



The making of a population: Challenges, implications, and consequences of the quantification of social difference



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ABSTRACT

How do we make a difference? This paper traces the connections made between quantified knowledge, population health, and social justice by examining the efforts of population scientists to assess sexuality as a point of difference within population-based data systems, including on national health and social surveys, electronic medical records, and the Census. Population scientists emphasize the importance of measuring social difference in order to identify and remedy structural disadvantage. This evaluation requires the assessment of difference and the comparison of distinct groups across standardized outcome measures. In quantifying social difference, however, population scientists obscure or minimize several difficulties in creating comparable populations. I explore some of these challenges by highlighting three central tensions: the *separation* of difference from other aspects and categories of social experience, the *reduction* of difference through the use of one over several possible measures, and the *enactment* of difference as quantified knowledge loops back into society. As a theoretical inquiry into the form of social difference as it is conceptualized, operationalized, and materialized across the science-society nexus, this paper identifies the various commitments made during processes of scientific evaluation. By attending to the values and priorities that exist within and through practices of quantification, I aim to address the problem of measuring social difference as it pertains to the issues of social justice and health equity.

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1. Introduction

There has been growing attention to scholarly work on population health, including the social determinants of health (Braveman et al., 2011). One particularly successful research strategy in this line of work is the comparison of standardized outcome scores across social groups, which has drawn considerable attention to social and health disparities along the lines of race, gender, and class (Meyer et al., 2013; Williams and Sternthal, 2010). The social sciences have long identified these categories as crucial in studying social structure and its effects on individual outcomes. More recently, a fourth axis has been proposed: that of sexual orientation, such that we can now extend the triad to a quartet of gender, race, class, and sexuality. Population scientists have continued this research strategy of comparing outcomes across social groups in order to identify and address health and health care disparities along the axis of sexuality.

This paper examines the efforts of population scientists to

measure sexuality as a point of difference within population-based data systems in order to stratify health outcomes and identify disparity. The assessment of this difference, its use for group comparison against standardized metrics, and the identification of differential outcomes are argued to be crucial components in identifying the collective effects of disparity, social hardship, and structural disadvantage for sexual minorities. The measurement of this difference is thus of paramount importance for population scientists seeking to make meaningful claims of structural disadvantage. It is only once evidence of structural disadvantage is created (e.g., through the identification of poorer group health outcomes or decreased access to care) that these actors can make the case for social justice, calling for social policy reform and other initiatives specifically targeting the well-being and welfare of sexual minorities.

These efforts revolve around the translation of social difference into standard population measures for the purposes of conducting science and working towards social justice. However, despite its central role within the overall project of population health research, the nature of social difference remains undertheorized within this work. The concept of “population” serves as a flexible

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technology that can be mapped onto a set of categories used to sort people. Within comparative disparity research, “population” manages social heterogeneity through the creation of complementary homogeneities. Because the very basis of a “population” is founded on “a shared characteristic,” different people are unified and constructed through similarity at the expense of considering difference within the category. This process of creating similarity out of social difference may have unintended consequences for understandings of social differences that may undermine the pursuit of health equity in unexpected ways. This paper seeks to open the black box of quantifying social difference in order to reveal the specific commitments and decisions made within measurement practices. By drawing upon theoretical insights from across the social sciences, I identify some of the challenges, implications, and consequences of quantifying people into populations.

2. The current state of affairs

In recent years, there has been significant interest in identifying and eliminating health disparities, which refer to differences among people in terms of poor health outcomes along the lines of social difference (U.S. Department of Health and Human Services, 2011; Meyer et al., 2013). Social scientists have considered differences in various outcomes by gender, race, and class, highlighting the relational nature of social experience and access to resources (Link and Phelan, 1995; Williams and Sternthal, 2010). It is through this process of evaluation, which consists of developing categories with which to sort people, producing standardized outcomes to be assessed, and then comparing outcomes across these categories, that social scientists are able to make claims of structural disadvantage and then advocate for social change. This process of evaluation, including the sub-processes of categorization and comparison, deserves closer sociological attention and scrutiny (Lamont, 2012). Here I consider some of the difficulties in mobilizing a particular classification that sorts people into standardized populations.

The subject of lesbian, gay, bisexual, and transgender health has also drawn increasing amounts of attention over the last several years from social scientists, government officials and policymakers, and community advocates.¹ Within this growing arena, most actors have focused on the centrality of measurement for documenting disparity. The Institute of Medicine's (2011) groundbreaking report on the state of lesbian, gay, bisexual, and transgender health highlights the importance of measuring sexual orientation for comparing the various social and health outcomes of sexual minorities against those of heterosexuals. In 2011, the Agency for Healthcare Research and Quality began including information on LGBT-related health and health care within its annual National Healthcare Disparities Report. These reports, however, primarily draw upon findings from other published studies and reports because of the lack of national, population-level data. In 2014, a new goal was added to *Healthy People, 2020* to improve the health and address the disparities faced by lesbian, gay, bisexual, and transgender people compared to their heterosexual counterparts by increasing the number of population-based data systems that measure these populations. More recently, the National Institute of Health designated sexual and gender minorities as a health

disparity population for research purposes, demonstrating strong support for future population research to advance the health of all Americans, including sexual minorities (Pérez-Stable, 2016). Data collection and population health research are expected to play a key role in documenting disparity and working towards change.

Population scientists have thus called for the measurement of this difference across several distinct channels of administrative data collection, including on national health and social surveys, the Census, and electronic medical records (Cahill and Makadon, 2014; Mayer et al., 2008; Mollon, 2012). The Office of Management and Budget and the Census Bureau are currently considering the addition of questions of sexual orientation to the Census' data collection initiatives (Census Scientific Advisory Committee, 2014; Park, 2015). Aligned with these efforts, the Centers for Disease Control and Prevention added an assessment of sexual orientation to the National Health Interview Survey in 2013, thereby producing a large-scale, nationally representative dataset incorporating this difference (Dahlhamer et al., 2014). Through this measurement, final reports identify differences among various social groups as defined by sexuality in mental health outcomes, health-related behaviors such as drinking and smoking, and access to care (e.g., Ward et al., 2014). Data collection precedes the identification of disparity, social disadvantage, and poor health outcomes. Measurement of this difference is thus an issue of social, political, scientific, and national significance.

These developments concern the quantification of people across social difference into “populations.” In this paper I use the word “difference” to refer to sorting of people into social groups. As such, the use of difference in social science calls attention to classificatory distinctions made between groups of people, which are then translated into “populations” for population health research. A consideration of epidemiology, as one of the main disciplines that provides a methodological foundation for the growing field of population health, and its understanding of population is therefore useful here.

Several textbooks of epidemiology incorporate the use of population in defining the field and study. One refers to epidemiology as “the study of the occurrence and distribution of health-related events, states, and processes in specified populations, including the study of the determinants influencing such processes, and the application of this knowledge to control relevant health problems” (Porta, 2014:95; emphasis added). Aschengrau and Seage (2014) explain the connection between population and epidemiology further:

Populations are at the heart of all epidemiologic activities because epidemiologists are concerned with disease occurrence in groups of people rather than in individuals. The term *population* refers to a group of people with a common characteristic such as place of residence, gender, age, or use of certain medical services (6).

Epidemiologists construct “population” through the belief in a common, underlying characteristic unifying different people. Another textbook suggests that comparison, and thus the classification that precedes it, is central to the epidemiologic project: “Epidemiology is all about comparison – without some reference of what is usual, how can we identify excess?” (Webb et al., 2005:6). Epidemiologic comparison, as a scientific activity that involves categories and standardized metrics, involves the sorting of people into social groups and the translation of social difference into populations.

However, this process of translating social difference into populations rarely receives much attention in the everyday conduct of population science (Shim, 2014; Krieger, 2012). Who and what

¹ In this paper I focus on the assessment of sexual minority status, and for this reason I do not address the difficulties in measuring transgender people. However, the separation of sexual orientation and gender identity in population health research (and social science more broadly) is one that should also be subjected to sociological scrutiny, as this separation is a rather recent phenomenon (see Valentine, 2007; Richardson, 2007).

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