Chapter **2** Problems of Health and Health Care

Rafael Ben-Ari/Alamy Stock Photo

Learning Objectives

2.1 Describe health care as a global social problem.
2.2 Identify the scope of health care problems in America.
2.3 Discuss Americans' unequal access to health care.
2.4 Review the reasons for the high costs of health care.
2.5 Summarize the ethical issues surrounding health care.
2.6 Classify explanations for health care problems.
2.7 Identify key issues in social policy, including the Affordable Care Act.

My son Marcus was complaining about a stomachache, and I just didn't take it very seriously. He's seventeen, and I figured he could just deal with it. But when he started to cry, I knew something was up. I can't remember when it was the last time he cried over pain—maybe when he broke his arm in fifth grade? But, a stomachache? I don't have any insurance so

what am I supposed to do? I didn't want to pay for an emergency room visit over just a stomachache. I figured it would go away as they usually do. But as the night went on, I could tell that something was really wrong. He was rolling on the floor in pain, and at one point he seemed to be even losing consciousness. This had to be far more than just a stomachache, so I ended up taking him to the emergency room. It's a good thing I did because after they examined him they told me that his appendix had burst. Poisons were spewing through his body. The doctor told me that if I had waited much longer Marcus could have died. I feel horrible—risking my only son's life because I don't have any money to pay the bill. I know it sounds crazy, but I just didn't know what to do. I don't have any insurance.

Over the past few years, Americans and observers around the world witnessed the implementation of historic legislation to reform the health care system in the United States. After decades of mounting health care costs and increases in the number of people without access to health care, the U.S. Congress passed a compromise reform plan, the Patient Protection and Affordable Care Act (ACA), that promised to add at least 32 million people to those with health care insurance, people like Marcus who have often suffered without it. After a period of intense campaigning by President Obama and his supporters, and equally intense campaigning by ACA opponents, a bitterly divided Congress finally passed the historic health care reform bill in 2010 to be implemented over the next several years. Few legislators or American voters were entirely pleased with the reforms, but the bill culminated many decades of effort to bring the U.S. health care system closer to those of other developed nations to which we often compare ourselves. However, in 2018, under the administration of President Trump, much of the "meat" of the ACA has been stripped away, and the number of people without health insurance is expected to skyrocket. We will examine this issue later in this chapter. But first, let's introduce the various ways in which health and inequalities of access to adequate health care are serious social problems on a global as well as national level.

Health Care as a Global Social Problem

2.1 Describe health care as a global social problem.

The lack of adequate health measures presents a variety of social problems everywhere. In affluent regions like Western Europe, North America, and Australia, problems associated with physical health often involve reducing unequal access to high-quality health care while controlling health care costs. In impoverished regions where high-quality medical care is often lacking, social problems associated with physical health are even more profound: the spread of infectious diseases, high rates of infant and maternal death, low life expectancy, scarcity of medical personnel and equipment, and inadequate sewage and water systems.

It is true that in the past half-century life expectancy has increased in most regions of the world. These improvements often reflect better water and sewage systems and adequate child vaccination programs. But recent reviews of the global health situation indicate that continued improvements in public health systems and in delivery of medical services will be necessary, especially in poor regions, if these gains are to continue (**United Nations Development Programme, 2018**).

The United Nations rates nations based on a series of indicators of health, education, equality of political participation, and many other factors. The nations are then grouped into high, medium, and low levels of human development for purposes of comparison. The numbers in **Table 2–1** indicate how much or how little improvement various nations have made in two key health indicators: **life expectancy**, which is defined as how long a person can expect to live and is usually calculated at birth, and **infant mortality**, which is the number of deaths in a child's first year of life, for every 1,000 live births (**Population Reference Bureau, 2018**).

Table 2–1

Health Indicators for Selected Nations, 1970–2017

	Female Life Expectancy at Birth (years)		Infant Mortality Rate (per 1,000 live births)	
	1970	2017	1970	2017
Highly developed (1st world)				

United States	75	81	20	6
Sweden	77	84	11	3
Argentina	70	80	59	10
Costa Rica	68	83	58	8
Less developed (2nd world)				
Hungary	72	79	36	4
Mexico	64	79	79	18
China	61	78	85	10
India	47	70	130	37
Developing (3rd world)				
Nepal	41	71	156	32
Nigeria	42	54	120	69
Sierra Leone	35	52	206	92

Sources: Population Reference Bureau. 2018. "2017 World Population Data Sheet With Focus on Youth." Retrieved 2 April 2018 (www.prb.org/2017-world-population-data-sheet/).; World Bank. 2018. "Life Expectancy at Birth, Female (Years)/Data." Retrieved 2 April 2018 (data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?end=2015%26start=1970).

Slide Show

Health Care Needs in Less Developed Countries

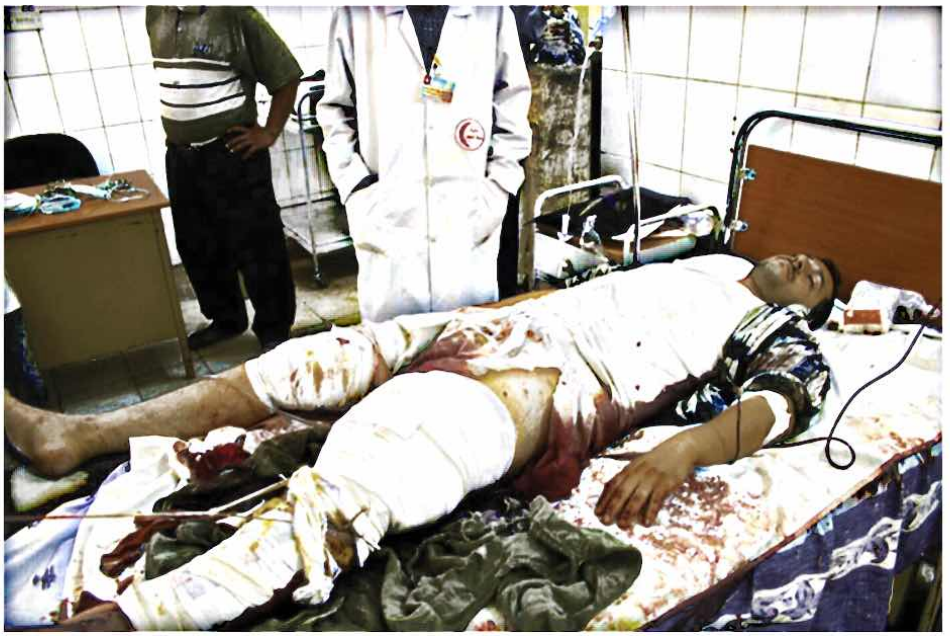
Less developed countries face considerably different health issues, or face health issues on a significantly different scale than what is found in more developed nations. People in less developed countries fight for basic survival daily: access to

food, clean water, and shelter. These pictures reveal some of the many issues faced by people in developing countries.

This woman from rural Ghana, Africa, is 38 years old. Her life has been hard, and she has faced a number of health issues. She bore six children, only four of whom lived past the age of ten, and she had no prenatal care during her pregnancies. She has rarely been to a doctor and has never been to a dentist.
Michele Burgess/Alamy Stock Photo

This little girl of 16 months cries while she is measured for signs of malnutrition. Regular natural disasters in the Philippines, an overreliance on rice, and a lack of breastfeeding have left Filipino children some of the most malnourished in Asia. Over 7 percent of children in the Philippines suffer from acute malnourishment. *Jeoffrey Maitem/Getty Images*

Sanitation standards are not the same throughout the world. This dirty squat toilet represents facilities available in many countries, and there are others in the world who would consider themselves lucky to have even this.
fine art/Alamy Stock Photo



A wounded man lies in a hospital bed in Baghdad after a night of fighting, the victim of a bomb. The ongoing violence has left two of his cousins dead and several others wounded. Many developing nations are engaged in violence that kills, maims, and terrifies men, women, and children.
QASSEM ZEIN/Stringer

This woman travels miles to collect water from this canal that she uses for drinking, cooking, and bathing. Access to clean drinking water is a serious social problem, and viruses and worms contained in dirty water kill millions of people every year.

Critical Thinking

What is the United States' responsibility to assist people in developing countries with the health crises they face? Should we be providing more aid? How will we ensure that aid gets to the people who really need it? Or should Americans focus on problems in our own country and let other countries take care of their own problems?

life expectancy
How long a person can expect to live, it is usually calculated at birth.

infant mortality
The number of deaths of children in their first year of life, for every 1,000 live births.

Life expectancy is highly correlated with a society's quality of health care. As a population's health improves because of better medical care and improved living conditions, the average age to which its members live (i.e., the life expectancy of the population) rises dramatically. For example, **Table 2–1** indicates that a person born in Sierra Leone in 2017 (the most recent year for which international comparisons are available) can expect to live only about 52 years; in contrast, a person born in the United States in 2017 can expect to live about 81 years. Differences in life expectancy between developed (sometimes referred to as "industrialized") and less developed (sometimes referred to as "nonindustrialized") nations are largely due to the increasing chance that people in developed nations will survive the childhood diseases and parasites that cause such high death rates in less developed nations.

What Do You Think?

Realistically, what can be done about global health disparities? And if help is possible, why hasn't it been provided, or has it?

Table 2–1 also shows the wide gap between these countries in infant mortality rates, the most important comparative indicator

of health. In Sierra Leone, the infant mortality rate is 92 per 1,000 live births, almost three times the rate in Nepal, 15 times the rate in the United States, and 30 times the rate in Sweden.

Infant mortality rates and life expectancy are highly correlated with the number of health care professionals in a society, which serves as a measure of the quality of the health care available to its members. However, other factors besides the availability of health care professionals may affect a population's health. In the world's poorest regions, malnutrition, a decline in breastfeeding, and inadequate sanitation and health facilities are associated with high mortality. Poor maternal health and lack of prenatal care contribute even more to persistently high rates of infant mortality and other poor birth outcomes. The feature box **A Global View: "Fistulas"** explains how obstructed labor can not only lead to infant death but also leave the woman with a hole between her vagina and bladder (or rectum), otherwise known as a fistula (**The Fistula Foundation, 2018**; **World Health Organization, January, 2018a**).

A GLOBAL VIEW

Fistulas

Celia Mannings/Alamy Stock Photo

Beza was a small Ethiopian girl of 15 when she married her husband. She had seen him only once before her wedding day, but they had never spoken to one another. Her father told her he was a good man, and so she quit school to become his wife. Five months later Beza was pregnant and she felt a combination of excitement and dread. She didn't see a doctor during her pregnancy because she had no money and the doctor was too far away. When labor began, she lay on the floor of the hut, but the pain was more than she could bear. Labor lasted for three days, but the baby wouldn't come. Finally, on the fourth day, with the help of a neighbor woman, the baby was delivered, but he was dead. As she healed from this trauma she noticed that she was leaking urine and had no ability to control it. Unknown to her at the time, the obstructed labor tore a hole in the tissue between her vagina and bladder. The smell was foul, and she was self-conscious about wetting herself. Her husband wanted nothing more to do with her—she killed his baby, as he saw it, and God was now punishing her—and

> he kicked her out of their home. She went back to live with her parents, but they too felt shame, so they built a hut for her in the back of their house where she could live, alone.

A story like this one plays out at least 100,000 times every year. Beza suffers from a fistula, a hole between her vagina and bladder caused by the many days of obstructed labor when the pressure of the baby's head against her pelvis cut off blood supply to delicate tissues in the region. The dead tissue falls away, and Beza is left with a hole between her vagina and her bladder. Some women also have a hole between their vagina and rectum as well. This hole results in permanent incontinence of urine and/or feces. The World Health Organization estimates that approximately 2 million women have untreated fistulas.

Fistulas are most prevalent in sub-Saharan Africa and Asia. They once were present in the United States but were largely eliminated in the latter nineteenth century with improved obstetric care and the use of C-sections to relieve obstructed labor. Yet, nearly half of women in developing countries give birth without any trained personnel, and when complications arise no one is available to assist the woman, leading to injuries such as fistula. Hospitals and personnel who can help them are often hundreds of miles away, and poor roads or a lack of transportation make travel difficult or impossible.

The majority of women who develop fistulas, like Beza, are abandoned by their husbands and ostracized by their communities because of their incontinence and foul smell. They fear going out in public because of the chronic leaking and smell.

The cause of fistulas may be obstructed labor, but the root causes are crushing poverty and the low status of girls and women. In developing nations, poverty and malnutrition stunt growth; a girl's skeleton, including her pelvis, does not fully mature. This stunted condition can contribute to obstructed labor, and therefore a fistula. Couple this condition with very early marriage and childbearing, and we can see why fistulas are an epidemic in the developing world. Very little money is spent on women's reproductive health care; women's needs are low priority.

Yet, fistulas can be treated. A fistula can be easily closed with

surgery, and the patient has a good chance of returning to a normal life with full control of her bodily functions. The cost of the surgery is about US$450, which includes the operation, high-quality postoperative care, and even a new dress and bus fare home. The Addis Ababa Fistula Hospital in Ethiopia has treated more than 20,000 women over the past several decades. Their cure rate is over 90 percent.

As for prevention, ready access to emergency obstetric care such as a Caesarean section when complications arise could easily eliminate fistulas, as would delaying the age of first pregnancy. The bottom line for prevention is placing a greater value on women's lives.

Sources: Adapted from ***The Fistula Foundation, 2018; World Health Organization, January, 2018****.*

Critical Thinking

Why do you think that so little attention has been given to this issue? Is the silence related to culture, shame, patriarchy, economics, or other factors? How are these factors sociological issues? Pretend you have unlimited resources and are asked by the World Health Organization to develop a program to curb, treat, and/or eliminate fistulas. What would your program look like? Be sure to address the root cause.

The Scope of Health Care Problems in America

2.2 Identify the scope of health care problems in America.

Although the health of Americans is vastly superior to most developing nations, it is relatively poor as compared to peer developed nations, such as Canada or countries in Western Europe. A primary reason our country's health registers so badly is that our low-income and minority populations have such poor health. Our comparatively poor health in the United States is due largely to two social conditions: (1) growing inequality and (2) lifestyle problems. Poverty and inequality are associated with lack of health insurance and lack of access to high-quality medical care. Problems in the way we live include sedentary occupations; fattening, nonnutritious foods; and lack of proper exercise, all of which contribute to the high incidence of obesity, heart disease, and other ailments. Environmental pollution and cigarette smoking contribute to the high incidence of respiratory disease and cancer. There can be little doubt, however, that many of our health problems are aggravated by the kind of medical care that is—or is not—available.

Medical sociology is the subfield of sociology that specializes in research on the health care system and its impact on the public, especially access to health care (**Weiss and Lonnquist, 2015**; **Weitz, 2017**) and the evolution of health care institutions (**Starr, 2010**). In describing problems of physical health, sociologists are particularly interested in understanding how a person's social class (as measured by income, education, and occupation) influences his or her access to medical care and its outcome. Sociologists also work with economists and health care planners in assessing the costs of different types of health care delivery systems.

medical sociology
The subfield of sociology that specializes in research on the health care system and its impact on the public, especially access to health care.

Medical sociologists often point out that health care institutions themselves are the source of many problems we associate with health in the United States. They emphasize that the health care system has evolved in such a way that doctors maintain private practices while society supports the hospitals and insurance systems that allow doctors to function (**Weitz, 2017**). In other words, American health care never developed as a purely competitive industry or a regulated public service. Instead, as we will see shortly, it became a complex institution comprising many private and public organizations.

As great strides were made in the ability to treat illnesses—especially with antibiotics—and to prevent those illnesses through improved public health practices, some doctors began to develop narrow specialties and to refer patients to hospitals with special facilities. This practice created a situation in which specialized doctors and hospital personnel became highly interdependent, and family doctors and preventive medical practices suffered in comparison (**Starr, 2010**). All efforts to change our health care system, to make it less costly, more efficient, or more humane, must deal with the power of insurance companies, doctors, and other health care providers, power that derives not from their wealth or their ownership of health care facilities but from their mode of relating to one another and to the public. This power is a subject that will become clear after discussing some of the specific problems of American health care.

The range of situations in which health care can be viewed as a social problem is extremely wide. At the micro, or individual, level, where family and friends are affected, such problems comprise issues such as whether the correct medical treatment is being applied, whether an elderly parent should be placed in a nursing home, or whether life support should be terminated. But as the sociological imagination reveals, people's experiences are influenced by larger forces that act throughout society and touch the lives of millions. These forces are the structural problems of health care. At the personal level, individuals may worry about care for elderly loved ones, but at the structural level the issue is how effectively health care is distributed among all people (including the elderly and the poor) and what can be done to improve the delivery of needed medical services.

This section explores several aspects of American health care that contribute to social problems at both the personal and structural

levels. Unequal access to health services, the high cost of health care, and our own behaviors and use of technology are among the problems that must be addressed if more Americans are to receive more and better health care.

Unequal Access to Health Care

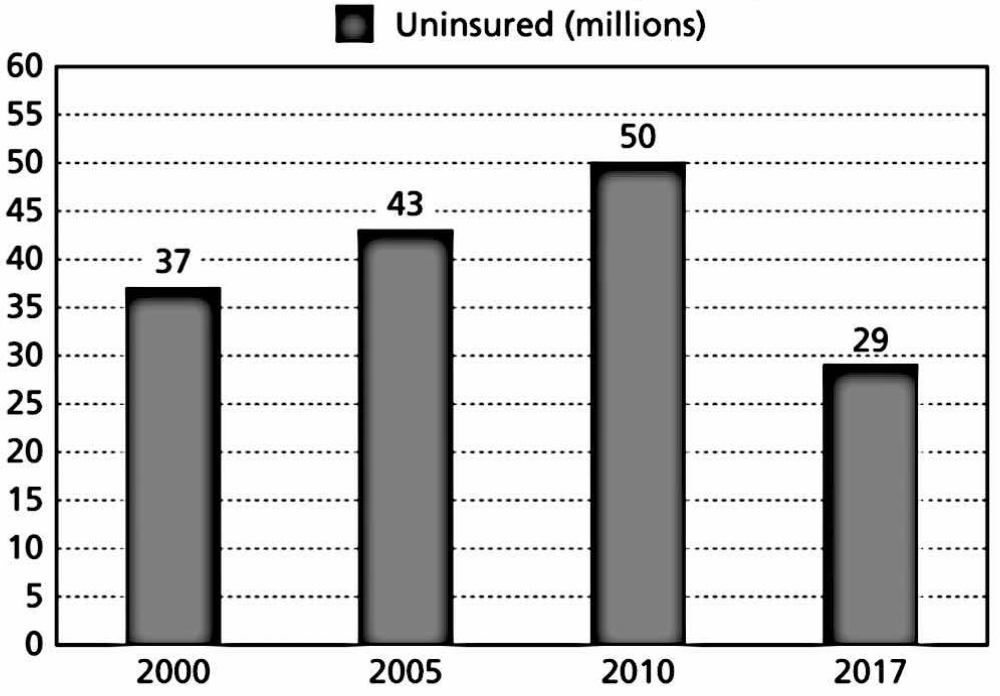
2.3 Discuss Americans' unequal access to health care.

When we compare ourselves with other advanced industrial nations, the United States is doing a relatively poor job of providing health care for its population. More affluent individuals and families tend to get excellent care in the most up-to-date facilities, and they tend to say that they are satisfied with their care. Low-income persons, in contrast, often have difficulty accessing basic health care, let alone more specialized care.

To a large extent, health care as a social problem can be viewed in terms of unequal access to health care services. Marcus, introduced in the opening vignette, suffered unnecessary pain and almost died because his family had no health insurance. Unfortunately, he is not alone. Many Americans have trouble getting the health care they need when they are ill because they are without health insurance. In 2010 there was an all-time high of 50 million Americans—over 15 percent of the population—without insurance, although that number has declined since then to 29 million in large part because of the Affordable Care Act, as shown in **Figure 2–1**. A decline is good news, but still, how could so many people be uninsured in a country as wealthy as the United States?

Figure 2–1

Number of Uninsured in the United States (millions), 2000–2017



Sources: Garfield and Young, 2015; Berchick, Hood, and Barnett,

2018.

The short answer to this question is that the United States has traditionally had a **fee-for-service health care system**; in other words, if you get sick or injured, you must pay for medical care; the cost is not rolled into taxes. Other countries roll the price of health care into their taxes so that there is little or no additional cost when a person is sick or injured.

> ***fee-for-service***
>
> A type of health care system in which patients are expected to pay directly for their own medical care; the cost is not rolled into taxes.

During World War II, when wage freezes were in effect, some large companies decided to offer health insurance as a fringe benefit of the job, and why not? Insurance was cheap to purchase because health care costs were relatively inexpensive, and few drugs were available. To compete for labor, medium-sized and small businesses also decided to get into the act (**Blumenthal, 2006**).

By the 1950s and 1960s, Americans began to equate health insurance with employment: you get a job and you get insurance. Americans forgot that this connection began through a simple historical accident (i.e., war-induced wage freezes led employers to offer health insurance instead), and they also forgot that no other developed nation ever tied health insurance to employment. In all developed nations (and many less developed ones), access to health care is a guaranteed right of citizenship, much like education or access to police protection. The result is that many Americans likely took jobs, or stayed in a job, simply because they needed the health insurance the job provided.

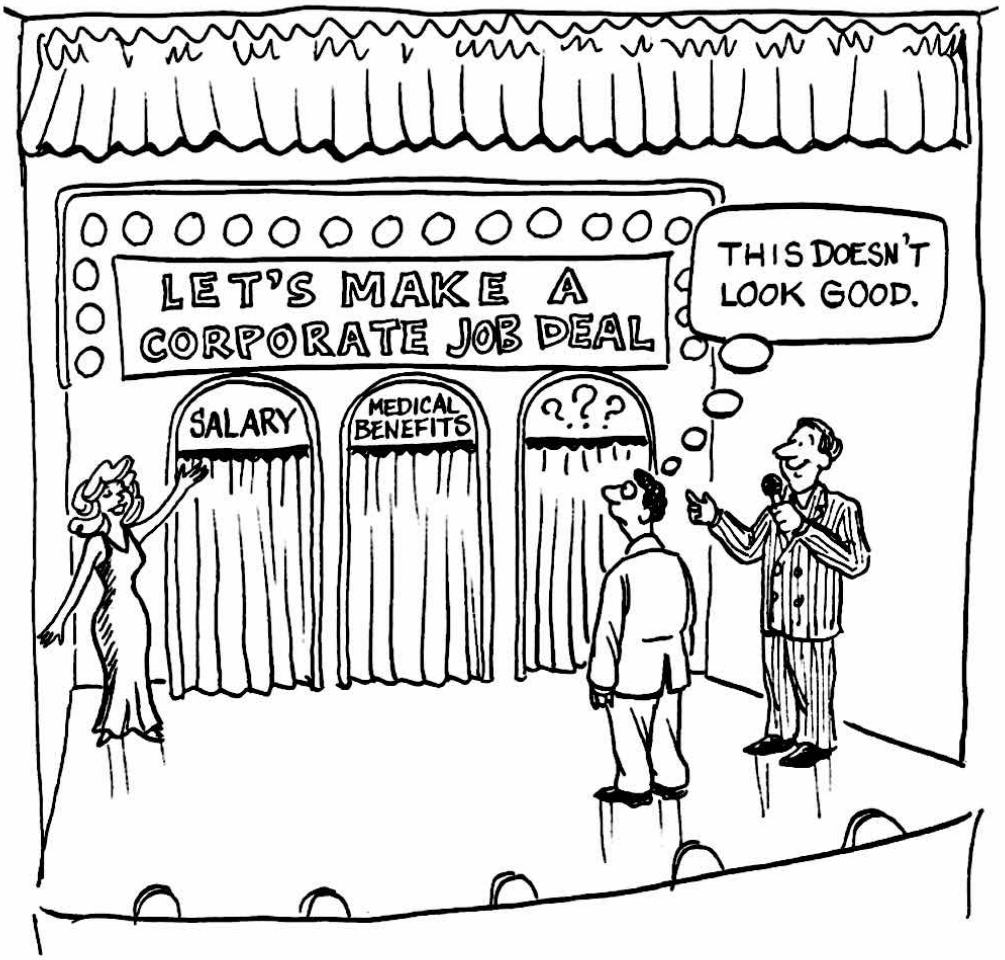
However, by the 1970s and 1980s, health care costs began to rise substantially. Small businesses were the first to say, "Hey, we cannot afford this." Today, companies of all sizes are dropping health insurance coverage completely or asking workers to pay more of the costs of the insurance plan. Only 53 percent of firms offered health insurance to employees in 2017, down from 60 percent in 2011 (**Henry J. Kaiser Family Foundation, 2017b**). Clearly, the connection between health insurance and employment is eroding.

Well, then, why not just purchase insurance yourself if you cannot get it from an employer? Many people in America cannot afford to

purchase health insurance privately because the average price of family coverage is now almost $19,000 per year (**Kaiser Family Foundation and Health Research and Educational Trust, 2017**). Also, until the ACA went into effect, just because a person applied for insurance there was no guarantee that he or she would be granted coverage; many people were turned down by insurance companies because of a preexisting condition. Moreover, although the ACA expanded **Medicaid** coverage (the federal-state health care program for certain categories of low-income people) in those states that opted in, even today most low-income Americans do not qualify for Medicaid.

Medicaid

The federal-state health care program for certain categories of low-income people.



Henry was suspicious of the job offer right from the beginning.

Unlike most countries, U.S. health insurance is designed to be a fringe benefit provided by employers. From the employers' perspective, the costs of health insurance are expensive and therefore many

employers are reducing benefits or eliminating them altogether. It is as though they are saying, "You can have a salary, or you can have benefits. You choose."
Cartoonresource/Fotolia

The consequences of being without insurance can be devastating (**Foutz et al., 2017**). Compared with those who have insurance, people without health insurance:

- are twice as likely to postpone seeking health care, are over four times as likely to forgo needed care and are more than twice as likely to have a needed prescription go unfilled.
- pay large sums of their own money for their limited care, thereby reducing the amount of money for food, heat, and other necessities. One-third of uninsured patients and half of low-income uninsured patients say that doctors make them pay upfront before any health care is rendered. Medical bills are a major financial hardship, and they contribute to debt and bankruptcy.
- are less likely after an accidental injury to receive any care, are twice as likely to receive no recommended follow-up care, and are more likely to report not fully recovering.

> ## What Do You Think?
>
> (1) Why do you think the U.S. health care system is so complicated? (2) What ideas do you have for making the system less complicated?

2.3.1 Profile of the Uninsured

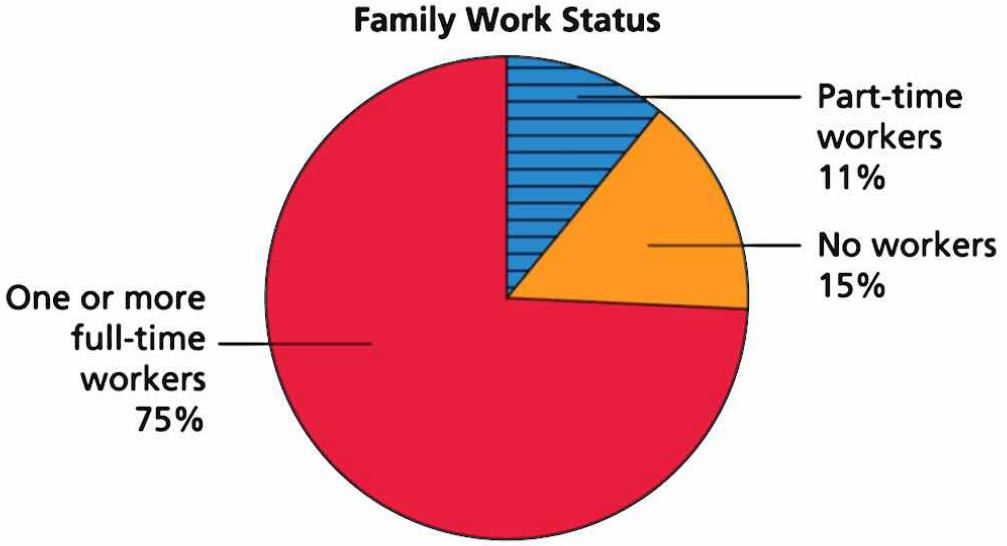
In 2016 approximately 29 million Americans were uninsured. This represents a significant decline in the number of people without insurance, largely because of changes in health care policy. A decline is something to celebrate. However, 29 million people still represents a substantial portion of the American population. Who are these people? Some of the answers may surprise you.

First, three-quarters of the uninsured are in families where one or both parents are employed full-time, as shown in **Figure 2–2a** (**Foutz et al., 2017**). Another 11 percent have a family member who is employed part-time. Their employers do not provide insurance for the worker or his or her dependents, and it costs too much for

the family to purchase insurance privately. Only 15 percent of those who are uninsured are also unemployed.

Figure 2–2a

Characteristics of the Non-Elderly Uninsured: Family Work Status, 2016

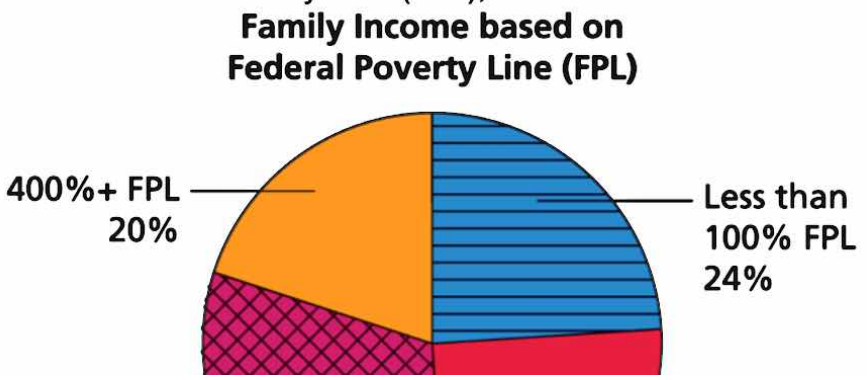


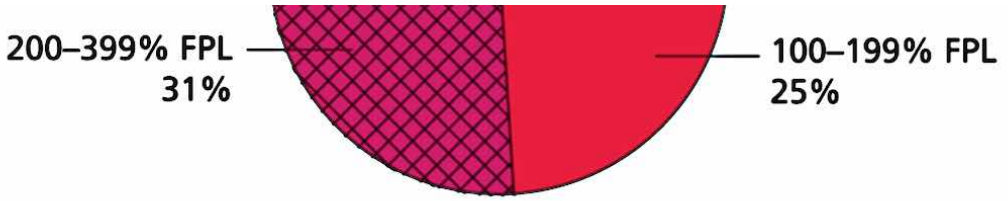
Source: Data from Foutz, J., et al. (December 14, 2017) "The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act," Kaiser Family Foundation.

Second, as you can see in **Figure 2–2b**, the incomes of uninsured Americans are quite varied. While many uninsured persons are poor with incomes at or only slightly above the official poverty line, about 20 percent of those who are uninsured have incomes four times the poverty level, or about $100,000 a year for a family. Even these relatively well-off families may not have insurance through their employer, and feel that paying nearly $19,000 for their own insurance is cost prohibitive. So, while it is fair to say that many uninsured people have lower incomes, certainly not all do (**Foutz et al., 2017**).

Figure 2–2b

Characteristics of the Non-Elderly Uninsured: Family Income based on Federal Poverty Line (FPL), 2016

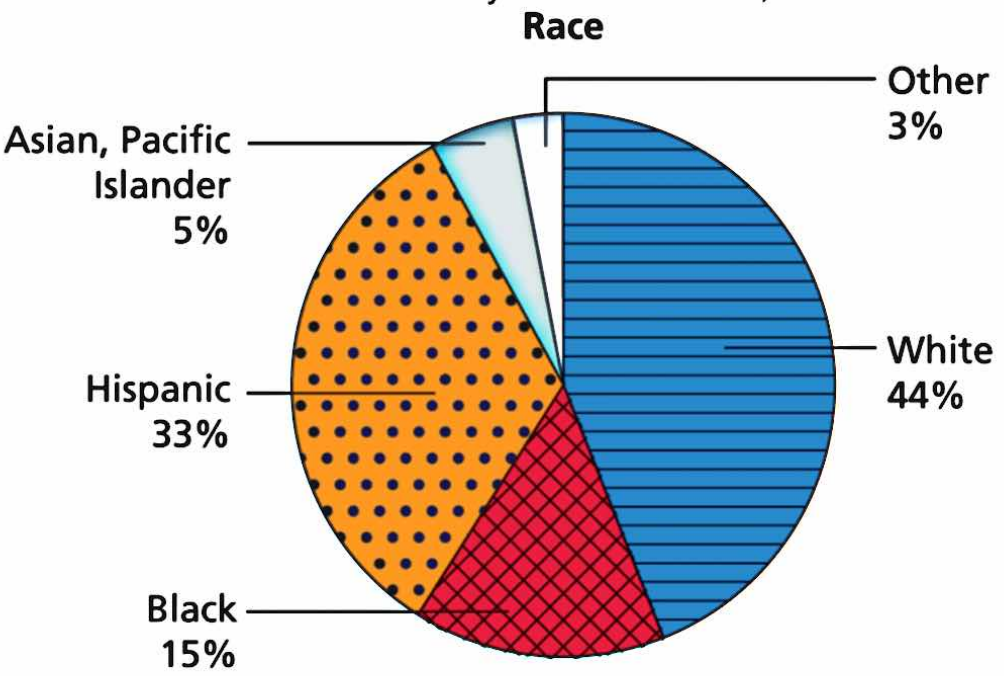




Finally, Figure 2–2c shows that non-Hispanic whites make up the largest uninsured group, but minority groups, especially Hispanics, are overrepresented among those who are uninsured given their size in the population (Foutz et al., 2017). Taken together, these findings are particularly disturbing because low-income people and racial and ethnic minorities tend overall to be in poorer health and therefore need to have good access to health care services (National Center for Health Statistics, 2017).

Figure 2–2c

Characteristics of the Non-Elderly Uninsured: Race, 2016



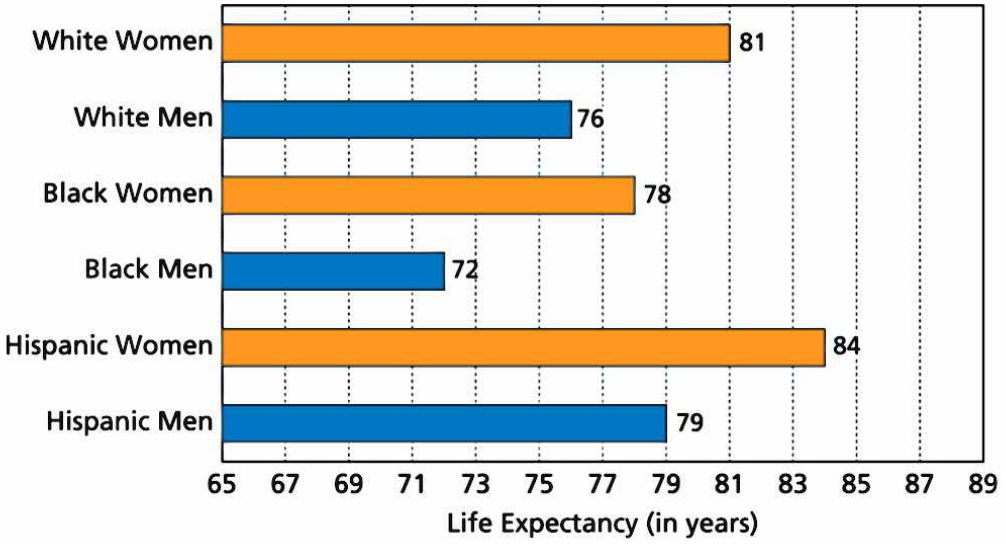
2.3.2 Inequalities of Race and Ethnicity

Race and ethnic differences in health are well-documented, and several examples of these health disparities are noted in Figures 2–3a, 2–3b, and 2–3c. Perhaps the most obvious sign of health status can be illustrated by life expectancy—on average, how long a person born today can expect to live. A comparison of life expectancy for Hispanics, whites, and blacks reveals that Hispanics have the longest life expectancy, with whites and blacks trailing behind. The largest gap—seven years on aver-

age—is between Hispanic and black men. The gap between Hispanic and black women is only slightly smaller at six years (**National Center for Health Statistics, 2017**). Blacks suffer disproportionately more from almost every illness than do whites, and because they are less likely to have been immunized, they suffer higher rates of death from infectious diseases. Blacks are also far more likely to be victims of lethal violence. In addition, the infant mortality rate for blacks is more than twice that for Asians, whites, and Hispanics. Finally, Native Americans and blacks are more likely than other groups to rate their health as only fair or poor (**National Center for Health Statistics, 2017**).

Figure 2–3a

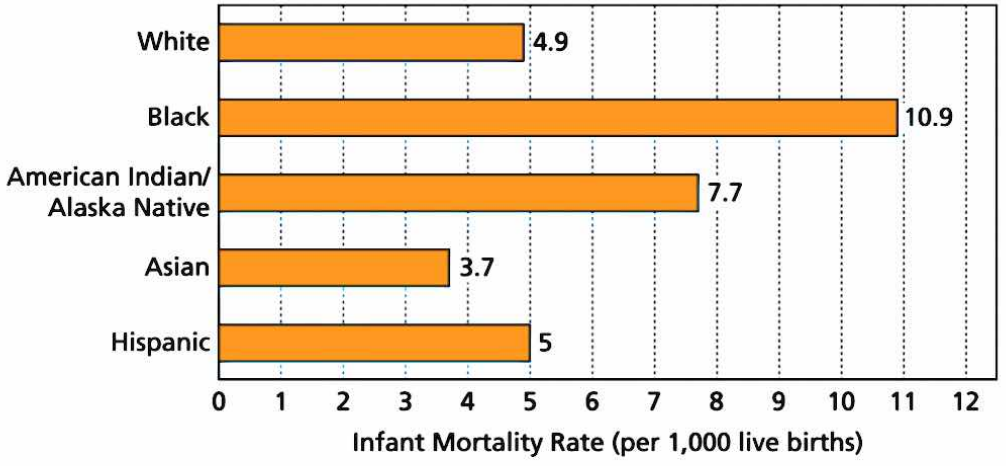
Major Health Indicators, by Race and Ethnicity: Life Expectancy in Years, 2015



Source: Data from National Center for Health Statistics, 2017.

Figure 2–3b

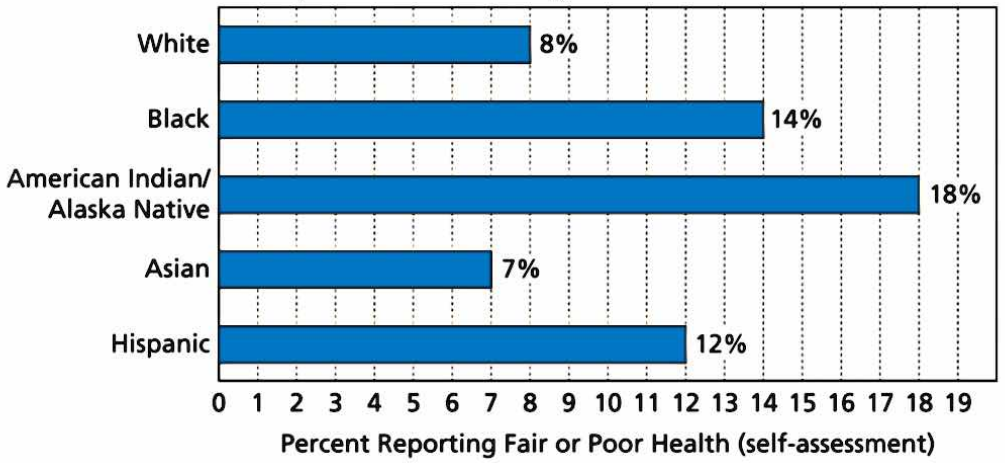
Major Health Indicators, by Race and Ethnicity: Infant Mortality Rate, 2014



Source: Data from National Center for Health Statistics, 2017.

Figure 2–3c

Major Health Indicators, by Race and Ethnicity: Percent Reporting Fair or Poor Health (Self-Assessment), 2016



Source: Data from CDC/National Center for Health Statistics, March 30, 2018.

Some people are surprised to learn that the life expectancy of Hispanics is so high and that their infant mortality is so low, given higher-than-average levels of poverty, prejudice, and discrimination. Yet, as we make these sweeping generalizations about groups such as *"Hispanics"* or *"Asians,"* it is important to remember that significant differences exist within broad racial or ethnic categories, as discussed in **A Closer Look: "Disparities in Hispanic Health Care."** After all, these broad ethnic categories represent diverse groups with distinct cultures. Nevertheless, most data sources lump groups together under these types of umbrella categories.

A Closer Look

Disparities in Hispanic Health Care

DCPhoto/Alamy Stock Photo

What is behind the statement that Hispanics in the United States live longer, on average, than do whites? Or that Hispanics are almost twice as likely as whites to lack health insurance? The answer to these questions requires that we explore the meaning of the term Hispanic. Often, social categories that lump together large numbers of quite diverse people can mask important trends. In the case of Hispanics, further analysis of the Hispanic subgroups in the United States reveals great variations in rates and sources of health insurance.

Coverage differs substantially among the major Hispanic groups in the United States. Cuban Americans, the majority of whom live in Florida and have been in the United States since the 1960s if not earlier, have by far the highest rates of job-based or other private insurance. Cuban Americans, on average, enjoy a high standard of living. Puerto Ricans, like Cuban Americans, also are quite likely to have insurance, but they have high rates of public government insurance (Medicaid and Medicare) because they are American citizens working in poorly paid jobs with long histories of job discrimination. People of Central American or Mexican descent also have low rates of job-based insurance, but, unlike Puerto Ricans, have extremely high rates of being uninsured. Some of these Hispanics are undocumented and therefore not eligible for public government programs, or they have relatives who are undocumented and therefore fear that claiming benefits could hurt these relatives. The label Hispanic (or Latino) covers groups that are so diverse that it makes almost no sense to lump them together. Theoretically, Hispanic refers to people who trace their ancestry to Spain or Latin America. In reality, it includes people with roots all over the world who have widely different social, cultural, and economic patterns. These patterns help to explain their disparities in health and access to health care. These same concerns can be applied to Asian groups, who share few social and economic characteristics, yet are usually lumped together as one homogenous statistical group.

Critical Thinking

List the different groups classified as Hispanic and

Asian. Can you identify ways in which they are culturally different? For example, describe any differences in food, language, or values. Do you think it is racist to lump groups together? Why or why not?

The most comprehensive recent research on inequalities in health care shows that, even with equivalent insurance, racial and ethnic minorities are likely to receive less or inferior care compared with whites, especially for the following conditions:

- **Heart disease.** Blacks are less likely to receive advanced heart treatments; 13 percent fewer undergo coronary angioplasty and one-third fewer undergo bypass surgery.
- **Asthma.** Among preschool children hospitalized for asthma, only 7 percent of black and 2 percent of Hispanic children, compared with 21 percent of white children, are prescribed routine medications to prevent future asthma-related hospitalizations.
- **Breast cancer.** The length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long in Asian American, black, and Hispanic women as in white women.
- **Human immunodeficiency virus (HIV) infection.** Blacks with HIV infection are less likely to be on antiretroviral therapy and less likely to be receiving protease inhibitors than are other people with HIV.
- **Nursing home care.** Asian American, Hispanic, and black residents of nursing homes are all far less likely than white residents to have sensory and communication aids such as glasses and hearing aids (**Altman, 2014**; **Unger and O'Donnell, 2014**).

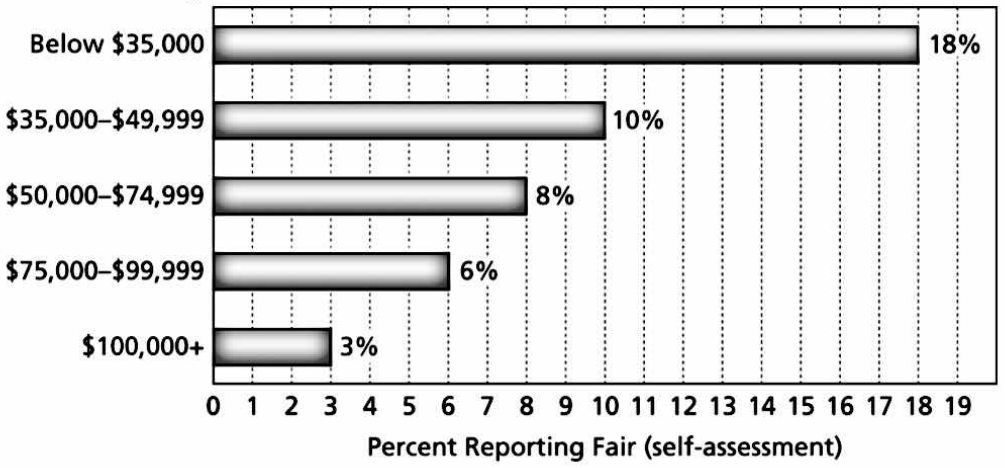
2.3.3 Inequalities of Social Class

From a socioeconomic point of view, there is a strong relationship between having a low income and a higher rate of illness, as is shown in **Figure 2–4** (**National Center for Health Statistics, 2017**). The wealthier people are, the more likely they are to feel, and to be, healthy. For example, only 3 percent of those with household incomes of $100,000 a year or more report that their health is only fair or poor, as compared to 18 percent of those

earning less than $35,000—a sixfold difference.

Figure 2–4

Major Health Indicator, by Income: Only Fair or Poor Health (Self-Assessment), 2016



Source: ***Data from CDC/National Center for Health Statistics, March 30, 2018.***

Having a low income affects health from the time of birth. The high rate of infant mortality among poor people is due to several factors associated with poverty. Inadequate nutrition appears to account for the high death rates among the newborn children of low-income mothers. The babies most at risk are those with a low birth weight. Among the causes of low birth weight are the low nutritional value of the mother's diet, smoking or other drug use by the mother during pregnancy, and lack of prenatal care. After the neonatal period (the first three months), the higher rate of infant death among infants living in poverty is linked with a greater incidence of infectious diseases. Such diseases, in turn, are associated with poor sanitation and lack of access to high-quality medical care, as well as with drug use in some cases.

The High Cost of Health Care

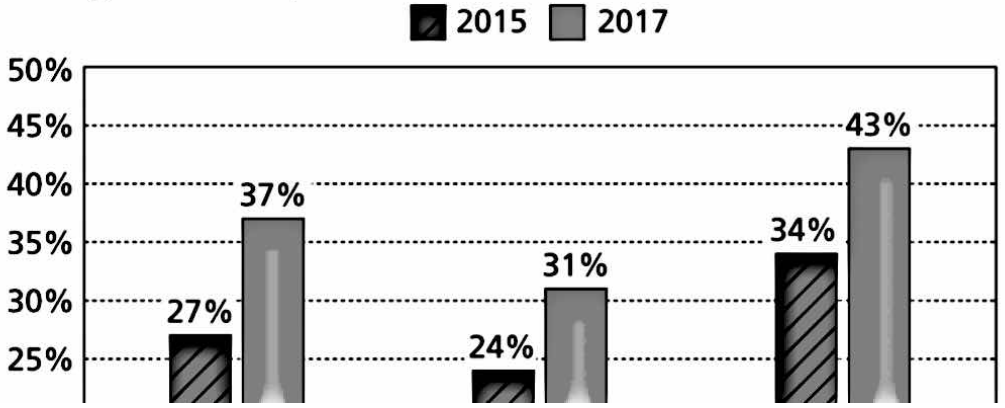
2.4 Review the reasons for the high costs of health care.

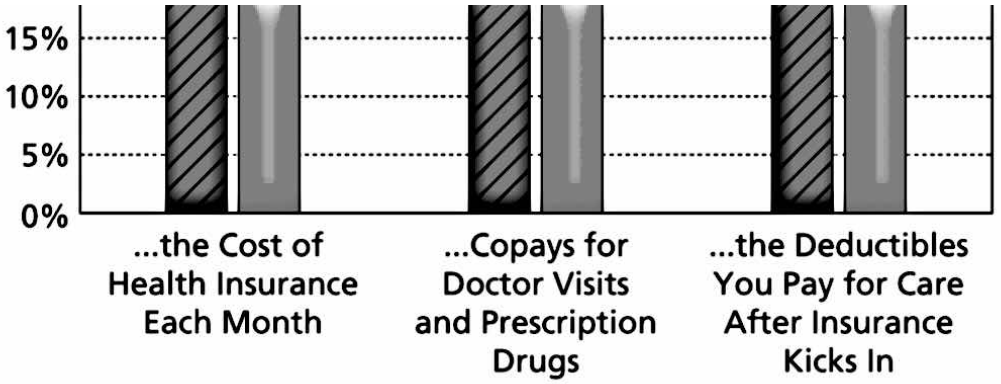
Unequal access to health care is related to its cost which, in the past several decades, has been very high. In fact, because of the rapidly increasing cost of medical care in recent years, the U.S. health care system is often said to be in crisis. Problems such as containing hospital expenses and the costs of new diagnostic technologies, the cost of prescription drugs, the effects of malpractice lawsuits, and problems with managed care and other medical insurance systems are all specific aspects of the general crisis in health care economics in the United States. Other nations have some of the same problems and some different ones, depending on how they fund their health care systems, but this analysis focuses primarily on conditions in the United States.

In 2017, U.S. health care spending reached $3.5 trillion, or about $10,500 per person (**Centers for Medicare and Medicaid Services, 2018**). Yet, most Americans are likely to spend an even higher proportion of their incomes on health care in coming years. Declining personal incomes due to global wage competition; dwindling government resources at the state and federal levels; the steady arrival of new drugs, new procedures, and advanced technologies; the continued profit motive in providing health care; and the difficulty of persuading people to change risky behaviors continue to make health care unaffordable for many people. As shown in **Figure 2–5**, even people with health insurance are concerned about the high cost of health insurance, copayments, and deductibles. The problem is that, even with insurance, many people must pay large sums of money for care.

Figure 2–5

Among the Insured, the Percent Who Find It Difficult to Afford. . .





Source: Based on ***DiJulio, B. et al. "Data Note: Americans' Challenges with Health Care Costs," Henry J. Kaiser Family Foundation (March 2, 2017)***.

What are the consequences of medical debt?

Jackie, age 51, went for a routine checkup and mammogram, and the doctor was concerned about a lump in one of her breasts. Further tests revealed cancer. As Jackie tells it, she is not sure which caused her greater stress, the cancer or the continuous flow of medical bills demanding immediate payment, which she refers to as "a complete nightmare." Jackie has insurance, but it covered only part of her very expensive and lengthy treatment. To help cover costs, she withdrew $48,000 out of her retirement account; it had taken her over 11 years to save that amount, and the withdrawal left her without any retirement cushion. But the bills continued to mount and the creditors began to call day and night, hounding her for payment. She sold her car and earned $14,000 for it, and the money went straight to medical bills. At one point, things were so dire that Jackie wondered whether she should go without treatment, risking possible death, but instead, a friend suggested that she ask her mortgage company whether they would revise her loan and lower the monthly payment on her house. They turned her

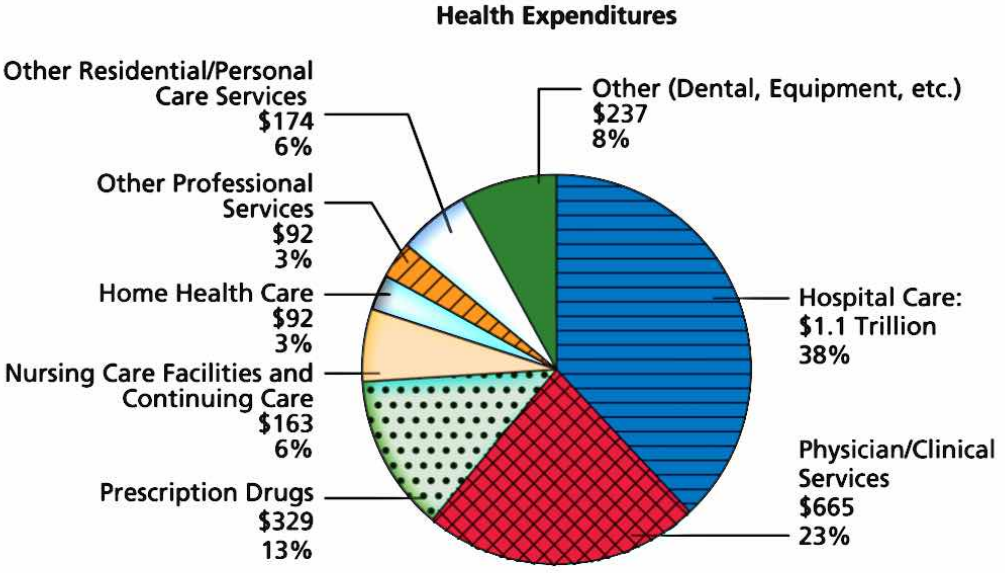
down, and Jackie subsequently skipped a few payments. The skipped payments resulted in foreclosure proceedings. Jackie hoped she would be better able to pay past debts, as well as her ongoing care, if she didn't pay the mortgage so, as she put it, "I let them take the house."

Jackie's story reveals that there are many consequences to the high cost of medicine and medical debt, including damaged credit, economic deprivation, depleted savings and other long-term assets, and housing instability. Some people file for bankruptcy, and others are forced to go without the care they need. These consequences can lead to grave emotional distress (**Pollitz et al., 2014**).

Specifically, what about health care costs so much? Many salient facts about and trends in health care costs can be gleaned from a careful look at **Figure 2–6** (**Centers for Medicare & Medicaid Services, 2018**). Notice that the largest expenditures are for hospital care and physicians' clinical services.

Figure 2–6

Distribution of National Health Expenditures, by Type of Service (in Billions), 2016



Source: Based on ***Centers for Medicare & Medicaid Services, January 8, 2018****.*

What Do You Think?

Why do you think medicine costs so much? This situation

> hasn't always been the case. Brainstorm to come up with at least five reasons why health care is so expensive. Then compare your answers with those provided in the text.

2.4.1 Hospitals

Until the mid-1980s, hospital costs rose at a dramatic pace, primarily because hospitals had little incentive to keep costs down. This situation was aggravated by health insurance programs like Blue Cross, which enabled hospitals to raise their fees almost at will. Expensive medical technologies are another important factor in the increase in hospital costs, as is the aging of the population, which increases the demand for hospital services.

In recent years, the rate of increase in hospital costs slowed somewhat, largely because of improvements in the efficiency of hospital administration that have been brought about largely by federal and state legislation. One technique used to reduce the level of hospital costs is to lower the average length of hospital stays. Some critics argue that patients are pushed out too early. Stories have circulated in the media of hospitals bussing patients out of the area to avoid further costs (**Hubert, Reese, and Sanders, 2013**). In addition, many procedures that previously were performed on an inpatient basis have been moved to outpatient and office settings. Other factors in the reduction of the overall level of hospital care are greater use of second opinions and an increase in care by nonhospital providers such as nursing homes and home health agencies.

Unfortunately, these various measures to control costs have not been successful. And as more patients are treated outside of hospitals or stay in hospitals for shorter periods, the costs of home care of the ill are rising rapidly. Another problem is that severe measures to reduce hospital costs disproportionately affect the poor and the elderly, who are more likely to suffer from chronic illnesses that may require hospitalization. These and similar situations illustrate the tendency of cost-control efforts in one area to result in higher costs elsewhere, and they provide an argument for comprehensive reform of the nation's health care system.

2.4.2 Physicians

During much of the twentieth century, a shortage of physicians, together with an increasing demand for medical services, helped doctors command high fees. The supply of doctors has grown significantly since 1950, but this growth has not necessarily led to improved access to medical care or to lower costs. Understanding the distribution of physicians will indicate why. People living in cities and suburbs can find both general and specialized medical care. These places also tend to be more attractive than rural locales to physicians. Even in densely settled urban areas, poor sections may have too few practicing physicians. As a result, physicians who engage in private practice tend to be clustered in metropolitan and wealthier suburban areas, producing shortages elsewhere. For example, there are roughly 31 physicians for every 10,000 people in urban areas, but only 13 per 10,000 people in rural areas. And those 13 physicians are highly dispersed (**National Rural Health Association, 2018**).

Contrary to what many Americans believe, the share of health care dollars that goes to doctors and clinical services has remained relatively steady over recent years, but they are and will remain a significant share of the nation's health care expenditures. An important component of these services is the cost of medical specialization. Less than one-third of physicians are general practitioners, and the remainder are specialists (**Agency for Healthcare Research and Quality, 2014**). One reason for the high degree of specialization is the rapid increase in medical knowledge, which means that physicians can become especially competent only in limited areas. Another reason is that high-quality medical care often requires the availability of specialists. The fact remains, however, that specialists command more income than doctors who engage in primary care. A specialist's income may be double or triple that of a general practitioner, although some effort is being made to limit Medicare and Medicaid payments to specialists while increasing payments made to primary care practitioners. Specialization also increases costs in another way; patients must consult several physicians for a variety of ailments instead of one physician for all of them. Visiting several different specialists multiplies the cost of treatment many times, whereas a primary care practitioner can coordinate care for the patient, resulting in greater continuity and ultimately better care.

2.4.3 Malpractice

One factor in the high cost of physicians' services is the cost of malpractice insurance. Fees vary but range from around $9,000 a year for a general practitioner in the South, to over $100,000 for an OB-Gyn in the Northeast (**Gallagher Health Care, December, 2017**). Malpractice litigation has become more frequent for several reasons. Ineffective health insurance programs play a significant role. If more people were adequately covered, they would be less likely to go to court to recover their health care costs. The increasing sophistication of medical technology also plays a part in the rise of malpractice litigation. Although recent advances enable doctors to perform treatments that once would have seemed miraculous, the treatments can be more hazardous for the patients if they are performed incorrectly or without sufficient skill and care. Public expectations about the powers of modern medicine also increase the likelihood of malpractice suits.

2.4.4 Medical Technologies

Steadily improving medical technologies, many of which can prolong life, are another reason for high medical costs. The list of advanced medical technologies that did not exist a few decades ago is impressive. It includes invasive cardiology (e.g., open heart surgery and angioplasty), renal dialysis, noninvasive imaging (e.g., sonograms, CAT scans, and MRI imaging), complex infertility treatments, organ transplantation, intraocular lens implants, motorized wheelchairs, and biotechnologies that are yielding new but costly drugs. Although some technologies may reduce the costs of health care, most studies indicate that they have caused total health care spending to rise because they are very expensive to purchase and operate, and are overused (**Clemens, 2017**; **Henry J. Kaiser Family Foundation, 2012**; **Rosenthal, 2014**). For example, the Hastings Institute, a nonpartisan health research organization, claims that new or increased use of medical technology is responsible for at least 40 to 50 percent of the annual rise in health care costs. Although medical technology and expertise have dramatically advanced, it has not necessarily resulted in a higher quality of life for patients.

2.4.5 Prescription Drugs

The cost of prescription drugs is a large and growing factor in the high cost of health care. The amount of money spent on prescription drugs in the United States far exceeds that in all other countries, largely driven by brand-name drug prices that have been increasing in recent years at rates far beyond the consumer price index (**Kesselheim, Avorn, and Sarpatwari, 2016**). Even generic drugs, which consumers turn to because of their cost savings, have skyrocketed in price (**Hirst, 2014**; **Wouters, Kanavos, and McKee, 2017**). Throughout the industrialized world, advances in pharmaceutical research and technologies are bringing new and more effective drugs to market each year. These remedies often result in major savings for employers and individuals when measured in terms of lower rates of absence from work. But their costs threaten to accelerate the rate of increase in overall medical expenses. Total spending for prescription drugs increased over the past decade, due especially to the demand for new drugs to combat depression, allergies, arthritis, hypertension, and elevated cholesterol. In most other developed nations, the national government negotiates drug prices with drug companies to ensure lower costs for consumers. However, in the United States, the government only gets involved in drug price negotiations associated with federal health programs, such as Medicare or Medicaid. For most people who get insurance through an employer, purchase it privately, or have no insurance (and therefore have to pay the full cost for prescription drugs themselves), there is no federal negotiation, and drug companies are generally free to set their own pricing. Although drug companies say that the prices are justified by the high cost of drug development, there is no evidence of an association between research costs and prices; rather, prescription drugs are priced in the United States primarily on the basis of what the market will bear (**Kesselheim, Avorn, and Sarpatwari, 2016**).

2.4.6 Demographic Factors

Another set of explanations for the high cost of American health care can be traced to demographic factors. Among the primary demographic factors influencing the cost of health care is the aging of the U.S. population, a phenomenon that is mirrored in many parts of the world but is particularly salient in Western urban industrial nations. Although the rapid increase in the older population—people 65 years or older—will be discussed more fully in

Chapter 9 , let me say here that they number over 50 million people (**Administration on Aging, 2017**). They represent about 1 in every 7 Americans. Projections suggest that the number of elderly will almost double to approximately 98 million by 2060.

Marie and Gabrielle are twins celebrating their birthday. People who live to be 100 years old, centenarians, used to be rare, but that is no longer the case. However, these two may be the oldest twins on record.
NICOLAS LAMBERT/AFP/Getty Images

Why is the number of older people in our society growing so quickly? The rapid aging of the U.S. population is being driven by two realities: First, Americans are living longer than in previous decades and, given the post–World War II baby boom, there are proportionately more older adults than in previous generations. Many Americans are now living into their seventies, eighties, and beyond. The leading edge of the baby boomers reached age 65 in 2011, launching an unparalleled phenomenon in the United States. Now, each and every day for the next 20 years, roughly 10,000 Americans will celebrate their sixty-fifth birthdays. By 2030, when the last baby boomer turns 65, the demographic landscape of our nation will have changed significantly.

The second reason for the large growth in older persons is that the baby boom cohort, the generation of Americans born in the 15–20 year period after World War II, is reaching old age. As this large segment of the population passed through the life span, it exerted a strong influence on national social issues—school shortages when they were young, social activism when they were college-

Obesity is a unique problem found primarily in developed countries. While many people in the world struggle to find enough food, Americans in particular face an obesity epidemic.
kwanchaichaiudom/Fotolia

Smoking

On January 11, 1964, Luther L. Terry, M.D., the ninth Surgeon General of the United States, released the first report on the health consequences of smoking: Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service. That report marked a major step in reducing the adverse impact of tobacco use on health worldwide by highlighting its many dangers and addictive qualities. The tobacco companies fought long and hard to discredit these findings (**Proctor, 2012**). Some catchy slogans they came up with to promote their products include the following (**Stanford Research into the Impact of Advertising, 2014**):

- "Smoke like a chimney? Who cares? Your mouth will taste clean as a whistle"[1]

  1Stanford Research into the Impact of Tobacco Advertising. 2014. "Slogans." Retrieved from (tobacco.stanford.edu/tobacco_main/slogans.php).

- "We don't try to scare you with medical claims"
- "Sensitive throats welcome Luckies"
- "Inhale to your heart's content"
- "More doctors smoke Camels than any other cigarette"

And perhaps the most famous slogan targeted women, tying smoking to liberation: "You've come a long way, baby."

More than fifty years have now passed since that seminal report was published. During this period, over 30 Surgeon General's re-

index" (BMI). For most people, BMI correlates with their amount of body fat.

- An adult who has a BMI between 25 and 29.9 is considered overweight.
- An adult who has a BMI of 30 or higher is considered obese.

See **Table 2–2** for an example of BMI calculation (**CDC, 2016**).

Table 2–2

An Example of Calculating BMI to Determine Weight Category

Height	Weight Range	BMI	Considered
5'9"	124 lb or less	Below 18.5	Underweight
5'9"	125 lb to 168 lb	18.5 to 24.9	Healthy weight
5'9"	169 lb to 202 lb	25.0 to 29.9	Overweight
5'9"	203 lb or more	30 or higher	Obese

NOTE: BMI (body mass index).
Source: Based on CDC, June 16, 2016.

Today, about 71 percent of Americans age 20 and over are overweight, including about 38 percent who are obese (**National Center for Health Statistics, 2017**). Among children, one-third are overweight, and 17 percent are obese (**Fryar, Carroll, and Ogden, 2016**). However, we have not always been such an overweight group. In the past several decades, obesity has become much more prevalent among Americans than it was during the mid-twentieth century.

Why are people obese? It may seem obvious—people eat too many high calorie foods. But obesity is also related to a sedentary lifestyle. Some people talk about genetics as a probable cause. Genetic changes in human populations occur too slowly to be responsible for the obesity epidemic. Further evidence against genetics is the fact that while first-generation immigrants who come to the United States usually have normal weight, second-generation Americans are often overweight or obese. Nevertheless, the variation in how people respond to the environment that promotes physical inactivity and intake of high-calorie foods suggests that genes do play a role in the development of obesity. Obesity may also be related to illness (e.g., Cushing disease) and medication

Race/Ethnicity		
	White	17%
	Black	17%
	Hispanic	11%
	American Indian/Alaska Native	32%
	Asian	9%
Age		
	18–24	13%
	25–44	18%
	45–64	18%
	65+	9%
Poverty Status		
	At or Above Poverty Level	14%
	Below Poverty Level	25%
Region		
	Northeast	13%
	Midwest	19%
	South	17%
	West	13%

Source: Data from CDC, February 15, 2018.

Smoking remains the leading high-risk behavior associated with poor health, untimely death, and extremely high health care costs. In fact, smoking-related illness in the United States costs more than $300 billion each year, including nearly $170 billion for direct medical care and over $156 billion in lost productivity, including $5.6 billion in lost productivity due to secondhand smoke (CDC, November 16, 2017).

Most smokers begin as adolescents (CDC, March 26, 2018d). In consequence, many health experts consider preventing tobacco

use among young people, or getting them to quit, to be among the nation's most important health challenges. School programs and public service announcements are specifically designed to target youth. Efforts have been somewhat successful, with smoking rates among young people declining significantly over the past couple of decades. However, it remains that 8 percent of high school students smoked cigarettes at least once within the past 30 days, and 20 percent have used some type of tobacco product during this period (e.g., electronic cigarettes, cigars, or smokeless tobacco). This use by young people is not surprising given the tremendous marketing efforts targeted at them. In 2015, tobacco companies spent $8.9 billion marketing cigarettes and smokeless tobacco in the United States. This amount translates to more than $24 million each day, or about $1 million every hour (CDC, November 16, 2017).

> ### What Do You Think?
>
> Do you know someone who smokes? How does he or she justify it, given the scientific evidence outlining the health dangers?

Risky Behaviors and Costly Procedures

Costly injuries due to skiing, rock climbing, mountain biking, skateboarding, and roller blading are associated with higher-income adolescents and young adults. Sports injuries are only one of many examples reflecting how features of American culture drive up the cost of medical care and health insurance. American culture, more than those of other highly developed societies, emphasizes seeking the most up-to-date medical treatments, whether those treatments have proven helpful. Bone marrow transplants to fight advanced cancers, hormone replacement therapy for women after menopause, and the indiscriminate use of MRI or CAT scans are all examples of expensive procedures or practices that increase costs for all health care consumers. At the same time, Americans have shown great reluctance to support any health care system that would limit their ability to seek whatever medical treatment they desire; this mindset drives up the cost of insurance and means that people who are less able to pay medical bills will postpone important preventive treatments.

Ethical Issues

2.5 Summarize the ethical issues surrounding health care.

As medical technology has improved, and life-prolonging procedures have become more available and dependable, many complex ethical issues have arisen, and our society is only beginning to grapple with them. For example, some new technologies, such as heart and kidney transplants, are extremely costly and cannot be provided to all patients who might benefit from them. Thus, the question arises of how to choose the patients who will undergo these procedures.

The availability of life-prolonging equipment and procedures has also given rise to new questions about the meaning of life and death. State legislatures across the country have been debating the question of whether death occurs when the heart stops beating or when the brain stops functioning. Courts have been required to decide whether patients should have the right to die by terminating life-prolonging treatments.

2.5.1 End-of-Life Issues

Few aspects of health care are as fraught with emotion and confusion as those dealing with how and under what circumstances loved ones die. On one side of the issue are people who believe in the "right to die." Many people have concerns about how they will die and suggest that the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. They claim that people should be able to commit suicide and have others assist them in doing so. **Euthanasia** refers to the painless killing of a patient suffering from a terminal illness or irreversible coma.

euthanasia
The painless killing of a patient suffering from a terminal illness or irreversible coma.

Michigan doctor Jack Kevorkian became the personification of the right-to-die issue when he helped a 54-year-old woman with Alzheimer's disease kill herself, using an intravenous device that

allowed the patient to receive a lethal drug by pressing a button. The doctor was arrested and charged with first-degree murder; later the charges were dropped, but the doctor was ordered to refrain from using the suicide device in the future. Kevorkian continued to defy the authorities in Michigan and eventually was sentenced to a term in prison. Although many doctors and health authorities condemned the practice at the time, Kevorkian's sensational methods brought the right-to-die issue to national attention.

Today Oregon, Montana, Vermont, Washington, Hawaii, California, Colorado, and Washington D.C. have laws that permit some form of physician-assisted suicide. It's estimated that only a couple of thousand people have used this option. The American College of Physicians oppose physician-assisted suicide, stating instead, "Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care"[2] (**Sulmasy and Mueller, 2017**). Nonetheless, physician-assisted suicide has the support of more than two-thirds of American adults, including 81 percent of adults under age 35 (**Dugan, 2015**).

2Sulmasy, L. S. and Mueller, P. S. (2017) "Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper," *Annals of Internal Medicine*, 167(8):576–578.

As the populations of the urban industrial nations continue to age and given the appearance of ever more sophisticated methods for prolonging life, the number of ethical, legal, and technical questions about life's end grows. Imagine that your elderly parent has had a stroke. Doctors express little hope that consciousness can be restored or that life-support systems could be removed without causing death. This scenario is not a rare situation. Unless your family and the terminally ill parent have prepared **advance directives** (a written statement that explains the patient's wishes for medical care should the person be unable to communicate them to the physician) for dealing with the situation, much agony and prolonged suffering can ensue for everyone concerned. Advance directives have two parts: a living will, which tells doctors and hospitals how the patient wants to be cared for should he or she become terminally ill, and a health care proxy, which designates an advocate, usually a close family member, who can make sure that those wishes are honored.

advance directive

A written statement that explains the patient's wishes for medical care should the person be unable to communicate them to the physician.

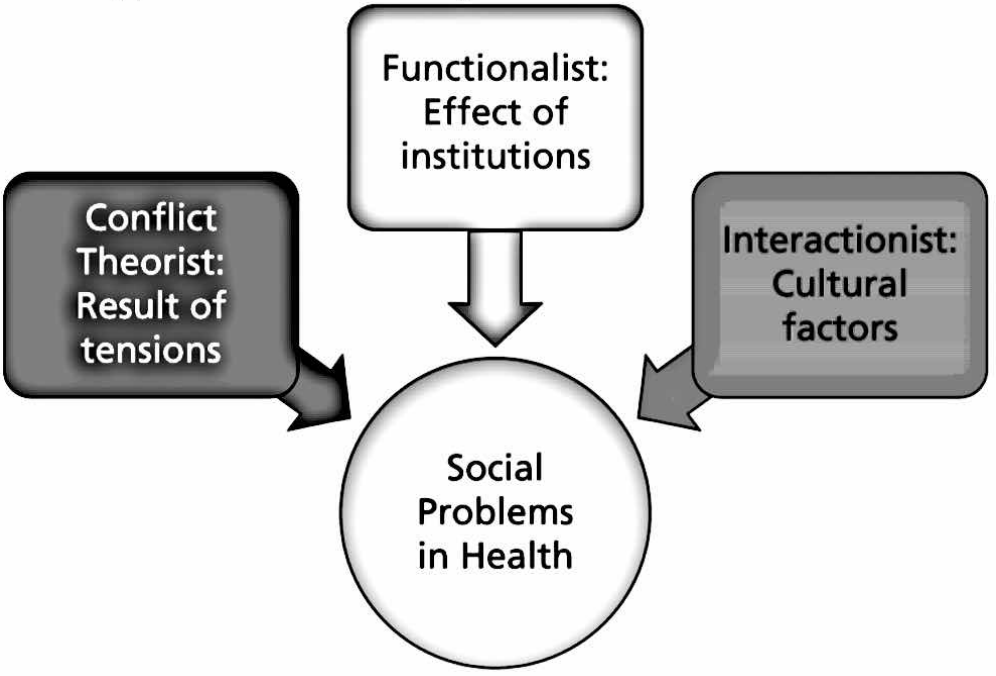
Explanations of Health Care Problems

2.6 Classify explanations for health care problems.

Why do we have such difficulty improving the quality of health care services and providing more equal access to them? The explanations offered by medical sociologists depend to a large extent on the perspective from which they view the problem. Conflict theorists, for example, tend to view the problem as an inherent feature of tensions associated with capitalism: The poor get less medical care because they get less of everything in American society. Those who approach this question from a functionalist perspective have sought the answers in medicine's development into a complex and costly social institution. And from an interactionist perspective, many problems of health care in the United States and other highly developed nations can be traced to cultural factors, including the way people are taught to interact with one another. (See **Figure 2–7** .) In this section, each of these approaches to the explanation of health care problems is briefly discussed.

Figure 2–7

Three Approaches to Explaining Social Problems in Health



2.6.1 Class and Class Conflict

Sociologists often point out that social class, measured by the income and wealth a household has at its disposal, goes a long way

toward explaining the types of illnesses experienced by members of that household and the kinds of health care they receive. We have already suggested that lack of access to good health care causes higher rates of illness and death among those who are poor. Until the early twentieth century, the ill health of poor people was caused largely by infectious diseases. Today, medical science can control and cure such diseases much more effectively, with the result that, by themselves, those diseases no longer account for tremendous differences in health between those who are poor and those who are not. Instead, the chief obstacles to good health in developed nations are lack of access to good health care, inadequate knowledge about health, failure to take preventive medical action, and delay in seeking treatment, all of which are especially prevalent among poor people (**Weitz, 2017**).

In fact, as control of chronic diseases like cancer becomes more important, the differences between the health of those who are poor and those who are not are likely to increase; that is, poor people will still have higher rates of illness and death than people who are not poor because of their relative lack of access to high-quality health care.

In a classic analysis of the relationship between social class and ill health, **Lee Rainwater (1974)** introduced the idea that lack of access to health care is not the only factor that affects the health of poor people: Just being poor promotes poor health. Poor people, for example, cannot afford to eat properly, so they are likely to be weak. They often live in the most polluted areas and hence are susceptible to respiratory diseases. Because they cannot afford proper housing, they are exposed to disease-carrying refuse and rodents. Perhaps most important, their lives are filled with stress due to constant worry about getting enough money to pay for necessities. Such long-term stress can cause both physical and mental illness. Being poor also makes it difficult to react to minor signs of ill health. A cough is likely to be dismissed if one does not have enough to eat; only a much worse cough will prompt a visit to a clinic, and by then it may be too late. Poor people also seem to feel middle-aged earlier than those who are not poor.

Social scientists who see class conflict as a basic cause of social-class differences in health and unequal access to health care are skeptical of the increasing privatization of the American health care system. They point out that, as public hospitals are replaced by hospitals run for profit, there is a tendency to avoid treatment of less profitable patients (**Wangsness, 2009**).

Studies have shown that, as more hospitals are managed by for-profit corporations (as opposed to the public sector), they are indeed more likely to be concerned about earning money and less concerned with providing medical care for patients, particularly those less likely to be able to pay, who require more expensive treatments such as drug counseling, suicide prevention, and AIDS therapy (**Ferdinand, Epane, and Menachemi, 2014**; **Kutscher, 2014**). Both public and private hospitals share the duty to accept all patients who require emergency care, but private hospitals can decide to eliminate their emergency facilities altogether, and the requirement for emergency care does not extend to nonemergencies.

Social scientists who view health care problems from a conflict perspective often explain the outcomes of conflicts over medical policy in terms of conflict between classes. For example, in an early study of the social, political, and psychological impact of AIDS in America, **Dennis Altman (1987)** showed that, as long as AIDS was perceived as a disease of homosexuals and intravenous drug users, members of the middle and upper classes did not put pressure on the government to invest heavily in its treatment and cure. Altman and others have pointed out that, because AIDS strikes disproportionately at less advantaged citizens and members of minority groups, it is often thought of as "their" disease, which was especially true in the beginning years of the epidemic.

2.6.2 Institutions and Health Care

Functionalist explanations of health care problems focus on features of health care institutions themselves. Sociologists with this institutional orientation point out that every society is faced with the problem of distributing health care services among its members. The United States uses a marketplace approach, which views health care as a commodity subject to the demands and spending power of consumers. Canada, by contrast, views health care as an entitlement of citizenship and extends full coverage to all its legal residents (HealthCanada, April 4, 2018).

There are several functionalist arguments for why a service that has come to be viewed as a basic human right, such as health care, should not be treated as a commodity:

- **Information.** A consumer is not in a position to shop for med-

ical treatment in the same way that one shops for other products or services because the need for such treatment cannot be evaluated by the consumer.

- **Product uncertainty.** The consumer does not have sufficient knowledge to judge the effectiveness of sophisticated treatments.
- **Norms of treatment.** Health care is provided under the control of a physician. A patient does not direct his or her own treatment.
- **Lack of price competition.** Prices for doctors' services are not advertised and are not subject to true competition.
- **Restricted entry.** There are numerous barriers to entry to medical school. Many qualified applicants are turned down because of a limited number of places.
- **Professional dominance.** Many health care services restricted to physicians could be performed by trained technicians. This restriction has created a monopoly.
- **Misallocated supply.** An abundance of specialists encourages the use of expensive and sophisticated treatments when simpler ones would be just as effective.

2.6.3 Health and Social Interaction

The relatively poor health of Americans is due in part to features of our lifestyle, including sedentary occupations, nonnutritious diets, lack of proper exercise, environmental pollution, and cigarette smoking (**Weitz, 2017**). But if activities like smoking are detrimental to health, why do people engage in them? Interactionist explanations of social problems related to health care often draw on studies of patterns of sociability (i.e., interaction among people in groups) and the ways in which people are socialized in different societies and communities. Features of a society's lifestyle, such as smoking, drinking, and diet, are deeply ingrained in the way people interact with one another. Very often we eat, drink, or smoke as much to be sociable as to sustain ourselves.

Excessive eating, leading to obesity, and high rates of alcohol consumption are among the health problems related to patterns of sociability in an affluent society. But as noted earlier, the most pervasive and serious problems are created by smoking. In addition, women may expose unborn infants to the negative effects of smoking, especially low birth weight.

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Excessive eating, leading to obesity, and high rates of alcohol consumption are among the health problems related to patterns of sociability in an affluent society. But as noted earlier, the most pervasive and serious problems are created by smoking. In addition, women may expose unborn infants to the negative effects of smoking, especially low birth weight.

Interactionist perspectives on issues like smoking and health typically focus on the way communications (e.g., advertising images and messages) seek to connect the use of tobacco with particular lifestyles. For example, vaping advertisements targeted to young adults are often sleek and glamorous, showing independent and free thinkers as they vape.

It is helpful to think of the major sociological perspectives as conceptual tools to be used in analyzing a complex social problem such as the prevention and treatment of physical illnesses. No single perspective explains all the important issues, but together they go a long way toward a full explanation. The functionalist view is most helpful in pointing out how social institutions like hospitals should function, why they do not function effectively, and how they could be improved. The conflict perspective allows for more insight into the influence of inequalities of wealth, education, and power on access to and quality of health care. The interactionist perspective points to the way differences in people's perception of social conditions such as the obesity epidemic influence their behavior toward others, as explored in **A Personal View: "My Experience with Obesity."**

Interactionists are interested in how messages are communicated. Not only do tobacco companies try to create visual images (e.g., smoking as glamorous, or smokers as "cool"), the government tries to create visual images as well. The words "slow" and "painful" have been deliberately chosen by the U.S. Surgeon General to make a larger impact.
Kim Steele/Alamy Stock Photo

A Personal View

My Experience with Obesity

Daisy-Daisy/Alamy Stock Photo

I was a very pudgy kid. I didn't know I was overweight until I went to school. Until then I was happy and enjoying all the rich and sugary foods my momma would make. "These will taste yummy," she used to say, as we devoured two dozen chocolate chip cookies in one sitting. Momma was obese, weighing in at more than 300 pounds. But I never noticed. She was what you might call a binge eater. She said it calmed her nerves. And I learned this habit early in life.

By the time I went to kindergarten I weighed nearly 80 pounds. I was much heavier than any other child, but I continued not to notice. I did see that I was the slowest one at PE, and I seemed to huff and puff more than the others, but I didn't give it much thought. That is, until Brian Hemling, the class clown, called me "fatso" when I stood in line to get a drink of water. "Hey fatso, don't drink all the water. Save some for the rest of us." He laughed, and soon several other kids joined in. I felt so embarrassed. I knew what the word fat meant; I just hadn't noticed that I fit the description. But that day changed my life, and not for the better.

Instead of being the happy child I used to be, I began a slow descent into depression. I hated school. A few people were mean to me, but most just ignored me. I didn't have any friends. I was always the last one picked for a team in PE, or the last one picked as a square-dancing partner in third grade. When the teacher decided to start assigning partners, all the boys had their eye on me, hoping that I would be assigned to someone else.

I consoled myself with food. This was easy to do because my momma continued to have fattening foods around the house, and together we would binge on what was available. A large bag of potato chips? No problem. I'd wash it down with a coke and ice cream. Of course, this only made my weight continue to skyrocket.

When I was in seventh grade I had to go to the doctor to get a physical for summer camp. I hadn't been to the doctor in years, and I was embarrassed to take off my clothes in front of her. At this point I weighed almost 190 pounds. But the doctor saw my shyness and was actually really kind about it. However, she also told me directly that I was overweight and needed to be on a special weight loss program. She asked a lot of questions: What foods does my mom buy? What do we eat for dinner? Do we eat in front of the TV? What do I snack on? She called my mother into the room to discuss diet, exercise, and fitness. Then she made us agree to sign me up for a special class designed to help teens with weight loss. This day also changed my life, this time for the better.

I met new friends from the class and was now no longer lonely. Together we had weekly weigh-ins that were made into celebrations, not punishments. We socialized outdoors and exercised: We hiked, biked, and swam our way to fitness. We took cooking classes; if our parents didn't want to cook healthy foods, then we would do it ourselves. It worked! The pounds came off, and within eleven months I was down to my desired weight.

Fortunately, my mom supported my changes, although she did not incorporate them for herself. She remains obese, and now has diabetes, among other health problems. Her feet swell badly, which makes daily life difficult for her. Even working her eight-hour day is tough, and she has missed a lot of work because of her health. I wish she would get serious about losing weight.

—Elise, Age 18

Critical Thinking

Why is there stigma surrounding obesity? Is obesity seen as a medical problem or a personal failing?

Social Policy

2.7 Identify key issues in social policy, including the Affordable Care Act.

All developed nations are having difficulty coping with the demands on their health care systems, demands brought on by aging populations with more chronic illnesses. None of them has found easy solutions or avoided the need for compromises and less-than-perfect solutions. But in the United States—as compared with Canada, France, Germany, England, and the Scandinavian nations—there is an even greater lag in arriving at reforms of health care institutions that address the major problems.

2.7.1 Health Care Reform in the United States: The Affordable Care Act (ACA)

With health costs spiraling upward far faster than the rate of inflation and the number of uninsured steadily increasing, there has long been debate about what to do. President Obama was not the first to tackle health care reform, but in 2010 he was successful in signing into law the **Affordable Care Act (ACA)** ⓘ. Nicknamed "Obamacare," the ACA mandated the first major overhaul of the U.S. health care system since the creation of Medicare and Medicaid in 1965.

Affordable Care Act (ACA)
Legislation developed by President Obama and passed in 2010 that is the first major overhaul of the U.S. health care system since the creation of Medicare and Medicaid in 1965.

The ACA is complex, but **Table 2–4** outlines some of the major provisions (**Henry J. Kaiser Family Foundation, 2015**).

Table 2–4

Key Components of the Affordable Care Act (ACA)

- Most individuals were required to have health insurance by 2014.

- Individuals without access to affordable employer coverage will be able to purchase coverage through a health insurance exchange with "credits" available to make coverage more affordable to some people.
- Small businesses will be able to purchase coverage through a separate exchange.
- Employers will be required to pay penalties for employees who receive credits.
- New regulations will be imposed on health plans that will prevent health insurers from denying coverage to people for any reason, or for charging higher premiums based on health status or sex.
- Young adults will be allowed to stay on their parents' plan until they are 26 years old.
- Medicaid will be expanded to 133 percent of the federal poverty level (roughly $15,000 for an individual and $30,000 for a family of four).

Source: Based on Henry J. Kaiser Family Foundation, 2015.

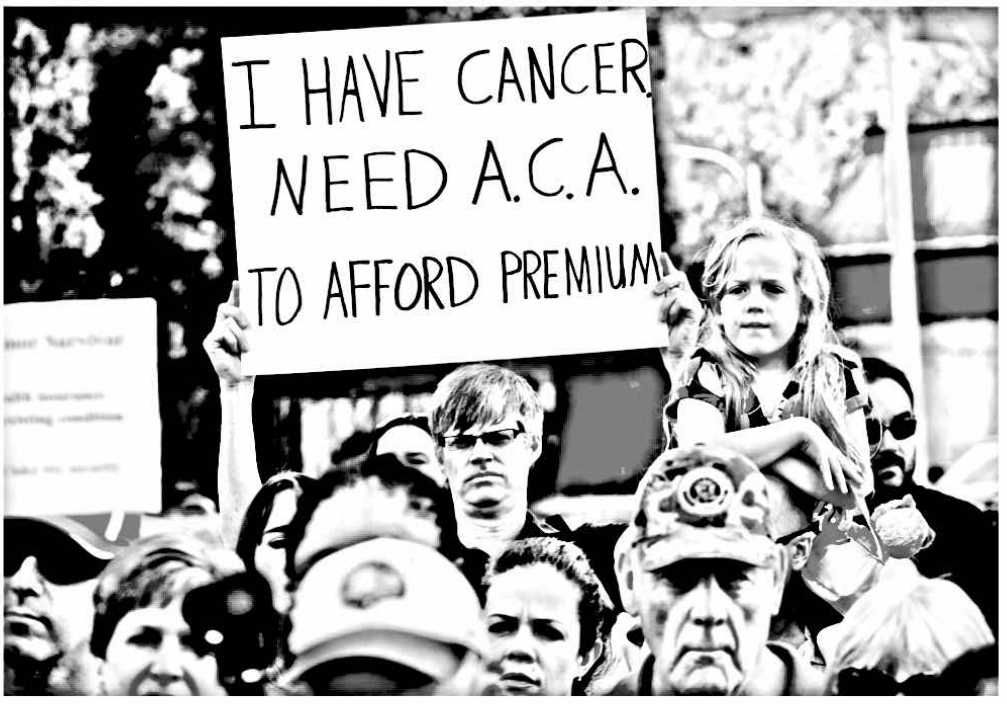
As soon as the bill was passed, several important measures took immediate effect. Adults and children who were previously denied coverage due to preexisting conditions became eligible for access to health care. Children up to age 26 could stay on their parents' health insurance plan. Small businesses that offer insurance to their employees got a 35 percent tax credit from premiums paid, making it much easier for many small businesses to afford health insurance for their employees.

Other components of the ACA were incorporated more slowly. By 2014, the ACA was in full effect, increasing the number of persons with health insurance by millions. The number of people without insurance fell from 50 million in 2010 to 29 million in 2017. The ACA modeled the strategy of the successful Massachusetts health care system, which requires all citizens to have medical insurance. This individual mandate helps to keep the overall costs down by requiring a very large pool of both healthy and sick people to have insurance. If only a few very sick people had insurance, for instance, health care costs would soar trying to cover their costs. Therefore, in 2014, an IRS penalty of $750 per individual or 2 percent of income—whichever is greater—went into effect for any citizen not covered by an employer or a public plan such as Medicaid or

Medicare, and who chooses not to purchase health insurance.

Despite bringing health insurance to millions of people, the program remained somewhat controversial, with Republicans vowing to repeal it; a chant that became especially pronounced during the 2016 Presidential election. "Repeal and Replace" was the Republican slogan, although it was not clear what the ACA was supposed to be replaced with.

One reason for the unpopularity of the ACA is that many people do not know that Obamacare and the ACA are the same thing. A recent survey with a nationally representative sample of adults found that 35 percent of respondents either thought Obamacare and the ACA were different policies (17 percent) or did not know whether they were the same or different (18 percent). This confusion was more pronounced among people ages 18 to 29 and among those who earned less than $50,000—two groups that would be significantly affected by repeal. When respondents were asked what would happen if Obamacare were repealed, even more people were stumped. Approximately 45 percent did not know that the ACA would be repealed. In other words, many people denigrated Obamacare but supported the basic tenets of the ACA (**Dropp and Nyhan, 2017**; **Linkins, 2017**).



The Affordable Care Act (ACA) became highly politicized, with Republicans vowing to repeal it. Since President Trump's election, several of the basic tenets have been eroded, even though the ACA remains.
Paul Hennessy/Alamy Stock Photo

What Do You Think?

Give an example of the arguments made by people who (a) think the ACA goes too far, (b) support the ACA, and (c) think the ACA does not go far enough.

One of President Trump's signature issues during the campaign was to repeal the Affordable Care Act and replace it with an alternative. Trying to make good on that promise, President Trump turned to health care soon after the election but learned that devising an insurance program that both reduces cost *and* reduces the number of Americans who are uninsured is trickier than it seemed. The "Repeal and Replace" mantra turned into just "repeal," but this approach never quite got off the ground. All Democrats and a few Republicans opposed President Trump in eliminating the ACA, and many Americans joined in at town hall meetings around the country to tell their Congressperson to leave their health insurance alone. Consequently, anticipating failure, the Republican plan to repeal the ACA was never brought to Congress for a vote.

Since that time, however, President Trump and the Republican-led Congress have chiseled away at the ACA. For example, they have done away with the individual mandate requiring people to have (or purchase) health insurance. But this is at the heart of keeping costs controlled and increasing access to health care. The administration has also proposed to expand the availability of short-term health plans that do not guarantee minimum benefits or prohibit discrimination against consumers with preexisting health problems. While this may sound good at first ("they will be cheap"), it will again encourage healthier people to opt out of the system, leaving fewer people and those who are the sickest in the insurance pool. This would raise premiums and reduce access to care.

2.7.2 Future Prospects

Senator Bernie Sanders, Vermont, has energized the conversation about health care by calling for a "single-payer" health care system, sometimes referred to in the United States as "Medicare for All." **Single-payer** is a health care system that is financed by taxes and covers the costs of essential health care for all residents including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug, and medical supply costs. The costs are covered by a single gov-

ernment system. Supporters, such as the **Physicians for a National Health Program (2016)** argue that the program would be funded by the savings obtained from replacing today's "inefficient, profit-oriented, multiple insurance payers with a single streamlined, nonprofit, public payer, and by modest new taxes based on ability to pay."[3] It is likely that 95 percent of all households would save money. Patients would no longer face financial barriers to care such as co-pays and deductibles and would regain free choice of doctor and hospital. Doctors would regain autonomy over patient care. The only real losers, they say, are insurance companies, pharmaceutical companies, and other for-profit medical industries because they have an economic self-interest in keeping the status quo.

3"What is Single Payer?," Physicians for a National Health Program (2016). Retrieved from http://www.pnhp.org/facts/what-is-single-payer.

single-payer

A healthcare system that is financed by taxes and covers the costs of essential healthcare services.

Going Beyond Left and Right

The broad sociological issue here is how to improve health care institutions to provide the best possible care for the greatest number of people. Most medical sociologists do not agree that health care should be treated as a commodity that is available in higher amounts and quality to those most able to afford it. But this position does not mean that they believe a single-payer system could be imported to the United States without a great deal of effort and compromise. Any attempt to reform the health care system generates intense political debate and lobbying efforts, either in Congress or in state legislatures. This has most certainly been the case with the ACA.

Summary

2.1 Describe health care as a global social problem.
The lack of adequate health measures presents a variety of social problems to societies everywhere. In affluent regions of the world, problems associated with physical health often involve reducing unequal access to high-quality health care while controlling health care costs. In impoverished regions where high-quality medical care is often lacking, social problems associated with physical health are even more profound: the spread of infectious diseases, high rates of infant and maternal death, low life expectancy, scarcity of medical personnel and equipment, and inadequate sewage and water systems.

2.2 Identify the scope of health care problems in America.
Health care is considered a social problem when members of a society have unequal access to health care institutions and when its cost is too high for people to afford. Medical sociology is the subfield of sociology that specializes in research on the health care system and its impact on the public, especially access to health care and the evolution of health care institutions.

2.3 Discuss Americans' unequal access to health care.
Access to health care is distributed very unequally in the United States. The use and availability of health care are directly related to socioeconomic class and race. People in the lower classes tend to have higher rates of untreated illnesses and disabilities and higher mortality rates for most diseases than do people in the middle and upper classes.

2.4 Review the reasons for the high costs of health care.
Unequal access to health care is related to the cost of obtaining it. Health care costs have risen significantly. The costs of hospital care, physician fees, medical technology, and prescription drugs are major contributors to the high cost of American health care. Population demographics are changing, and the number of people who are elderly and need chronic care is increasing. Cultural factors that raise the cost of health care in the United States include aspects of lifestyle such as heavy use of tobacco and alcohol, unhealthful diet, and lack of exercise. Obesity is a major health problem in the United States and other affluent nations.

2.5 Summarize the ethical issues surrounding health care.
As medical technology has improved and life-prolonging procedures have become more available and dependable, many complex ethical issues have arisen, and our society is only beginning to grapple with them. One example is end-of life issues and the dilemmas surrounding "death with dignity."

2.6 Classify explanations for health care problems.
Conflict theorists believe social class goes a long way toward explaining the types of illnesses experienced by members of a household and the kinds of health care they receive. Functionalist explanations of health care problems focus on features of health care institutions themselves. The interactionist perspective on health care problems points to the role of lifestyle features such as poor diet, lack of exercise, and smoking–including passive smoking (breathing air that contains cigarette smoke).

2.7 Identify key issues in social policy, including the Affordable Care Act.
In March 2010, Congress passed important health care reform legislation called the Affordable Care Act. It is designed to reduce the number of uninsured Americans and to lower health care costs. Under President Trump the program is being dismantled.