a state changed its labor policies to raise the minimum wage, offer state-sponsored disability insurance, and repeal its right-to-work laws. According to our estimates, such policy changes could raise life expectancy in that state by one full year. On the flip side, life expectancy might decline by one year if a state's labor policies moved in the opposite direction.

Could we change U.S. life expectancy by changing state policies? The answer, it seems, is yes. And by a large amount. As an example, if all states mimicked the policies of Connecticut, U.S. women's life expectancy could increase by two years. However, it could decline by a full year if all states adopted the policies of Oklahoma. We also explored more extreme scenarios. We estimated that U.S. women's life expectancy would rise by 2.8 years if all states

enacted liberal policies or decline by two years if all states implemented conservative ones. These scenarios are admittedly unrealistic in today's polarized policy environment. Nevertheless, they illustrate the potentially profound consequences that changing states' policies could have on life expectancy.

State policies over the last 40 years have not been kind to U.S. life expectancy. Some policy changes have been beneficial, but others have not. Those countervailing forces may help explain why U.S. life expectancy has stagnated since 2010. In fact, we estimate that the U.S. life expectancy trend during the last five years of our study (2010-2014) would have been 25 percent steeper among women and 13 percent steeper among men if state policies had not changed in the way they did.

In [another study](#), we examined the effect of state preemption laws on infant mortality. As mentioned above, state preemption laws remove local authority to legislate on certain issues. In recent years, about half of states have removed local authority to raise minimum wage. This is a potentially serious public health concern because raising the minimum wage has a host of health benefits such as reducing teenage pregnancy, economic

distress, mother's smoking, and infant mortality. We assessed how many infants die each year because states revoked attempts by cities and counties to raise the minimum wage and preempted them from ever raising the wage again. We estimated that over 600 infant deaths each year can be attributed to that preemption.

Future of U.S. Health

The widening gaps in life expectancy across states and the troubling trends in overall U.S. life expectancy are unlikely to reverse themselves without systemic and evidence-based changes. Sociologists must have a voice in outlining those changes and have a seat at the table, which has recently happened with the appointment of [Alondra Nelson](#), Harold F. Linder Professor in the School of Social Science at the Institute for Advanced Study and president of the Social Science Research Council (SSRC), to the position of deputy director for science and society in the Office of Science and Technology Policy (OSTP) by President Biden.

With that goal in mind, I conclude with four recommendations for sociologists:

(1) **Turn attention to structural explanations.** The roots of

troubling trends and gaps in life expectancy are more likely to be found in politics, corporate boardrooms, and lobbying organizations than in the circumstances of people whose lives are cut short by those power structures.

- (2) **Build collaborations with scholars from other fields, especially political science, history, and law.** They bring essential knowledge on the long arc of structural changes that may be culpable.
- (3) **Expand the conventional social determinants of health framework to include the political, commercial, and legal determinants.** Sociologists have long been interested in social determinants, such as education, gender, and race. The determinants for health should be further expanded to include the political, commercial, legal, and other such institutional forces.
- (4) **Track and study legislative activity at the state level.** States will likely remain an active battleground of policymaking for the foreseeable future with profound implications for U.S. life expectancy. ■

Pandemic's Impact

From Page 10

across the country, continued well into 2021, significantly hindering children's social interactions and activities. This disruption will undoubtedly impact their social, mental, and physical well-being for years to come. The transition to online learning came with challenges for many, and the ability of students to effectively work remotely is proving to be uneven across socio-demographic groups. Black youth are more likely to be learning solely online than their white counterparts, which carries a host of immediate and long-term educational and developmental consequences. Additionally, Black youth are experiencing these disruptions as they potentially deal with the health and financial issues of their family members and close friends.

Using a Life Course Perspective

As the number of COVID-19 cases continues to fall and vaccinations increase, researchers are focusing on the long-term consequences of the pandemic. As sociologists, one of our many strengths lie in providing strong, theoretical foundations for contextualizing the lived experiences of individuals and groups. I believe the use of a life course perspective is crucial in understanding the impact of COVID-19 on Black Americans and their health. A life course perspective not only would amplify intragroup variations and complexities in health outcomes, but also would aid in identifying and highlighting existing and emerging health-related inequities. How might we think about the pandemic's lasting impact on Black Americans' health from a life course perspective?

Life course concepts have been utilized extensively to explain how social systems shape the health of groups as they age. Although various approaches to studying the life course exist, Glen Elder's longitudinal work on the long-term impact the Great Depression had on children can be

helpful in understanding how to contextualize the pandemic's effect on children's health and other social trajectories. For life course theory, human development and aging are processes that span one's entire life and are rooted in four key principles: historical time and place; the timing of lives; linked lives; and human agency.

We must situate the historical nature of the pandemic. In addition to the direct effect that COVID-19 has had on our daily lives, Blacks also have endured a year in which we've seen numerous protests over the continued killings of unarmed Black people at the hands of law enforcement and a racially charged

insurrection within the halls of the U.S. Capitol. Racism has been linked to adverse mental health outcomes for children of color and both mental and

physical health for adults; the added financial, social, and educational concerns related to COVID-19 may lead to an accumulation of risk factors for various health outcomes.

The concept of the timing of lives reflects both our society's expectations of when individuals should start and maintain roles throughout their lives and our assumptions regarding the sequencing of such roles. For instance, exposure to household financial issues related to the pandemic early on in life can shape youth's development in numerous ways, from insecurity to inconsistent health care and housing concerns. Likewise, Blacks' higher unemployment rates during the pandemic have only widened the income and wealth gaps already present between Blacks and whites. Depending on the age at which these circumstances occur, and the duration, these issues

can alter the social pathways of individuals' lives and substantially influence their health.

The pandemic's impact on Black people's health and well-being is undoubtedly dependent on others within their families and social networks, regardless of age. Just as children and adolescents are highly dependent upon the adults in their lives for help with navigating their experiences during the pandemic, adults' links to families and social networks can play a vital role in their health. Physical and social distancing has limited the ways in which people connect with each other and, for some, cut off interaction to those who may provide

“Just as children and adolescents are highly dependent upon the adults in their lives for help with navigating their experiences during the pandemic, adults' links to families and social networks can play a vital role in their health.”

essential emotional and material support. Conversely, we must also think about the effects of stressful relationships during this time, where

people may have been forced to shelter in place in precarious situations. This is evident in the rising reports of domestic abuse globally during the pandemic.

A person's ability to craft their trajectories through their decisions and actions is a guiding principle of life course theory. These decisions and actions are not made in a vacuum; human agency reflects the opportunities and constraints of lived experiences, both past and present. The existing and pandemic-related inequities Blacks experience will factor into the decisions they make regarding their well-being. Reports showing that Black parents are more hesitant than their white counterparts to send their children back to school due to safety concerns illustrate the decisions these parents must make, while being well aware of the structural constraints that limit their agency.

Additionally, any COVID-19-related research on Blacks should take into consideration the historical, structural limitations and inequalities that will shape perceptions and decisions related to their health and care. A prime example is the ongoing discussions regarding hesitancy among the Black community in getting the COVID-19 vaccine. One cannot hear or read a news story about vaccinations and Black Americans without a mention of medical distrust and the Tuskegee syphilis study. Though Tuskegee may be on the minds of some, opinions regarding the vaccine are not really based on the study for many. Other factors rooted in personal experiences across the life course are likely more important and can vary by age cohort and other social circumstances. Moreover, life course concepts are also useful in providing the necessary tools to examine the health of adults in midlife and later adulthood.

What Research Should Focus On

At the moment, we are unsure of the lingering effects of the virus and whether those who are exhibiting COVID-19 symptoms over an extended period of time (long haulers) will continue to do so, further exacerbating health disparities in later life. The multiple intersections of age, race, gender and, in some cases, disability of older Black adults during the pandemic underscores the need to think about the data, research, and policies developed to address the health needs of the Black community. Calls for studying the manner in which both structural racism and structural gendered racism play a role in how COVID-19 is impacting specific groups within the Black community are necessary. As a whole, research on the pandemic should speak to both the health-related inequities and the intersectional complexities of everyday Black life that are often not captured in research comparing different racial/ethnic groups. ■

COVID-19 and Sociology's Mental Health Moment

Bernice A. Pescosolido, Distinguished Professor of Sociology and Founder of Indiana University's Network Science Institute, Consortium for Mental Health Services Research and Sociomedical Sciences Research Institute; Byungkyu Lee, Assistant Professor of Sociology, Department of Sociology, Indiana University

The COVID-19 pandemic death toll, while still below the number of mass casualties of the 1918 flu epidemic and the Bubonic Plague of the 14th century, has exposed what physician-anthropologist Paul Farmer famously called the “biological expression of social inequalities.” Frontline workers, including low-paid, non-medical support staff, especially those in the Global South, have been disproportionately exposed to the virus and affected. Mexico records, by far, the highest case-fatality ratio, according to [Johns Hopkins Coronavirus Resource Center](#). Many reports have tallied a larger toll among U.S. African American, Latinx, and Native American populations who are at greater risk than white Americans to contract the virus, to be hospitalized, and to die.

None of this is a surprise to sociologists. From Kai Erikson's reports of the devastation of the poorer communities in the Buffalo Creek Flood, to Eric Klinenberg's “social autopsy” of the 1995 Chicago heatwave, to the Louisiana State University and Harvard University sociologists who marked the unequal effects of Hurricanes Andrew and Katrina, and Patrick Sharkey's notion of “stuck in place,” these studies capture the greater exposure of disadvantaged groups to dangerous social conditions marked by geography, employment, and safety nets.

While the death toll represents the clearest marker of COVID-19 devastation, such health events are known to have dramatic spillover effects on society; have been implicated in political change; and widely seen as having long-term generational effects. Our work on the American heartland reveals that pandemic precarity (i.e., food, housing, and employment insecurity) disproportionately hit already vulnerable groups, deepening inequality. It is, in essence, Merton's

“Matthew effect” in retrograde, where the poor get poorer in the face of disaster, economic crises, or otherwise. Yet, considering a longer sweep of time, there are claims that such cataclysmic events may also produce unexpected and positive changes for the disadvantaged. For example, the Black Death led to a golden age of prosperity for 15th century workers.

A Mental Health Moment

It has not been obvious where the silver lining of the COVID-19 pandemic lies. For us, concerns about the ramification of lockdowns on isolation, loneliness, and, in turn, mental and physical well-being captures a sociological moment of “emotional identification” (see Andrew Abbott *Procesual Sociology*). The one winner that may emerge in this time of great loss is the grand awakening of the salience of mental health, the primacy of social life in it, and the potential to decrease the stigma of mental illness.

Is the COVID-19 pandemic a turning point? As Abbott points out, identifying turning points as they happen is unlikely. But the trajectory is clear. Even a cursory search of social media reveals that an increase in concern for mental health issues was already in progress by the early 21st century. So debates about mental health among politicians, physicians, and teachers may not be new, but an acceleration that is framed by trajectories or master narratives that are continuously in the process of making, remaking, and unmaking themselves (e.g., consider the response to school shootings).

What is novel, and perhaps part of the larger interconnection of moral judgment and values that shape events and actions, is the focus on children and on Hayward and Gorman's concern with “the long arm of childhood.” It was not that long ago that mental health professionals would not diagnose mental health problems, other than ADHD, below teenage years or that suicides in high schools were virtually



Bernice A. Pescosolido



Byungkyu Lee

unknown. That has all changed, fundamentally altering the moral judgments and values associated with mental health, a point to which we will return.

A Moment for Sociology

In understanding mental health problems, the COVID-19 pandemic's increasing pressure for physical isolation has brought to the fore the central role of social interaction in preserving health—not only in the genesis of mental health problems, but in

their redress to counter all aspects of the pandemic. In our ongoing work, we are finding some purchase in differences that target Massey's “categorical inequality.” For example, collaborating with a NORC team on its analyses of a three-wave [COVID Response Tracking Study](#) using AmeriSpeak, our preliminary work in progress reveals significant effects of age, gender, and socioeconomic status on self-reported mental health status, depression, and emotional problems throughout the course of the pandemic. However, in our Person-to-Person (P2P) Health Interview Study and COVID-19 Rapid Response Study in Indiana—where we have both pre- and during the pandemic data on mental health—few socio-demographics differentiate those with poor or good mental health.

However, our ongoing analyses with the NORC team on the three-wave [COVID Response Tracking Study](#) show that the effects of social connectedness are significant, large, and consistent. Notably, those who reported that they lack companionship and feel isolated were more likely to report worse mental health conditions as the pandemic prolonged.

While this is no surprise to sociologists, sociological research on these issues has much left on its plate. It may be obvious that “stay-at-home” orders constrain the salubrious effects of social network ties and their interactions, but we still have little idea of what kinds of social network structures, cultures, and

processes have these effects, especially when physical social interactions are discouraged. In other words, the perennial question of “What works for whom under what conditions?” plagues our precise understandings and ability to translate them into any public sociology beyond the recommendation that social networks matter.

Given the clear role that biology plays in the COVID-19 pandemic, transdisciplinary research that embeds the key role of social interaction is in its infancy. The results above do not run afoul of issues that represent the traditional concerns of psychiatry or neuroscience. In fact, the role of social connectedness apparently has its counterpart in the brain. A recent [study of teens](#) in *Biological Psychiatry* found that greater biological connectedness in the brain was associated with a lower probability of COVID-related depression and anxiety. Together, this work finds intriguing similarity with some of our earlier work on the influence of multilayered peer groups on adolescent depression using the Add Health data as well as our call for more [multilevel translational research](#).

A Sobering Note. As important as the mental health issues discussed above are, we would be remiss in not pointing out the neglect of the most vulnerable of persons on that count—those with serious mental illness (SMI). In the pandemic and in sociology, generally, the research effort devoted to those with serious mental illness pales in comparison to that targeting distress.

Psychiatrist Ben Druss, in an [early paper](#), warned that people with SMI may be among the most vulnerable and hardest hit during the pandemic. And the reports followed: Those with diagnosed mental illness, particularly those with psychotic disorders, experience a higher level of COVID-19-related morbidity and mortality. While the risk of “severe acute respiratory syndrome coronavirus 2 infection” has been implicated in the higher death rate, social factors such as barriers to care, especially in the public mental health system, and the

Continued on Page 13

Mental Health

From Page 12

smaller social networks among those with chronic mental illness are also among the forces at work.

It takes little effort to see the role of stigma, and even more directly intersectional stigma, shaping the outcomes for Daniel Prude, the 41-year-old Rochester, N.Y., man, who lost consciousness in a police encounter and died a week later. While highlighted as yet another example of racism and police behavior, Peter Early, a mental health advocate, has routinely reported that almost 25 percent of individuals killed by police have mental illness. As our ongoing research is revealing, the actual public stigma attached to COVID-19 appears to be low. The impact that other stigmas have on the mortality, morbidity, and pandemic precarity among those with mental illness has yet to be understood.

The Challenge to Sociology—Beyond Research

These concerns raise questions on what role sociology does and can play to improve mental health, prevent mental health problems, and improve the life chances of those with mental illness. The current professional and public dialogue is replete with suggestions—none of them sociological. Psychologists have done a great deal of research on meditation and its effects. Public health recommendations focus on proper nutrition, workouts, yoga, and counselling. The mental health specialties (psychiatry, psychology, nursing, and social work) support Cognitive Behavioral Therapy of one sort or another. But the essence of the sociological imagination focuses on supra-level effects on these issues to reduce poor life chance. Strategically deployed relief efforts and longer-term policy reforms are needed to challenge the perennial and unequal impact of disasters.

Is it our intellectual Achilles's heel, figuring out how to go past the identification of problems and their roots in social life, to suggest policy changes? Are there ways to map out directions for change, even if in broad strokes, that offer those who are charged with redress of

social problems novel ways to move? Taking a note from Charles Tilly and his notion of “durable inequality,” the simplest thing that we can do is to suggest that moving from individualistic solutions to organizational ones may provide the best path to enduring change.

As sociologists well know, changing “hearts and minds” is difficult, tends to happen over long periods of time, and may happen more because of cohort replacement than individuals' shifts, as Kiley and Vaisey have recently pointed out. We suggest four directions: 1) renegotiating organizational arrangements, 2) in ways that foster novel social interactions, 3) in which those affected have some ownership, and 4) which focus on the ability to shape social orientations among the young rather than trying to change attitudes, beliefs and behaviors among those who are older.

Below we describe two examples replete with sociological history, interest, and research—suicide and stigma. In regard to COVID-19, they are interesting because they are directly related to mental health and they have experienced different fortunes in contemporary sociology.

Suicide

While the study of suicide has a well-known Durkheimian pedigree in sociology, the contemporary study of completed suicide (as opposed to suicidal ideation or attempt) is close to a vacant lot. Perhaps stymied by concerns over the accuracy of suicide rate data, the methodological limitations of macrolevel census data, or the inability to collect sufficient individual or mixed-level data, new sociological findings are rare. Enter a new generation of researchers who focus on the surprising rise of suicide in young age groups and who focus on schools rather than geographical units.

These researchers also come with a different sense of the balance between the pure observer role and the responsible give back to those who let us enter their lives. For example, in the line of research by Anna Mueller and Seth Abrutyn, and more recently Sarah Diefendorf, the study of suicide clusters faces immediate requests for information and assistance. To that

end, this team has developed a set of in situ responses, including answering questions for principals, school counselors, parents, and others based on existing science and evidence. During a crisis, Mueller reviews and edits their communications to ensure that they align with known best practices. She attends parent debriefing sessions, serves as an “expert scientist” who parents can ask questions about suicide, postvention, and bereavement; and strategizes with school officials on how to best support youth after a suicide loss at a school without potentially sensationalizing or overresponding to the death, and in the current time, doing so while following COVID-19 guidelines.

The Stigma of Mental Illness

Best understood by sociologists through the pioneering work of Erving Goffman, research on the prejudice and discrimination attached to mental health problems, has had a different fate than suicide research. Seemingly always of theoretical and empirical interest to sociologists, stigma research has experienced a resurgence over the past two decades. However, like suicide, the insights of that research had little influence on change.

Specifically, it has proven very difficult to “move the needle” on stigma, and sociologists have rarely been involved in those efforts. The majority of change efforts targeted small, randomized clinical trials (RCTs) focused on improving mental health literacy. In fact, our research on public stigma revealed that slow change in Americans' discarding moral attributions of mental illness with embrace of scientific causes did not alter their willingness to interact with individuals with mental health problems. Where the RCTs were successful in recording changes in stigma, follow-up studies found that these promising changes evaporated over time. Replicated in other countries like Germany, these findings spurred some nations (e.g., Australia, UK) to develop multilevel, coordinated national efforts. While the 2016 National Academies of Sciences, Engineering and Medicine's report, *Ending Discrimination Against People with Mental and Substance Use*

Disorders: The Evidence for Stigma Change, pushed for a parallel effort in the U.S., efforts to pursue that path have failed.

Unlike the study of suicide, seasoned researchers in the U.S. have—explicitly or implicitly—also seized on the potential of educational institutions. They have used classic work on cohort replacement theory, models by a younger generation of sociological work by Stephen Vaisey and Omar Lizardo on “acquired dispositions,” and the rising concerns about mental health in schools to shift the focus to youth and to “meet students where they are.”

Sociologists Bruce Link and Jo Phelan, working with a team in Texas, developed, integrated, and assessed specific curricula materials on diversity, difference, and/or health in middle school to assist (rather than require) teachers to cover emerging issues and classroom responsibilities surrounding mental health. Given the intense pressure on high school students to “fit in” or find a place “to belong,” psychologist Stephen Hinshaw worked with interested students in a newly established extracurricular club, now in over 400 schools. Deploying an expanded club model that shifted to opportunities for professional development, advocacy, and generational leadership targeting the college campus climate and institutional social change, our research has demonstrated that campuses can become “safe and stigma-free zones” with the potential of addressing mental health issues in college.

The advantage of life course-targeted approaches is that they renegotiate the organizational arrangements in a way that does not face endless and high organizational barriers. They can also pivot to respond to mental health issues that may arise from events like the COVID-19 pandemic. They face resource and logistical issues for dissemination but, as a first step, they avoid the limited, well-meaning, and untested “business as usual” approaches of “campaigns” by a wide variety of sponsors. This approach may or may not get off the ground as national initiatives; however, they bring the insight and energy of sociologists and other social scientists to the table. ■