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The Health Disparities Research Industrial Complex: Remastered

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In 2024 and beyond, *every* researcher, *every* educator and *every* conference organizer, *every* research funder, and *every* academic publisher who focuses on health disparities should be asking themselves about the value and necessity of continued research and discussions on the nature and causes of health disparities. In other words, and more acutely put, how much more can be researched and written about disparities in conditions like cancer, HIV/AIDS, drug overdose deaths, asthma, heart disease, diabetes, hypertension, stroke, and severe mental illness that has not already been researched and written, in terms of risk factors, scope, scale, or consequences?

In Walden, Thoreau writes:

> If we read of one man robbed, or murdered, or killed by accident, or one house burned, or one vessel wrecked, or one steamboat blown up, or one cow run over on the Western Railroad, or one mad dog killed, or one lot of grasshoppers in the winter - we never need read of another. One is enough. If you are acquainted with the principle, what do you care for a myriad instances and applications?

The Health Disparities Research Industrial Complex—this referring to the structured and parasitic network of actors whose interplay reifies the existence of health disparities while positioning itself as a solution to said health disparities (Ezell, 2023b)—says *the more instances and applications of the same research, the better*. Like modern commercial cinema with its endless chasm of creativity, stoked by a lack of incentive to foster, no number of reboots, remasters, and multiverses is sufficient, and the audience passively indulges the regurgitations.

Enjoying the same panoptic elements and prosocial aura as its siblings, the Military Industrial Complex and the Prison Industrial Complex, the Health Disparities Research Industrial Complex is accordingly all-seeing, ever-present, and projected as imminently necessary for the health and well-being of a society. Thus, questions about the Health Disparities Research Industrial Complex's actions or inactions, its effectiveness, or its ineffectiveness, are deemed illiberal or are simply deferred and left unproblematized; and its actors and proponents are therefore validated in their own right against the backdrop of its putative philanthropy.

Through the circular "allyship" that health disparities research promotes as a necessary condition for societal impact (Came and Griffith, 2018), health disparities researchers maintain an endless presence, establishing and occupying an endless *Health Disparities State*. Power is never decentralized or otherwise transferred from the apex of the Health Disparities State, and capacity for underrepresented populations therefore remains suspended and illusory. Like the Military State and Police State, the Health Disparities State constantly reshapes, redefines, and extends boundaries, processes, and priorities to thwart criticism and intervention against it.

In response to my original piece (Ezell, 2023b), Mrig and Spencer (2024) argue that there is a need to further ground the Health Disparities Research Industrial Complex in several additional theoretical concepts in order for it to be fully operationalized. Among these concepts is the notion of *health equity tourism* (Lett et al., 2022; Nweke et al., 2022) and its effects on the depth and quality of health disparities research. I

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submit that while health equity tourism is a key, well-documented problem that is characteristic of both the roots and spoils of the Health Disparities Research Industrial Complex, it is ultimately more of a symptom of the Health Disparities Research Industrial Complex than a cause. In other words, the health equity tourist, lacking endemic relationality and thus earnest commitment, is trapped in the *id* stage and thus does not see the disparity as it is and how it occurs and is stopped (*ego*); as a result, the reality of the disparity and its discontinuation fails to shape the health equity tourist's *superego* toward generative scholarship. And by this ceaseless and unflinching process, the health equity tourist supports the manifestation and reproduction of the health disparity in perpetuity.

The idea of health equity tourism serves as a device for understanding the processes by which the Health Disparities Research Industrial Complex presents through opportunistic individual-level action. The intermittently whimsical, naive, and cynical health equity tourist is ultimately an actor in the Health Disparities Research Industrial Complex (or more precisely, a tourist who never leaves).

A piece of the action: The indirects Ponzi scheme in health disparities research

To another key concern that Mrig and Spencer (2024) raise concerns regarding the ways that certain minority populations, namely Black individuals, submit grants to the National Institutes of Health (NIH), etc. that are topically less attractive to reviewers, this warrants further consideration as well. Multiple reports vividly illustrate that efforts to eliminate racial gaps in grant funding, for example via training, mentorship, and targeted awards, have failed (Chen et al., 2022; Lauer and Roychowdhury, 2021; Saif et al., 2022; Taffe and Gilpin, 2021; Zimmermann et al., 2022). These racial differences in funding, with or without intervention of this nature, also continue into the grant renewal/follow-up phase for those who have previously been funded (Nguyen et al., 2023). The Health Disparities Research Industrial Complex concept can aid us in elucidating how the "solutions" of the Health Disparities State foment and sustain these racialized cleavages in funding.

If underrepresented applicants are, through new initiatives and guidelines, being encouraged to submit applications that better correspond to NIH priorities and reviewer preferences (Williams et al., 2023), this begs the question of why the funding disparities continue to persist and which benefits are gained from the persistence of the funding disparities and for whom. A chief source of benefit for the Health Disparities State derives from "indirects support" that is awarded to the institution upon the investigator's awarding. Since "soft-funded" faculty and researcher positions dominate the public health sciences, from principal investigators down to research assistants, it again must be stressed that the very existence and continuation of health disparities is necessary to support research positions and to continue inflows of revenue and indirects support for the institution. Indirects, a *quid pro quo* bolstering institutions' bottom lines often to the tune of 50% or more of the direct costs of the grant (Johnston et al., 2015), are typically duly divorced from the direct and immediate purposes and needs of the primary research or the researcher, supporting instead amorphous ancillary research "infrastructure" needs amounting to slush funds. The funder, at the apex, doles out funds to the institution, which then itself becomes both the funded and funder; the Principal Investigator and their team subsequently buy-in via their labor and output of research, with Reaganomic logic that some "benefits" will eventually spill out to the research population.

The Ponzi scheme ethos of indirects invites a deeper, or at least parallel, need to consider the extent to which grant reviewer bias is less associated with the grant topic or domain (or even objective overall quality of the application) and more fundamentally linked to bias against the racial/ethnic identity of the investigator and broader institutional prerogatives around revenue sourcing. This, of course, would be more attuned to how racial bias is conventionally investigated: In short, we must consider if grant reviewers' topical preference is intertwined with and propelled by considerations of the investigator's racial/ethnic identity and/or a tacit interest in maintaining extant racial hierarchies in research that incidentally secure these broader institutional prerogatives. Relatedly, there is a need to understand whether the lack of funding is attributable to 1) a general lack of submissions from underrepresented populations, which in whatever case would be tautological, or 2) a lack of submissions in preferred/"fundable" categories from underrepresented populations, dynamics which may or may not be mutually exclusive.

We should add that the public funding agencies' solutions to the "Diversity Problem" often frequently further pigeonholes minority researchers. In particular, this is seen in the proliferation of cudgels such as so-called "diversity supplements" that are frequently nested under grants held by non-minoritized principal investigators (Travers et al., 2022). Diversity supplements likewise provide indirects support to the institution, cultivating an environment wherein the minoritized investigator simultaneously bolsters the portfolio of the Principal Investigator, pays for their own labor, and effectively launders the capital back to their institution.

To this end, diversity supplements and their offshoots cynically reinforce the Health Disparities Research Industrial Complex's relational hierarchies and the master-slave relationship that rests at its core. As major funding agencies such as the NIH, Centers for Disease Control and Prevention, National Science Foundation, and the Robert Wood Johnson Foundation shift even further in the direction of health disparities research, this entanglement will become more apparent and reach a proverbial chokepoint. And ironically, we must call attention to the deep stream of research and interventions addressing grant funding disparities for health inequities research (e.g., focusing on grant-writing workshops, workforce training, diversity supplements, etc. Given their meta and still highly secondhand nature (Boulware et al., 2022; Tilghman et al., 2021), these efforts can be said to constitute another generally vacuous and predictable permutation of the Health Disparities Research Industrial Complex.

1. The big three: Diversity vs. underrepresentedness vs. lived experience in research leadership

Mrig and Spencer (2024), like I, further cite the need for more "diverse" research leadership. However, I encourage deeper consideration of not simply the need for diversity, but for inclusion of research leaders who are diverse in terms of their (under)representativeness in the field and also diverse in terms of their *lived experience* with the research topic. Diversity, as typically articulated in the health sciences, whether in terms of scholars, research participants, or research populations, often reflects a canted view of social identities. This canted view is one that Raudenbush (2024) adopts in her critique. The dichotomy that the Health Disparities Research Industrial Complex conjures is one focused on power and control; therefore, we must think beyond binary notions of diversity to more nuanced understandings of underrepresentation and disempowerment, a reckoning that prospectively brings our attention to the notion of lived experience. A focus on engendering research leadership from individuals with lived experience will better capture the cultural climate and context of the research population than unseasoned notions of "diversity" and "minoritization" do either together or in isolation. This said, one can assume a certain degree of lived experience from individuals who are diverse in the conventional sense—namely racial/ethnic minorities, women, LGBTQ+ individuals, etc.—at least in terms of their exposure to social, political, medical, and legal disenfranchisement, and so on. Beyond this, those with lived experience are typically considered only suitable and optimized for the least powerful roles in the research hierarchiary–like being data collectors/peer interventionists–despite the exceptional, singular benefits that are derived from their performance in these roles.

In better delivering on the expectations of diversification in research leadership, stakeholders must consider (lived) experience as a function

of one's *equity clout* (Ezell, 2023a)—the authenticity, trustworthiness, and authority that the researcher presents to the target research population and community. This hypothetical research project on Black individuals who are unhoused illustrates the ways that the principle of *equity clout* manifests. In such a project, we would need to consider who might have the most equity clout in leading such a project: 1) a senior white Principal Investigator, 2) a mid-career Asian, Latinx, or Indigenous Principal Investigator, or 3) a junior Black Principal Investigator. And, alternatively, let us add "personal experience with houselessness" to some/all of these investigators' "credentials". While these are deliberately not apples-to-apples referents, assuming all are options for our chosen Principal Investigator, we might consider this to be a generally "good" problem to have. And still, the most germane question here should not be about diversity in broad strokes, but about pursuing the best tailored and most culturally salient and acute form of diversity. In brief, who will "connect" best with the research population and be best positioned to derive the richest data and most efficacious, culturally acceptable interventions?

To this end, while I echo the reservations of Mrig and Spencer (2024) on Participatory Action Research and Community-Based Participatory Research being silver-bullet solutions to the Diversity Problem, each approach starkly telegraphs how said research participants would be well-positioned to choose the research leadership—or at least contest and parry some of the extractive proclivities of the research leadership—based on their perception of the researcher's equity clout.

Importantly, like the Military Industrial Complex and Prison Industrial Complex, the individual elements, or actors, that contribute to it need not have full awareness of the existence of or actions of the other individual elements in the complex, which seems to be a point of contention for Raudenbush (2024). For example, the soldier, the actor who can be regarded as the ultimate executor of the Military Industrial Complex (rather than its author), may have very little awareness or understanding of the specific actors, institutions, and mechanisms that have cultivated his role and called him to action. The soldier is nevertheless intimately connected to them, acting as a vessel for the Military Industrial Complex's continuous execution and its most visceral impacts. The police officer's consciousness and role manifest similarly. Shee may or may not be aware of her embeddedness in the Prison Industrial Complex, or of the vast cast of actors that she serves, but she nevertheless is a direct conduit to manifestation. Likewise, the health disparities researcher need not be aware of their connection or proximity to other actors and entities in the Health Disparities Research Industrial Complex. However, the health disparities researcher's unawareness does not render them wholly innocent in the Complex's perpetuation.

Raudenbush's retort ostensibly orbits less around the question of whether the Health Disparities Research Industrial Complex materially exists, if the health disparities researcher is part of it, and if the theory is thus otherwise viable, but rather if the health disparities researcher is, in a meaningful way, culpable for either the induction of health inequities or the continuation of health inequities. In short, comments from Raudenbush (2024) compel us to consider where—if anywhere—along the continuum of a health phenomenon's manifestation at the population-level does the health disparities researcher's most central influence emerge. I argue that the health disparities researcher is acutely implicated along the entire continuum, though at different angles: They are *indirectly* responsible for the induction of health disparities and *directly* responsible for their persistence.

I now clarify the 'dubious virtuous cycle' that Raudenbush believes that I have insufficiently operationalized, noting that it is refracted in three ways: 1) the 'virtuous' component refers to how the Health Disparities Research Industrial Complex's actors benefit from the cycle; 2) the 'cycle' refers to the dyadic and interactive ways in which intrinsic and extrinsic benefits, such as salary, benefits, indirects, social stature, and so forth, are developed, accrued, and then (re)distributed among all actors involved in the Health Disparities Research Industrial Complex, from senior researchers down to students and publishers, thus galvanizing one another; and 3) the 'dubious' element describes researchers' explicit awareness of the largely non-generative nature of their research and the associated benefits/advantages of this ongoing non-generativeness and the de facto impermeability of the health disparities research field. However, again, actors in a complex may not be aware of the extent of their presence or role in the complex, and to Raundenbush's salient point, they may not deem their purpose to produce generative, policy-informed scholarship. In complexes, there may be no satisfactory answer to the question of the individual actors' intentions or awareness, but interrogation reveals the steep consequences of their presence in the complex and deep malaise about the implications.

While I concur with Raudenbush's contention that the benefits and advantages afforded to scholars in public health (e.g., to gain scientific knowledge, a salary, praise from others, etc.) are not singular nor exclusive to public health, the volume and extent of these benefits and advantages in the field of public health are indisputable and unparalleled in the academy. These connections directly correspond to the financial interests of the state. For comparison's sake, consider the United States' investment and expenditures in healthcare, a considerable portion of which are connected to addressing (or at least evaluating and triaging) minority health outcomes (Dieleman et al., 2021), versus the nation's considerably lower investments and expenditures for arts/culture and technology, which we will consider as rough proxies for the humanities and technoscience fields, respectively. Healthcare is 17.3% of the United States' gross domestic product, versus 9.3% for technology, and 4.4% for arts/culture (Gross Domestic Product, 2023). Moreover, neither arts/culture nor technology have a manifestly public service-oriented ethos, unlike health disparities research, the military, and law enforcement, and thus do not haveentrenched, non-generative complexes. Accordingly, there is simply no disciplinary comparison for the stature, reach, and culpability of the public health field.

2. Undemocratic and unimpeachable: Public health's culpability problem

For several reasons, the impermeability of the Health Disparities Research Industrial Complex is even denser than that of the Military Industrial Complex and Prison Industrial Complex. Consider the hypothetical case of the spread of illicitly manufactured fentanyl, an opioid, in a medium-sized urban community. Its sheriff can be terminated for their department's failure to prevent the introduction of fentanyl to the community, to disrupt the dealing of the fentanyl in the community, and/or to efficiently respond to 911 overdose calls involving fentanyl. Its district attorney can likewise be recalled for their lack of policy know-how in marshaling effective preventive and mitigative resources for the fentanyl-related overdoses and/or in prosecuting offenders. Its health chief or commissioner, in contrast, would rarely be considered responsible for the fentanyl outbreak, despite their centrality in epidemiologic surveillance, capacity for public communication on its communal spread, risks of usage, role in resource deployment (e.g., naloxone, fentanyl test strips), etc. Even during COVID-19, the largest public health emergency of our time, public health officials, when they were felled, were typically causalities of burnout born from the sheer scale of the pandemic and in particular the politicization of mitigation policies (Stone et al., 2021)—not, per se, for their failures to contain the pandemic.

Public health seeks to have it both ways—to be both deeply responsive to and not liable for public health, a confused binary which Raudenbush (2024) doubles down on in her claim that there is an overstating of 'the capacity for researchers to, by themselves, enact social change and improve health disparities.' It is, however, not the researcher alone who is responsible for social change, whether it be via informing policy or otherwise, nor is it only their role as the presumptive social change agent, that is being exclusively scrutinized—it is (also)

their galvanizing role as tireless evangelists for the field of health disparities research, the cult of personality then assigned to the health disparities researcher, that implicates them in the dubious virtuous cycle.

Furthermore, in view of the critique that public health should not be deeply oriented toward generative, translatable, policy-driven work, consider the mission and vision statement for any given school of public health to get a sense of what we can then only regard as more deeply mixed, habituated messages on purpose and impact. The Harvard University T.H. Chan School of Public Health, on its website, notes that it works "to improve health and promote equity so all people can thrive," while my employer, the University of California Berkeley School Public Health, says it "innovate[s] solutions to the most pressing public health threats of our time." The Johns Hopkins Bloomberg School of Public Health even more bombastically says its coterie is "… protecting health and saving lives—millions at a time." These statements, far from passive or even aspirational, are stated both as mandates and realities. Each university also actively trumpets their number of active grants or research funds on their websites, to further burnish and validate their images as indispensable executors with expertise, largesse, and equity clout.

Along these lines, one would be hard-pressed to find a school of public health, health department, or other entity with substantial numbers of disparities researchers not parroting these sentiments. Health disparities researchers can either purport to intimately support, address, and "protect" public health through research and intervention or go the way of humanities and instead argue that their labor is (chiefly) in the interest of expanding knowledge and culture, which Raudenbush passively leans into (Reitter and Wellmon, 2023). However, they cannot do both—and, if they choose the latter messaging in focusing on knowledge and culture expansion, a reduction in financial and material support for our polyamorous health disparities research and curbing of its exotification is demanded.

As it stands, public health officials and health disparities researchers appear content to occupy the curious position as both academia's capable, all-knowing Wizard of Oz and the frail, insecure actuary he is eventually revealed to be. To this end, Raudenbush's critique summons consideration of the intertwined notions of researcher agency, autonomy, and capacity. In addition to the self-interest of health disparities researchers that I position as a contributor, Raudenbush highlights 'a lack of incentives in academic institutions for researchers to disseminate their research to policymakers and differences in academic and policy-making cultures.' Again, Raudenbush is intimating a kind of precocity and undesired inertia on the researcher that is inconsistent with their professed intellectual maturity and capacity, respectively. While it is true that institutions do not formally incentivize policy-informed work or dissemination, which I framed as indefensible, the health disparities researcher willingly enters the field without any pretense of the need to cultivate research that has an meaningful likelihood of impact in order to maintain employment. And when health disparities researchers *are* elevated to the highest rungs of academic institutions (or those of funding agencies, as part of public health's insidious revolving door culture) we must ask why do they not then institute such standards that would create an incentive-driven culture? After all, academic department and funding agency leadership were likely once active, untenured researchers scrambling for grants.

3. Searching for public health's central tower watchman

As the adage goes, no single raindrop believes itself responsible for the flood. The Health Disparities Research Industrial Complex theory is *not* an invitation to entirely dismiss the notion of structural causes or fundamental causes. Rather, it is an invitation to begin to earnestly and thoughtfully connect the paradigms of "structural causes" and "fundamental causes" to individual actions (i.e., to that of specific researchers, instructors, etc.). Raudenbush argues that my occasional focus on individual actions is counter to this proposition. Nonetheless, I would argue that the field of public health's obsession with the amorphous notions of "structures" and "systems" assigns blame and responsibility without actually pinning blame and responsibility on a tangible target. It recalls Bonilla-Silva's idea of "racism without racists" (Bonilla-Silva, 2006). Foucault, for all his abstractions, at least pinned totalitarianism on the central tower watchman.

As Bonilla-Silva explains, amorphous foci on structures and systems center our adverse social, economic, and political conditions as deriving from institutions themselves as opposed to specific individuals within the institutions.Interventions must intervene on the individuals *within* structures and systems, increasingly byzantine and fruitless metaphors, not on the structures and systems themselves. It is most beneficial to the Health Disparities Research Industrial Complex to indiscriminately cast blame on "structures" and "systems" for the induction and persistence of health disparities, rather than to cast a more tactile blame on the Surgeon's General, the Health Commissioner, the Chief of Internal Medicine, the Chair of Epidemiology, etc.

Concerning Raudenbush's critique of the Prison Industrial Complex analogy, removing the policymaker who creates the biased, regressive civic law on jailable behavior, the judge who upholds the law, and the police chief who enforces it is, in principle, the surest path to concomitant reductions in incarceration. Raudenbush argues that increasing incarceration is 'not because of an increase in criminal behavior, but because of changes in policy.' There is some fidelity to this statement; nevertheless, incarceration in the United States has not increased in recent years, much of this indeed attributable to policy-related changes in probation. From 2011 to 2021, the U.S. correctional population declined 22% (U.S. Correctional Population Continued to Decline in 2021, 2023). As/if crime declines, it follows that the roles that are used to support the Prison Industrial Complex will be eradicated. Whether this happens or not, to the scenario posed by Raudenbush, this broader logic would seem to confirm rather than reject the central thesis of the Health Disparities Research Industrial Complex. Irrespective of the causes of a presumptive decline in health disparities, whether due to some critical diminution of macro or micro-level risk factors, as health disparities decline, so too will the roles that are used to support research on them, and this is the chief threat to the Health Disparities Research Industrial Complex.

4. Health disparities chasers

The legal profession, for all of its follies, has a sense of humor about them. In the legal profession, they describe lawyers who have a propensity for accumulating clients based on the former's proximity and readiness as "ambulance chasers." The health disparities researcher is also an ambulance chaser, but their target is a new *Requestfor Application,* a new call for a health disparities article for a special issues in a journal, and the fresh release of updated secondary datasets like the National Health and Nutrition Examination Survey and Behavioral Risk Factor Surveillance System—all drops waited on with bated breath that further accumulate capacity for health equity tourism and in turn further nourish the Health Disparities State.

We do not blame the ambulance chaser for the accident, but rather for the grim nature of their deed, their greed, and their unscrupulousness, which we also stereotype as common traits of lawyers. Likewise, we can blame the health disparities researcher, the 'disparities chaser,' not for the "accident" that is health disparities, but for 1) their opportunism in the face of grave disparity; 2) the lack of intentionality that drives their scholarship; 3) their salami-slicing, theme-cascading, and slavish devotion to decontexualized secondary and "big" data; and 4) the resultant imbalance in benefits to the researcher relative to the research participant and the target population that the participant represents. It is possible that the ambulance-chasing lawyer fails to recognize their deeds as either greedy or unscrupulous. The client may even value the work of the lawyer. Nevertheless, each is locked in a relationship of toxic

trade-offs that ultimately has the most net benefits for the lawyer who is compensated regardless of outcome, crystallized as a compassionate steward and potential asset in such situations.

Health disparities research should not be driven by endless rounds of one-upmanship in aimless empirical experimentation and what increasingly amounts to a methodological kink, where the pioneering of new statistical models in and of itself justifies the resurrection and reanimation of research aims past and settled theory. It is true, as Raudenbush points out, that several dozens of iterations of research on sequelae from Hurricane Katrina—which I used as a case of theme-cascading run amok—*may* at some theoretical point have some applied value (e.g., in preparation for or response to a future hurricane). Nevertheless, the mere possibility of value and future application does not substantiate the grievous and frivolous sprawl of this research canon. For more timely examples, one need only look at the hodgepodge of articles written on COVID-19, or on the opioid epidemic, where one can find seemingly every nook and cranny of prevalence, incidence, prevention, and management science on each respective topic and research population (seemingly) thoroughly exploited and nary a conduit for policy or intervention in sight.

Police and military officials and their boosters likewise find ways to endlessly support the hiring of new personnel, budget lines for promotions, and the purchase of new offensive and defensive weapons-often under highly hypothetical and indeed improbable situations—through far-fetched, rhetorical what-if-isms (Robinson, 2019). In the last decade, for example, as an especially potent canard, local police forces have defiantly justified their investments in military-grade equipment, including tactical armored vehicles, submachine weapons, and tactical drones (Balko, 2021) for *potential* large-scale civilian unrest and terrorism. The military has also deeply invested in increasingly complex battlefield weapons and armament systems, including those undergirded by novel artificial intelligence-driven platforms and nanotechnology, for evermore automated, efficient, and lethal warfare (Calcara, 2022).

In the 1980s, President Ronald Reagan famously proposed the Strategic Defense Initiative as a way of deterring and protecting against nuclear threats from the then-already deeply decaying Soviet Union. Derided by the media as Reagan's "Star Wars," the plan called for the military to launch X-ray-like lasers into space as a form of defense (Fitzgerald, 2001). Reagan's vision was rejected by his cabinet, derided by members of his own Republican party, and eventually scrapped by President Bill Clinton in 1993. The what-if cudgel that existed here is of the same variety as the one used to justify endless extensions of health disparities research. These fear-driven, reactive mentalities underlying "just in case research" will invariably fall short of the aim of crystalizing priorities in the public health field, instead sowing further confusion and space for the manipulation and exploitation of populations experiencing real rather than hypothetical disparities.

In closing, the allure of the Health Disparities Research Industrial Complex is not its effectiveness; it is the naked perception of utter effectiveness and necessity. And it is this perception, a false but carefully curated projection of effectiveness and necessity, which is most pernicious. The Complex's delicately manicured and maintained stature serves to dissuade interrogation into and disinvestment in its myriad ineffective and typically redundant solutions. In short, to the public health professional, the Complex's deliverables do not need to be statistically or even "clinically" significant. They just need to have a modicum of surface validity and appear better than the null hypothesis.

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Jerel M. Ezell: Conceptualization, Writing – original draft, Writing – review & editing.

Declaration of competing interest

The author has no conflicts of interest, financial or otherwise, to report.

Data availability

No data was used for the research described in the article.

References

Balko, R., 2021. Rise of the Warrior Cop: the Militarization of America's Police Forces. PublicAffairs.
Bonilla-Silva, E., 2006. Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States. Rowman & Littlefield Publishers.
Boulware, L.E., Corbie, G., Aguilar-Gaxiola, S., Wilkins, C.H., Ruiz, R., Vitale, A., Egede, L.E., 2022. Combating structural inequities—diversity, equity, and inclusion in clinical and translational research. N. Engl. J. Med. 386 (3), 201–203.
Calcara, A., 2022. Contractors or robots? Future warfare between privatization and automation. Small Wars Insur. 33 (1–2), 250–271.
Came, H., Griffith, D., 2018. Tackling racism as a "wicked" public health problem: enabling allies in anti-racism praxis. Soc. Sci. Med. 199, 181–188.
Chen, C.Y., Kahanamoku, S.S., Tripati, A., Alegado, R.A., Morris, V.R., Andrade, K., Hosbey, J., 2022. Systemic racial disparities in funding rates at the National Science Foundation. Elife 11, e83071.
Dieleman, J.L., Chen, C., Crosby, S.W., Liu, A., McCracken, D., Pollock, I.A., Sahu, M., Tsakalos, G., Dwyer-Lindgren, L., Haakenstad, A., 2021. US health care spending by race and ethnicity, 2002-2016. JAMA 326 (7), 649–659.
Ezell, J.M., 2023a. Moving health policy research toward A community-engaged research standard. Health Affairs Forefront.
Ezell, J.M., 2023b. The health disparities research industrial complex. Soc. Sci. Med. 116251 https://doi.org/10.1016/j.socscimed.2023.116251.
Fitzgerald, F., 2001. Way Out There in the Blue: Reagan, Star Wars and the End of the Cold War. Simon and Schuster.
Gross Domestic Product, 2023. United States Bureau of Economic Analysis. https://www.bea.gov/data/gdp/gross-domestic-product.
Johnston, S.C., Desmond-Hellmann, S., Hauser, S., Vermillion, E., Mia, N., 2015. Predictors of negotiated NIH indirect rates at US institutions. PLoS One 10 (3), e0121273.
Lauer, M.S., Roychowdhury, D., 2021. Inequalities in the distribution of National Institutes of Health research project grant funding. Elife 10, e71712.
Lett, E., Adekunle, D., McMurray, P., Asabor, E.N., Irie, W., Simon, M.A., Hardeman, R., McLemore, M.R., 2022. Health equity tourism: ravaging the justice landscape. J. Med. Syst. 46 (3), 17.
Nguyen, M., Chaudhry, S.I., Desai, M.M., Dzirasa, K., Cavazos, J.E., Boatright, D., 2023. Gender, racial, and ethnic and inequities in receipt of multiple national institutes of health research project grants. JAMA Netw. Open 6 (2).
Nweke, N., Isom, J., Fashaw-Walters, S., 2022. Health equity tourism: reckoning with medical mistrust. J. Med. Syst. 46 (5), 27.
Reitter, P., Wellmon, C., 2023. Permanent Crisis: the Humanities in a Disenchanted Age. University of Chicago Press.
Robinson, W.I., 2019. Accumulation crisis and global police state. Crit. Sociol. 45 (6), 845–858.
Saif, A., Demblowski, L.A., Blakely, A.M., Zeiger, M.A., 2022. Current status of National Institutes of Health research funding for women surgeon-scientists. JAMA Surgery 157 (12), 1134–1140.
Stone, K.W., Kintziger, K.W., Jagger, M.A., Horney, J.A., 2021. Public health workforce burnout in the COVID-19 response in the US. Int. J. Environ. Res. Publ. Health 18 (8), 4369.
Taffe, M.A., Gilpin, N.W., 2021. Racial inequity in grant funding from the US national institutes of health. Elife 10, e65697.
Tilghman, S., Alberts, B., Colón-Ramos, D., Dzirasa, K., Kimble, J., Varmus, H., 2021. Concrete steps to diversify the scientific workforce. Science 372 (6538), 133–135.
Travers, J.L., David, D., Weir, M., Clark-Cutaia, M.N., Enwerem, N., Okunji, P.O., Schulman-Green, D., 2022. Demystifying the National Institutes of Health diversity supplement: mentee and mentor experiences and recommendations. Nurs. Outlook 70 (6), 856–865.
U.S. Correctional Population Continued to Decline in 2021, 2023. United States Department of Justice. https://www.ojp.gov/files/archives/pressreleases/2023/us-correctional-population-continued-decline-2021.
Williams, J.S., Walker, R.J., Burgess, K.M., Shay, L.A., Schmidt, S., Tsevat, J., Campbell, J.A., Dawson, A.Z., Ozieh, M.N., Phillips, S.A., 2023. Mentoring strategies to support diversity in research-focused junior faculty: a scoping review. Journal of Clinical and Translational Science 7 (1), e21.
Zimmermann, A., Klavans, R., Offhaus, H.M., Grieb, T.A., Smith, C., 2022. Award rate inequities in biomedical research. PLoS One 17 (7), e0270612.