Examining Power Relations to Understand and Address Social Determinants of Vaccine Uptake

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Well before vaccines for SARS-CoV-2 were ready for distribution in the United States, distinguished advisory groups articulated principles for vaccine equity, prioritizing those facing the highest burden of COVID-19.1 Notwithstanding these efforts, serious injustice has accompanied the rollout of vaccinations for SARS-CoV-2.2 Initially, this was driven largely by structurally induced inequities in access to vaccines, something that remains a serious problem. However, now that vaccines are abundant in the United States, other equally insidious social determinants of vaccine uptake have become more prominent. We contend that some of these are rooted in longstanding power relationships and reflected in sociohistorically generated mistrust of government among disadvantaged groups.

The ways in which this influences vaccine uptake have not yet been widely recognized or articulated across groups who are relatively low in power. Instead, people who resist or delay vaccination have been labeled vaccine hesitant. This potentially problematic term, similar to the label treatment resistant in mental health, implies a need to focus on apparently maladaptive behaviors of individuals rather than on social determinants of vaccine uptake.

To illustrate, we point to structural forces faced by 2 of the many groups who experience vaccine inequality: (1) Black individuals, who continue to experience racism and its attendant socioeconomic disadvantages and (2) important subgroups of socioeconomically disadvantaged White individuals. We begin with the former, given the relatively large body of research to buttress arguments about this group. Then we turn to socioeconomically disadvantaged White individuals whose situation also requires consideration of the particular reasons why vaccination uptake is lower in this group. Because there are far more data on education and vaccination than for other dimensions of socioeconomic status (SES), we identify people as having low SES if they have a high school education or less.

In our view, the mistrust of vaccines for SARS-CoV-2 emerges largely from the enactment of power differences. In general, people advantageously located in socioeconomic and racial hierarchies are able to benefit from inequality because their relative position of power allows them to secure and accumulate opportunities such as elite educations, safe neighborhoods, or vaccinations. Thus it is power, defined as “the distribution of resources, exercise of agency, and institutionalization of social control,”3 which undergirds the repeatedly enacted structural forces that benefit or harm groups relative to others (eg, past and ongoing systemic racism, ongoing social inequalities). We propose that it is in the context of enduring power differences that a sociohistorically induced mistrust emerges. This mistrust spreads to and includes scientific and governmental actors advocating for vaccine uptake, allowing such mistrust to join access issues as another major source of vaccine inequality. However, the sources of mistrust are necessarily distinct for different groups with lower power.

Beginning with the case of Black individuals, W. E. B. Du Bois more than a century ago identified the “peculiar indifference” with which the nation viewed the health-related challenges faced by Black citizens.4 Unfortunately, the indifference remains, as attention continues to be diverted away from systemic racism in examining sources of health inequalities experienced by Black individuals. Further, these systemic harms have been compounded by racism in health care and medical experiments. Thus, it is no surprise that some Black individuals might doubt pronouncements emanating from the government and mostly White elite medical establishment concerning vaccine-related messaging.5

White individuals with low SES make up the largest proportion of the estimated 20% of the US population who do not plan to receive a COVID-19 vaccine or only will get it if required.6 Many in this group refuse to accept vaccination even when this refusal comes at the expense of some individual freedoms and undermines their communities’ health. This dynamic, in the context of their relatively privileged position in racial hierarchies, presents a puzzle requiring further understanding. In tandem with other factors including political affiliation, religion, and exposure to misinformation, we view the low vaccination rates of this group as partly reflecting an ongoing mistrust of government that has extended to medical science and is intertwined with a perception that federal institutions value other groups’ interests (eg, college-educated White individuals, individuals from minoritized racial and ethnic groups) over their own.7 8

While recognizing the heterogeneity and geographic diversity of both of our example groups, we examine prominent themes in the sociohistorical circumstances that underlie the mistrust among important subgroups of White individuals with low SES. As we see it, mistrust toward government-initiated vaccine distribution is likely related to an antagonism grounded in these groups’ paradoxical relationship with governmental and corporate entities. Rich texts describing this relationship in rural/semirural Appalachia and southwestern Louisiana detail how large extractive economic endeavors (eg, large-scale agriculture, coal mining, fracking), which are often incentivized by federal or...
state governments, are welcomed or at least tolerated because they provide jobs that enable the valued self-perception of economic independence. Yet, this is not always in these groups’ best long-term interests, as corporations’ extractive activities have harmed local agents economically (eg, threatening viability of small farms) and communities environmentally (eg, polluting water supplies). However, many government efforts to mitigate these adverse effects are deemed incompetent and inadequate. Furthermore, the perceived governmental favoritism toward individuals from minoritized ethnic and racial groups, immigrants, and other marginalized groups above White individuals with low SES poses a threat to this group’s sense of pride and perceived economic self-sufficiency, which is partly derived from occupying a perceived rightful place in US racial hierarchies. This mistrust of government and medical science, reflected in this group’s overall low vaccination rates, has subsequently reinforced negative stereotypes of some White individuals with low SES (eg, ignorant). Furthermore, we might expect those who experience stereotyping to mistrust the people who stereotype them. Tracing these and other contextual influences will more effectively ground efforts to develop effective strategies and improve vaccine rates in such communities.

Owing to Black groups’ experience of systemic harms that have undermined the trustworthiness of the primarily White medical establishment, vaccine communication efforts by Black leaders and physicians, occurring within Black communities, remain crucial to increase vaccination rates. Correspondingly, strategies to promote vaccine equality could use similar reasoning to overcome mistrust of the federal government in locales where it poses a barrier to vaccination among White individuals with low SES. Vaccination outreach will be more likely to succeed if it is perceived as being visibly owned by respected regional actors. For example, this could mean developing strong alliances with respected local and regional actors, such as pastors and community leaders who understand that vaccination is essential for the health of their communities, despite having other (eg, political, religion based) values that directly conflict with the values of most public health professionals. Thus, recognizing the underlying power relationships that shape social determinants of individuals’ “vaccine hesitancy” and undertaking the challenging but necessary work of navigating potentially conflicting values in a highly charged political context will enhance efforts to extend vaccination in these groups.

In closing, we contend that instead of blaming reluctant groups for their hesitancy, we should recognize the social roots of their reluctance to vaccinate and act appropriately based on this knowledge. This includes considering these groups’ sociohistorical contexts in conjunction with their relatively lower power, which we see as essential to formulating effective strategies. We believe this framing enables a necessary reevaluation of contextual forces that vaccination efforts should address to ensure genuine opportunities for everyone to become vaccinated.