CHAPTER 10

Health and Health Care

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Health and Health Care as a Social Problem

At first glance, health seems a purely biological state, and health care a purely medical matter. Yet as this chapter will show, health, illness, and health care are deeply affected by social forces and social status.

Although it may seem that health and illness are not issues that need concern college-age students, this is far from true. Illness, disability, and traumatic injury can strike at any age. This is particularly important because the United States is alone among the industrialized nations in not providing access to health care to all citizens. As a result, 45 million Americans under age 65 lacked health insurance in 2007—a number that has surely increased, given current economic conditions—and health-related debt is a major cause of personal bankruptcy (Kaiser Commission on Medicaid and the Uninsured 2008; Newman 1999b; Sullivan, Warren, & Westbrook 2000). Furthermore, health is the single most important factor that influences overall quality of life. Thus, we need to consider not only the social forces that affect health and illness but also why the U.S. health-care system has taken the particular form it has and the consequences of that system. We begin by looking at how sociologists think about illness itself.

Theoretical Perspectives on Illness

Because of their different approaches, each sociological theory of illness focuses on a different set of questions and offers a different set of answers. The classic structural-functionalist theory of illness looks at how (some) illness can help society run smoothly and how society limits illness that can interfere with that smooth flow. Conflict theory illustrates how competing interests lead to different definitions of illness, and symbolic interaction theory has been particularly useful for understanding the experience of illness.

Structural-Functionalist Theory: The Sick Role

The classic sociological theory of illness was first formulated by Talcott Parsons (1951). As a structural-functionalist, Parsons assumed that any smoothly functioning society would have ways to keep illness, like any other potential problem, from damaging it.

Parsons's most important contribution to sociology was the realization that illness is a form of deviance, in that it keeps individuals from performing their normal social roles. The last time you were sick, for example, you might have taken the day off from work, asked your boyfriend or girlfriend to pick up groceries for you, or asked a professor to give you an extension on a paper. You might even have claimed to be sick just to get out of those responsibilities. To Parsons, therefore, illness (or claims of illness) is generally *dysfunctional* because it could threaten social stability.

Parsons also recognized, however, that allowing some illness was good for social stability. If no one could ever "call in sick" or take a "mental health day," no one would have the time needed to recuperate, and resentment would build among workers, students, and spouses who never got a break. In these ways, illness acts as a sort of "pressure valve" for society.

As the sick role describes, when we get sick we are expected to go to the doctor and to follow the doctor's orders.

Defining the Sick Role

How does society control illness so that it increases rather than decreases social stability? The answer, according to Parsons, is the **sick role**. The sick role refers to four social norms regarding how sick people should behave and how society should view them. First, sick persons are assumed to have legitimate reasons for not fulfilling their normal social roles. This is why we give sick people time off from work rather than firing them for malingering. Second, cultural norms declare that individuals are not responsible for their illnesses. For this reason, we bring chicken soup to people who have colds rather than jailing them for stupidly exposing themselves to germs. Third, sick persons are expected to consider sickness undesirable and work to get well. This is why we sympathize with those who rest when they are ill and chastise those who don't. Finally, sick persons should seek and follow medical advice.

Critiquing the Sick Role

Parsons's concept of a sick role was a crucial step in beginning to think of illness sociologically. Subsequent research, however, has illuminated the limitations of the sick role model (Weitz 2010). This critique is highlighted in the Concept Summary on Weaknesses of the Sick Role Model.

First, in contrast to Parsons's analysis, ill persons sometimes *are* expected to fulfill their normal social roles. While no one expects persons dying of cancer to continue working, we often expect people with arthritis to do so, as well as those we suspect are malingerers or hypochondriacs because doctors have been unable to diagnose their condition. Similarly, regardless of illness, some professors expect students to turn papers in on time, some husbands expect their wives to cook dinner, and some employers expect their employees to come to work.

Second, sometimes people *are* held responsible for their illnesses. The last time you had a cold, did anyone chastise you for not taking care of yourself well enough? for not taking vitamin C, getting enough sleep, or eating healthy meals? Similarly, newspaper stories and television shows often implicitly blame lung cancer on people who smoke, diabetes on people who eat too much, and so on.

The **sick role** consists of four social norms regarding sick people. They are assumed to have good reasons for not fulfilling their normal social roles and are not held responsible for their illnesses. They are also expected to consider sickness undesirable, to work to get well, and to follow doctor's orders.

concept summary

Weaknesses of the Sick Role Model

Elements of the Sick Role	Model Fits Well	Model Fits Poorly
Illness is considered a legitimate reason for not fulfilling obligations.	Appendicitis, cancer	Undiagnosed chronic fatigue
Ill persons are not held responsible for illness.	Measles, hemophilia	AIDS, lung cancer
Ill persons should strive to get well.	Tuberculosis, broken leg	Diabetes, epilepsy
Ill persons should seek medical help.	Strep throat, syphilis	Alzheimer's, colds

Third, the sick role's assumption that sick individuals should work to get well simply doesn't fit those who have chronic illnesses that medicine can't cure. In much the same way, the assumption that sick people should follow medical advice ignores those who can't afford or aren't helped by medical care.

Conflict Theory: Medicalization

Like other structural functionalists, Parsons assumed that social ideas about illness (in this case, the sick role) are designed to keep society running smoothly. In contrast, conflict theorists assert that, like other parts of social life, ideas about illness reflect competing interests among different social groups.

One of the major contributions of conflict theory to our understanding of illness is the concept of medicalization. As we saw in Chapter 6, medicalization refers to the process through which a condition or behavior becomes defined as a medical problem requiring a medical solution (Conrad 2007). One hundred years ago, masturbation, homosexuality, and, among young women, the desire to go to college were all considered symptoms of illness. These conditions are no longer considered illnesses not because their biology changed but because social ideas about them did. Similarly, one hundred years ago most women gave birth at home attended by midwives, few boys were circumcised, and plump people were considered attractive and lucky. Nowadays, pregnant women are expected to seek medical care, parents are expected to have their infant sons circumcised by doctors, and overweight people are considered to be at risk for illness or even to have the "illness" of obesity. These are all examples of medicalization.

For medicalization to occur, one or more organized social groups must have both a vested interest in it and sufficient power to convince others to accept their new definition of the situation. The strongest force currently driving medicalization is the pharmaceutical industry, which has a vested financial interest in enlarging the market for its products (Conrad 2007). For example, the pharmaceutical industry was the major force behind defining "male sexual dysfunction" as a disease—to be cured by Viagra (Loe 2004). Pressure for medicalization also can come from doctors who hope to enlarge their markets and from consumer groups who hope to stimulate research on or reduce the stigma of ambiguous conditions such as alcoholism or fibromyalgia (Barker 2005; Conrad 2007).

Mass marketing of Viagra "sold" both the drug and the idea that impotence was a symptom of the disease "erectile dysfunction disorder."

Conversely, doctors sometimes oppose medicalization because they don't want the responsibility for treating a condition (such as wife battering), and consumers sometimes oppose medicalization because they believe a condition is simply a natural part of life (such as menopause). Insurers, too, may support or oppose medicalization, depending on their interests. For example, initially insurers rejected requests for expensive gastric bypass surgery for obese patients, arguing that obesity was not an illness. Now that most insurers have concluded that these surgeries reduce their long-term costs, they support diagnosing obesity as an illness and surgically treating it (Conrad 2007). In each case, the battle over medicalization was won by the group that could bring the most money, influence, and other forms of power to bear.

sociology and you

Social Policy

The next time you are at a doctor's office, keep your eyes open. Do you see pamphlets, posters, pens, mugs, or anything else labeled with names or logos from pharmaceutical companies? Does your doctor offer you free samples of new drugs? Are there any health magazines you don't recognize (likely published by pharmaceutical companies)? All of these are evidence of the pharmaceutical industry's attempts to influence disease diagnosis and treatment.

Symbolic Interaction Theory: The Experience of Illness

The sick role model helps us understand cultural assumptions for how ill people should behave and how they should be treated by others, whereas conflict theory helps us understand how people come to be defined as ill in the first place. In contrast, symbolic interaction theory is particularly useful for understanding what it is like to live with illness on a day-to-day basis and, especially, what happens when doctors and patients have different definitions of the situation. This issue comes to the fore when doctors and patients disagree over treatment.

To doctors, any patient who does not follow their medical orders is engaging in *medical noncompliance*. Doctors typically assume that they know best how a disease should be treated, and therefore assume that any patient who does not follow their orders is either foolish or ignorant. Research by symbolic interactionists, however, suggests that the issue is far more complex. Some patients don't comply because health-care workers offered only brief and confusing explanations of what to do and why. Other patients lack the money, time, or other resources needed to comply. Still others conclude that following medical advice is simply not in their best interests. They may decide, for example, against taking a drug that lowers blood pressure but leaves them unable to achieve erection, that reduces schizophrenic hallucinations but causes obesity, or that brings substantial side effects but seems to have no impact on their symptoms (Lawton 2003). And increasingly, patients reach decisions about treatment based as much on the Internet as on their doctors' advice, a topic discussed in Focus on Media and Culture: The Internet and Health.

In sum, what doctors define as medical noncompliance, patients define as rational decision making. When doctors chastise patients for their noncompliance and fail to understand their perspectives, patients are likely to become even less willing to follow doctors' orders, creating a self-fulfilling prophecy.

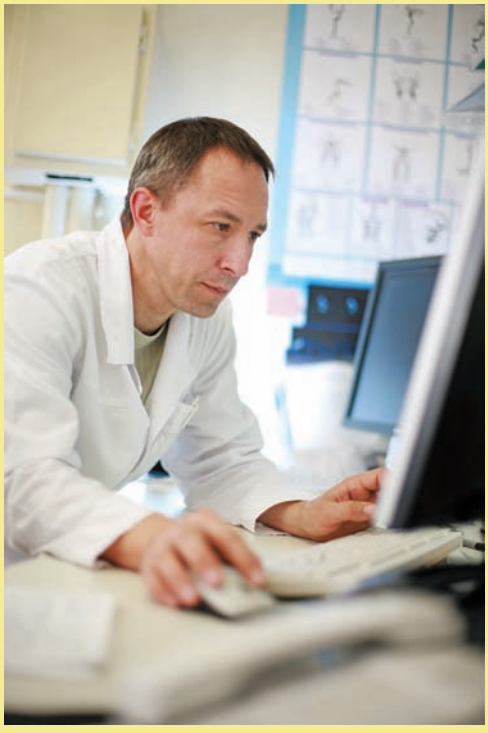
focus on MEDIA AND CULTURE

The Internet and Health

The rise of the Internet has dramatically affected how doctors, the government, the pharmaceutical industry, and the public deal with illness.

One major change is the shift to online medical records. These records allow multiple doctors, nurses, pharmacists, and others to access the same patient's records, even if they are working at different locations (such as a doctor's office, a hospital, and a drugstore). Such records reduce the chance that a patient will receive prescriptions from different doctors for drugs that interact dangerously and increase the chance that doctors will have a broader understanding of a patient's health problems. However, the use of online medical records raises serious concerns about patient privacy (Alpert 2003; Freudenheim & Pear 2006). For example, if the record indicates that a patient has been treated for alcohol-related problems, many people will *legally* gain access to that information and anyone with good computer hacking skills may do so *illegally*. As a result, patients may experience stigma or even lose their jobs or health insurance. Thus this change has the potential to shift power to any group that has access to the records.

Another major change is the rise in online pharmaceutical sales (Eckholm 2008). These sites benefit consumers by enabling them to purchase needed drugs at reduced costs. On the other hand, these sites enable anyone anywhere to obtain dangerous drugs without prescriptions. In some cases, people may risk their health when they purchase drugs they believe they need without first checking with a doctor. In other cases, people may risk their health by illegally buying addictive drugs such as Valium and Vicodin. Thus these sites have increased the power of individual users and of drug providers while decreasing the power of doctors and the government to control drug use.



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Finally, the Internet has affected the entire experience of illness (Barker 2005). These days, many people check the Internet whenever they feel ill—even before calling their doctor. The Internet is in fact a great way to learn, for example, how to tell a simple cold from influenza. The Internet is also especially helpful for those with stigmatized, difficult-to-diagnose, or difficult-to-treat illnesses, such as chronic fatigue syndrome, urinary problems, or multiple sclerosis. Many such individuals have diagnosed themselves (whether accurately or inaccurately), found tremendous emotional support, and garnered practical (if sometimes untested) advice from websites, online message boards, and blogs (Sulik & Eich-Krohm 2008; Seale, Ziebland, & Charteris-Black 2006; Berger, Wagner, & Baker 2005). And many of these have used this information and advice to challenge their doctor's views. Thus the Internet potentially can shift the balance of power between patients and doctors.

The Social Causes of Health and Illness

In a widely cited article titled "A Case for Refocusing Upstream," sociologist John McKinlay (1994) offers the following oft-told tale as a metaphor for the modern doctor's dilemma:

> Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another

> cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have *no* time to see who the hell is upstream pushing them all in. (McKinlay 1994, 509–510)

Like the would-be rescuer in this story, doctors have few opportunities to focus upstream and ask why their patients get sick in the first place. Sociologists attempt to answer this question at two levels: the micro-level, in which individuals make choices about adopting behaviors that risk their health, and the macro-level, in which social structures limit the choices available to individuals.

But before we can ask why individuals' health is at risk, we need to know what those risks are. To do so, we need to look at the underlying causes of preventable death.

Underlying Causes of Preventable Death

In a highly influential article published in the *Journal of the American Medical Association*, Mokdad and his colleagues (2004) reviewed all available medical literature to identify the underlying causes of preventable deaths (that is, deaths caused neither by old age nor by genetic disease). Nine factors—tobacco, poor diet and inadequate exercise, alcohol, bacteria and viruses, polluted workplaces and neighborhoods, motor vehicles, firearms, sexual behavior, and illegal drugs—emerged as underlying almost half of all preventable deaths in the United States (Table 10.1).

Of these nine factors, tobacco is clearly the most important—and is far more important than all illegal drugs combined. Whether smoked, chewed, or used as snuff, tobacco can cause an enormous range of disabling and fatal diseases, including heart disease, strokes, emphysema, and numerous cancers (World Health Organization 2008b). About half of all smokers will die because of their tobacco use, with half of these dying in middle age and losing an average of 22 years from their normal life expectancy.

TABLE 10.1 Underlying Causes of Preventable Death in the United States

Cause	Number of Preventable Deaths	Percentage of All Deaths
Tobacco	435,000	18%
Poor diet and inadequate exercise[1]	100–400,000	5–17
Alcohol	85,000	4
Bacteria and viruses[2]	75,000	3
Polluted workplaces and neighborhoods	55,000	2
Motor vehicles[3]	43,000	2
Firearms	29,000	1
Sexual behavior	20,000	1
Illegal drugs	17,000	1

SOURCE: Mokdad et al. 2004.
[1]Estimates vary.
[2]Not including deaths related to HIV, tobacco, alcohol, or illicit drugs.
[3]Includes motor vehicle accidents linked to drug use but not to alcohol use.

The second most common cause of premature deaths is a high-fat diet, sedentary lifestyle, and resulting obesity. Rates of obesity in the United States have skyrocketed since 1980 (Centers for Disease Control and Prevention 2009). The combination of poor diet and insufficient exercise increases the risks of cardiovascular disease, strokes, certain cancers (of the colon, breast, and prostate), and diabetes, among other problems.

The remaining seven factors cause preventable deaths in a variety of ways. Alcohol and illegal drugs make unsafe sex more likely; alcohol, motor vehicles, firearms, and illegal drugs all contribute to deadly accidents; and alcohol, pollution, unprotected sex, and illegal drugs (when injected) can cause cancer, hepatitis, and other illnesses.

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As the health belief model suggests, these boys are unlikely to stop smoking because they are unlikely to believe—or even know—that smoking places them at risk for lung cancer and other serious diseases.

Micro-Level Answers: The Health Belief Model

Why do individuals engage in behaviors that endanger their health? Or, to ask the question more positively, why don't individuals adopt behaviors that will *protect* their health? Sociologists have identified four conditions—known collectively as the **health belief model**—that consistently predict whether individuals will adopt healthy behaviors (Becker 1974, 1993). These conditions are:

1. Individuals must believe they are at risk for a particular health problem.
2. They must believe the problem is serious.
3. They must believe that adopting preventive measures will reduce their risks significantly.
4. They must not perceive any significant financial, emotional, physical, or other barriers to adopting the preventive behaviors.

The experience of Pittsburgh Steelers quarterback Ben Roethlisberger illustrates this model (as does the Concept Summary on the Health Belief Model on the next page). In June 2006, Roethlisberger suffered a concussion and numerous other injuries after crashing his motorcycle. He was not wearing a helmet at the time, even though helmets reduce the risk of dying in an accident by at least one-third and reduce the rate of brain injury by two-thirds (National Highway Traffic Safety Administration 2005).

Following his accident, Roethlisberger vowed never to ride a motorcycle without a helmet again. He now realized that the threat of a crash was real, and that the consequences of a crash could be serious or even fatal. Having crashed headfirst into a car's windshield, it now made sense to him that wearing a helmet would significantly reduce his risk of death or brain injury. And when weighed against these potential benefits, the cost and discomfort of a helmet and the potential threat to his "tough guy" image if he wore one no longer seemed like important barriers.

According to the **health belief model**, individuals will adopt healthy behaviors if they believe they face a serious health risk, believe that changing their behaviors would help, and face no significant barriers to doing so.

Macro-Level Answers: The Manufacturers of Illness

At first glance, it's easy to conclude that poor individual choices explain most or even all preventable deaths. After all, like Ben Roethlisberger, other people also weigh

concept summary

Health Belief Model

People Most Likely to Adopt Healthy Behaviors When They	Example: Adopting Healthy Behaviors	
	Likely	Unlikely
Believe they are susceptible:	Forty-year-old smoker with chronic bronchitis who believes he is at risk for lung cancer.	Sixteen-year-old boy who believes he is too healthy and strong to contract a sexually transmitted disease.
Believe risk is serious:	Believes lung cancer would be painful and fatal, and does not want to leave his young children fatherless.	Believes that sexually transmitted diseases can all be easily treated.
Believe compliance will reduce risk:	Believes he can reduce risk by stopping smoking.	Doesn't believe that condoms prevent sexually transmitted diseases.
Have no significant barriers to compliance:	Friends and family urge him to quit smoking, and he can save money by so doing.	Enjoys sexual intercourse more without condoms.

their options and then choose to smoke tobacco, use firearms, engage in risky sex, and so on. But those choices are made in a broader social context. If we look more closely at that social context, we quickly come to what McKinlay (1994) describes as the **manufacturers of illness:** groups that promote deadly behaviors and social conditions. For example, cigarettes, beer, fast cars, good rifles, and sugary foods are inherently appealing to many people. But it is the manufacturers of these goods that largely determine how safe or dangerous their products will be, to whom and how they will be advertised, and where they will be sold. For example, car manufacturers have fought against bumpers that would make SUVs less dangerous to other cars, soda manufacturers have fought for the right to sell their high-calorie products in schools, and tobacco manufacturers have (implicitly) promoted smoking to teens and children through such tactics as the Joe Camel campaign and sponsoring youth-oriented concerts and music festivals (Weitz 2010).

Individual choice is even less a factor for the other underlying causes of death (Weitz 2010). People work with dangerous pesticides, inject illegal drugs that they don't know have been cut with dangerous chemicals, and live in apartments with lead in the water pipes because they lack alternatives. Manufacturers of illness in these circumstances include corporations that expose their workers to dangerous conditions, landlords who don't maintain their buildings, and politicians who oppose legalizing drugs so the drugs can be regulated. Finally, individuals are most likely to engage in unsafe behaviors—from eating doughnuts to shooting crack and having sex without condoms—if they feel they have nothing to look forward to anyway. These feelings are most common among those who are trapped at the bottom of the social class system.

The **manufacturers of illness** are groups that promote and benefit from deadly behaviors and social conditions.

The Social Distribution of Health and Illness

Good health is not simply a matter of good habits and good genes. Although both elements play important parts, health is also strongly linked to social statuses such as gender, social class, and race or ethnicity. In this section, we provide an overview of how these statuses affect health in the United States and then briefly examine how changes in social structure have affected life expectancy in the former Soviet Union.

In the United States, the average newborn can look forward to 78 years of life (National Center for Health Statistics 2009). Although some will die young, the average U.S. resident now lives to be a senior citizen. This is a remarkable achievement given that life expectancy was less than 50 years at the beginning of the twentieth century. Not everyone has benefited equally, however: Men, African Americans, and poorer people on average die younger than women, whites, and more affluent individuals (Table 10.2).

There is much more to health, of course, than just avoiding death. The distribution of illness and disability is at least as important as the distribution of mortality in evaluating a population's overall well-being. For every person who dies in a given year, many more experience serious illness or disability that affects the quality of their lives. In the following sections, we consider why and how gender, social class, and race/ethnicity are related to illness and mortality.

TABLE 10.2 The Impact of Sex, Race, and Family Income on Health
White Americans are healthier than African Americans, and wealthier people are healthier than are poorer people. On average, men have lower life expectancies than do women. Men and women are equally likely to report being in fair or poor health.

	Life Expectancy	Percentage Reporting Fair or Poor Health
Sex		
Male	75	9
Female	80	10
Race		
White	78	9
African Americans	73	14
Hispanic	NA	13
Asian	NA	7
Family income		
Poor	NA	20
Near poor	NA	14
Not poor	NA	6

SOURCE: National Center for Health Statistics 2009.

Gender

On average, U.S. women live about 5 years longer than U.S. men (see Table 10.2). Yet, although women live longer, they also report significantly worse health than men at all ages: more arthritis, asthma, diabetes, cataracts, and so on (Lane & Cibula 2000; Rieker & Bird 2000). These differences mean that women more often than men experience disability and discomfort as they age. In part because of this combination of longer lives and more illnesses, women are considerably more likely than men to eventually enter a nursing home.

How can we explain why, as the saying goes, "Women get sicker but men die quicker"? The answer lies in both biology and society. Probably because of their hormones, females are inherently stronger than males: As long as females receive sufficient food and caring, their chances of survival are greater than for males at every stage of life from conception onward (Rieker & Bird 2000).

Social norms also protect women from fatal disease and injury (Rieker & Bird 2000). Odds are you know a lot more young men than young women who enjoy fast driving, daredevil sports, slugging whiskey, or slugging others. These and other similar behaviors, all of which increase the chances of death, are socially encouraged for males but discouraged for females. Men are also more likely than women to use illegal drugs and to work at dangerous jobs. Finally, women are more likely than men to seek health care when they experience problems, although this has only a small impact on their overall health status.

It is less clear why, despite their lower chances of dying at any given age, women have higher rates of illness than do men (Barker 2005). Most likely, women's higher rates of illness stem from both their hormones (a biological effect) and the fact that, on average, they experience more stress than do men but have less control over the sources of that stress (a social effect). Because stress makes it more difficult for the body's immune system to function, it often leads to ill health.

Social Class

The higher one's income, the longer one's life expectancy and the better one's health (see Table 10.2): Wealthy people live longer on average than do middle-class people, and middle-class people live longer than do poor people (Marmot 2004). This is true even in countries where everyone has access to health care, and even when we compare only people who have similar rates of smoking, obesity, and alcohol use (Banks et al. 2006). Moreover, these differences begin in infancy and childhood. For example, about 50 percent of children in New York City's homeless shelters have asthma, compared with 25 percent of children in the city's poorest neighborhoods and 6 percent of the city's children overall (Pérez-Peña 2004).

The reasons for the link between social class and illness are complex (Robert & House 2000; Marmot 2004; Wilkinson 2005). They are partially attributable to poorer people's inability to afford expensive medical care. However, environmental, economic, and psychosocial factors play even stronger roles in linking poverty with ill health. Lower-income people are more likely to live in unsafe and unhealthy conditions, near air-polluting factories, or in substandard housing. They are more likely to hold dangerous jobs and to lack sufficient, good-quality food. Low-income people also experience more stress than others but have less control over the causes of that stress. As a result, like women at all income levels, they are more likely to experience illness due to stress. In addition, whereas upper-income persons might cope with stress by

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Conditions in modern sweatshops, such as this one in New York City's Chinatown, place workers at high risk of injury and illness.

taking a vacation or hiring a maid to help out at home, lower-income people have few such options. Instead, some will try to cope with stress through drinking, smoking, and other calming but health-risking behaviors.

Race and Ethnicity

Although income affects health more than do race and ethnicity (Weitz 2010), the latter nonetheless has a strong and independent effect. Asian Americans of Chinese, Japanese, Filipino, or Indian heritage typically are at least middle class and experience health at least as good as that of whites; the prognosis for recent, poorer immigrant groups from Southeast Asia remains unclear. In contrast, African Americans, Hispanic Americans, and Native Americans are on average poorer than non-Hispanic whites, and primarily as a result suffer disproportionately from the effects of low socioeconomic status on health. Because of lower incomes, these nonwhites are significantly more likely than whites or long-established Asian groups to lack health insurance (Kaiser Commission on Medicaid and the Uninsured 2008). They are also more likely to experience stress and to live or work in areas contaminated by soot, carbon monoxide, ozone, sulfur, pesticides, and even radioactive wastes. For example, *60 percent* of all American children who have dangerously high levels of lead in their blood are African American, and only 17 percent are white non-Hispanic (Meyer et al. 2003).

In addition, regardless of income, the prejudice and discrimination experienced by minorities increases their rates of illness and death (Williams 1998; Williams & Jackson 2005). For example, because of racial segregation, even middle-class African Americans are more likely than whites to live in neighborhoods where violence and pollution threaten their health. Similarly, regardless of patients' symptoms or insurance coverage, doctors are more likely to offer white patients various life-preserving treatments (including angioplasty, bypass surgery, and the most effective drugs for

HIV infection) and more likely to offer minorities various less desirable procedures, such as leg amputations for diabetes (Nelson, Smedley, & Stith 2002).

Taken together, these factors lead African Americans, Hispanics, and Native Americans to have significantly higher rates of illness and higher chances of dying at any given age than do whites.

Age

Not surprisingly, age is the single most important predictor of health, illness, and death. The two groups most at risk are the very young and the very old.

In poor countries, deaths are very common among infants and children younger than age 5. Some die because they are born prematurely, others because they do not get enough food, and still others because their immune systems are unable to fight disease, especially if they are malnourished.

Deaths of young children were also common in the Western world before the twentieth century. These days, such deaths are very rare in the United States, and young people are typically healthy. Compared with other developed nations, however, infant mortality remains shockingly high (Table 10.3). Infant mortality is especially high among African Americans, who (for all the reasons just discussed) are more than twice as likely as white babies to die in infancy (National Center for Health Statistics 2009).

Once past infancy, the chances of dying or developing a disabling illness only begin to rise gradually beginning at about age 40. By age 65, most people will have at least one long-lasting health problem, such as arthritis, hypertension, or hearing loss (Federal Interagency Forum on Aging Related Statistics 2008). Yet even by age 85, the majority report being in good or excellent health. However, the odds of enjoying a healthy old age are significantly lower for racial and ethnic minorities: Among those

TABLE 10.3 Infant Mortality Rates per 1,000 Live Births

Hong Kong	1.6	**U.S., white non-Hispanic**	5.7
Singapore	2.4	Hungary	5.9
Sweden	2.5	Poland	6
Japan	2.8	Slovakia	6.1
France	3.6	**U.S., all races**	6.6
Spain	3.7	Chile	8.8
Germany	3.9	Russia	9
Denmark	4	Bulgaria	9.2
Switzerland	4	Costa Rica	9.7
Italy	4.2	Uruguay	10.5
Netherlands	4.4	Romania	12
Australia	4.7	**U.S., African Americans**	13.7
United Kingdom	4.9	Thailand	16
Cuba	5.3	Mexico	19
Canada	5.4		

SOURCE: Population Reference Bureau 2008.

focus on  AMERICAN DIVERSITY

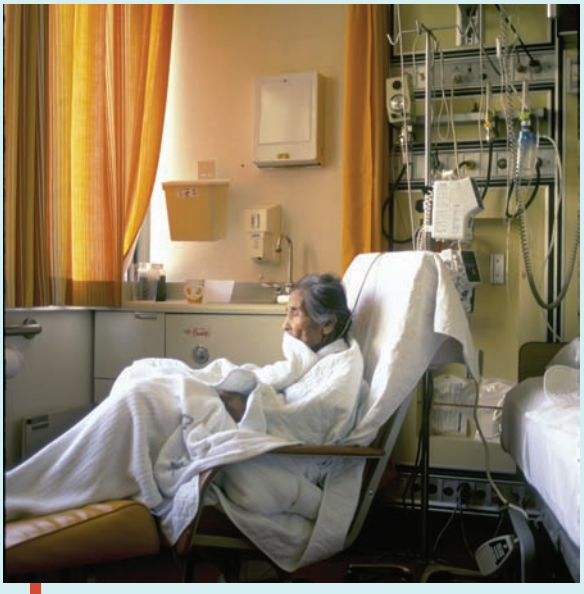
Changing Populations, Changing Health

With each passing year, fewer babies are born in the United States and more U.S. residents turn 65. At the same time, the white non-Hispanic population is shrinking while the Hispanic and nonwhite populations are growing. What are the combined consequences of these two population trends for health and health care in America?

One obvious result of having more older Americans and more nonwhite Americans is that in the future there will be more Americans who are both older *and* nonwhite. This will have many important consequences, for the experience of old age is substantially different for nonwhite compared with white Americans (Takamura 2002). Most importantly, minority elderly are more likely than others to be poor: Twenty-six percent of African American elderly live below the poverty line, compared with 21 percent of Latino elderly and only 8 percent of white non-Hispanic elderly. This has serious implications for health and health care, because poorer persons are both more likely to need services and less likely to have health insurance and less able to pay for them out of pocket.

But the problems extend beyond those who live in poverty. Even when incomes are equivalent, and after controlling for education, age, sex, marital status, and urban residence, minority elderly are still more likely than white elderly to lack health insurance. As a result, they find it more difficult to get the medical treatment they need, and their health problems are more likely to spiral out of control, making them more difficult (and expensive) to treat in the long run.

Finally, even if they are able to obtain health care, cultural barriers may make that health care less effective than it would otherwise be (Capitman 2002; Hayes-Bautista, Hsu, & Perez 2002; Takamura 2002). When doctors and patients don't speak the same language or come from different cultures or subcultures, doctors may not understand what their patients need and patients may not understand what their doctors want them to do. In these circumstances, patients can become dissatisfied, ignore instructions, or skip follow-up visits. In turn, doctors may come to regard patients as unintelligent or unmotivated. This is a serious problem in the United States, given that most doctors are white and speak only English but many patients are nonwhite and do not speak English well if at all. Conversely, communication is also a problem for elderly white patients living in nursing homes. Although most doctors and nurses are white, day-to-day care in nursing homes is primarily left to poorly paid nurse's aides. Most of these aides are nonwhite immigrants, many of whom speak English with heavy accents that older people with hearing problems find difficult to understand. For all these reasons, policy makers will need to pay close attention to both these population changes.



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As the number of minority elderly increase, we are likely to see an increased number of elderly people who are poor, who lack health insurance, and who face cultural barriers in interacting with health-care practitioners.

aged 68 or older, 80 percent of non-Hispanic whites consider themselves healthy, compared with 65 percent of Hispanics and 63 percent of African Americans (Federal Interagency Forum on Aging Related Statistics 2008).

The health consequences of the shift toward an older and more diverse population are explored more fully in Focus on American Diversity: Changing Populations, Changing Health.

Case Study: Declining Life Expectancy in the Former Soviet Union

The single most important social factor affecting mortality is the standard of living—access to good nutrition, safe drinking water, and adequate housing free from environmental hazards. Differences in living standards help to explain why African American infants in the United States are more than twice as likely as white infants to die in their first year of life and why the average life expectancy of African American men is 6 years less than that of the average white non-Hispanic male. Differences in living standards also help to explain why, on average, Americans can expect to live 30 years longer than citizens of Sierra Leone (Population Reference Bureau 2008).

Throughout the world, improvements in living standards have been accompanied by increased life expectancy. Consequently, the precipitous decline in life expectancy in the former Soviet Union over the last 20 years is one of the most surprising current developments in world health; life expectancy for Russian men is now only 60 years—far lower than before the collapse of the Soviet Union and far lower than in other developed nations (Population Reference Bureau 2008).

What explains this shocking drop in life expectancy? First, during its decades as a dictatorship, the Soviet Union put industrial development above environmental protection. As a result, the countries of the former Soviet Union are now plagued by extensive environmental pollution. This has significantly raised rates of cancer and respiratory diseases, especially in the most industrialized regions (Cockerham 1997; Haub 1994). Second, as we've seen, stress is often an underlying cause of illness. After the collapse of the Soviet Union, incomes plummeted, social services ground to a halt, political uncertainty and corruption increased, and an entire way of life evaporated. The resulting rise in stress levels directly explains much of the increase in deaths. In addition, this stress also fostered sharp increases in smoking and drinking, with resulting deaths from disease, violence, and accidents. Finally, the former Soviet Union had never invested much in health care for the chronic illnesses, such as heart disease, that now cause most deaths, and the health-care system only worsened after the collapse of the Soviet system. Conditions overall have improved in the last few years, but years of environmental damage, social turmoil, and poor living conditions continue to take a large toll.

In sum, in the former Soviet Union as in the United States, social conditions are closely tied to health, illness, and death.

Mental Illness

So far we have talked about health and illness as if the only thing that matters is *physical* health. But mental health is also a crucial issue, affecting millions of people each year.

How Many Mentally Ill?

National random surveys of the U.S. population suggest that during the course of any given year, approximately 11 percent of working-age adults experience a minor but still-diagnosable mental illness, and another 20 percent experience a moderate or severe illness (Kessler et al. 2005). The most common illnesses are major depression and problems with alcohol use. These estimates, however, are probably a bit high, since

they are based on reports of symptoms, not medical diagnoses of illnesses (Horwitz 2002). Survey researchers can't know, for example, if someone has lost weight because of depression or because they are getting ready for a wrestling match.

Who Becomes Mentally Ill?

As with physical illness, social factors strongly predict mental illness. We focus here on two important factors: social class and gender.

Social-Class Differences

Since the 1920s, when sociological study of mental disorder began, researchers consistently have found that poorer people experience more mental illness than do wealthier people (Eaton & Muntaner 1999). Researchers disagree, however, on the reasons for this pattern. Some argue that the social stress associated with lower-class life causes mental disorder. Others believe that the onset of mental illness causes people to lose their jobs and drift downward in social class.

Research clearly shows that the lower class does, in fact, experience more of the types of stress (such as job loss or chronic physical disabilities) that can cause mental disorders (Turner, Wheaton, & Lloyd 1995; Turner & Avison 2003; Ali & Avison 1997). The stresses of poverty and economic insecurity appear to be particularly important in understanding the causes of disorders such as major depression.

At the same time, research shows that the onset of disorders such as schizophrenia makes it difficult for people to keep a job. Not only may individuals lose their initial job, but once potential employers discover that an individual has a history of mental disorder, they may be reluctant to hire him or her for anything other than a minimum-wage job (Link et al. 1987, 1997). In these cases, a mental disorder clearly causes people to drift into a lower social class. Social drift, however, explains a lower proportion of mental illness than does the stress of lower social-class life.

In addition to social-class differences in *rates* of mental illness, there are also important differences in the *experience* of mental illness. Lower-class persons diagnosed with mental illness remain in hospitals for longer periods of time and receive less effective types of treatment. In fact, most mental health treatment goes to middle-class persons experiencing short-term emotional problems, rather than to persons (of whatever social class) who are seriously mentally ill. Meanwhile, as funding for hospitals and health care has declined, lower-class mentally ill persons increasingly have been sent to jails or prisons rather than to clinics or hospitals when their behavior becomes socially unacceptable; according to the U.S. Department of Justice, more than half of all jail and prison inmates are mentally ill (James & Glaze 2006).

Gender Differences

Depression is the most common form of mental illness, affecting about 17 percent of all adults living in the United States (Kessler et al. 2005). Because depression is so common and because it is much more commonly diagnosed in women, the overall rates of mental illness are higher for women than for men.

Why are women more likely than men to be diagnosed with depression? Most theorists hypothesize that women have higher rates of depression because they experience more stress *and* have less control over that stress (Horwitz 2002, 173–179). In fact, rates of depression are highest among those women with the least control over their lives: nonworking women and married mothers. A waitress with young children and a husband who expects a hot meal when he gets home, for example, has few means for controlling her life, schedule, or stress levels. By the same token, depression is

especially common among men who have less power than their wives, have little control over their work, or lose their jobs.

In contrast, men are more likely than women to report substance abuse and "personality disorders" characterized by chronic maladaptive personality traits, such as compulsive gambling or violence (Kessler et al. 2005). Scholars theorize that because the traditional male role encourages men to respond to stress with aggression or substance abuse, those who experience stress and mental illness are more likely to develop these sorts of symptoms.

Working in Health Care

As in any other area of social life, health care has its own set of roles, statuses, and battles over power. In this section, we look at the two most important health-care occupations, medicine and nursing, and discuss how each has fought to maintain or improve its position in the health-care hierarchy.

Physicians: Fighting to Maintain Professional Autonomy

Less than 5 percent of the medical workforce consists of physicians. Yet they are central to understanding the medical institution. Physicians are responsible both for defining ill health and for treating it. They set the standards for how patients should behave and play a crucial role in setting hospital standards and in directing the behavior of the nurses, technicians, and auxiliary personnel who provide direct care.

As will be described in Chapter 13, a profession is a special kind of occupation that demands specialized skills and permits creative freedom. No occupation better fits this definition than that of physician. Until about 100 years ago, however, almost anyone could claim the title of physician; training and procedures were highly variable and mostly bad (Starr 1982). Some doctors were almost illiterate, many learned to doctor through apprenticeships, and most of the rest learned through brief courses where virtually anyone who could pay the fees could get certified. With the establishment of the American Medical Association in 1848, however, the process of professionalization began; the process was virtually complete by 1910, at which point strict medical training and licensing standards were adopted.

Understanding Physicians' Income and Prestige

The medical profession provides an example for stratification theories. Family practitioners currently earn a median net salary of $156,000, and general surgeons earn an average of $283,000 (U.S. Bureau of Labor Statistics 2009a). Why are physicians among the highest-paid and highest-status professionals in the United States?

According to structural-functionalists, there is a short supply of individuals who have the talent and ability to become physicians and an even shorter supply of those who can be surgeons. Moreover, physicians must undergo long and arduous periods of training. Consequently, high rewards must be offered to motivate the few who can do this work to devote themselves to it. The conflict perspective, on the other hand, argues that the high income and prestige accorded physicians have more to do with physicians' use of power to promote their self-interest than with what is best for society.

In defense of this argument, conflict theorists point to the role played by the American Medical Association (AMA). The AMA sets the standards for admitting

physicians to practice, punishes physicians who violate the standards, and lobbies to protect physicians' interests in policy decisions. Although less than half of all physicians belong to the AMA, it nonetheless continues to wield considerable power. It has fought vigorously to ensure the continuance of the free market model of medical care, in which the physician remains an independent provider of medical care on a fee-for-service basis. In pursuit of this objective, the AMA has consistently opposed all legislation designed to create national health insurance, including Medicare, Medicaid, and President Obama's proposals. It also has fought to ban or control a variety of alternative medical practices such as midwifery, osteopathy, and acupuncture (Weitz 2010).

The Changing Status of Physicians

Although physicians have succeeded in maintaining high incomes, they have done less well in maintaining other professional privileges. Until the 1970s, most physicians worked as independent providers with substantial freedom to determine their conditions of work. They also benefited from high public regard; some patients considered them a nearly godlike source of knowledge and help. Much of this is changing. The many signs of changes include the following (Coburn & Willis 2000; Weitz 2010):

- A growing proportion of physicians work in group practices or for corporations, where bureaucrats determine fees, procedures, and working hours. As a result, physicians have lost much of their independence.
- The public has grown increasingly critical of physicians. Getting a second opinion is now standard, and malpractice suits have become much more common.
- Fees and treatments are increasingly regulated by government agencies and insurance companies. Physician autonomy is limited whenever these groups start dictating what treatments will be funded, for which patients, and at what fees.

Doctors have not accepted these changes lying down. Instead, they have fought for legal restrictions on malpractice lawsuits and on insurance company regulations. They have also fought in the court of public opinion to convince patients that physicians continue to have patients' best interests at heart.

Despite these problems, being a physician is still a very good job, offering high income and high prestige. But it is also part of an increasingly regulated industry that is receiving more critical scrutiny than ever before.

Francis Hogan/Electronic Publishing Services Inc., N.Y.C

The popularity of doctor play sets and the large number of children who aspire to medical professions demonstrate the continuing prestige of doctors in contemporary society.

Nurses: Fighting for Professional Status

Of the nearly 10 million people employed in health care, the largest single component is that of the 1.8 million registered nurses. No hospital could run without nurses, and no doctor could function without them. Yet despite their great importance to the health-care system, their status remains far lower than we might expect. Why have nurses' attempts to improve their status achieved only modest success?

Nurses' Current Status

Nurses play a critical role in health care, but they have relatively little independence, either in their day-to-day work or in their training and certification. Physicians have a major voice in determining the training standards that nurses must meet and in enforcing these standards through licensing boards. On the job, even the most junior physician can give orders to experienced nurses. Reflecting this status difference, nurses' median income is

now $57,000—only one-third the income of doctors in family practice (U.S. Bureau of Labor Statistics 2009a). Even when nurses have PhDs or master's degrees, their salaries remain a fraction of doctors' salaries. Finally, although the general public respects nurses for their dedication, it tends to discount nurses' specialized education. For all these reasons, nursing does not meet the sociological definition of a profession.

Why is nursing's status so low? The primary reason is its history as a traditionally female occupation. Before the twentieth century, most people believed that caring came naturally to women and, therefore, that mothers, daughters, cousins, and sisters should always be willing to help care for any sick family member (Reverby 1987). Nursing did not become a formal occupation until the mid-nineteenth century. Because of its historic roots, from the start it was considered a natural extension of women's character and duty rather than an occupation meriting either respect or rights (Reverby 1987). Nurses were encouraged to enter the field in a spirit of altruism and self-sacrifice and, as proper young women, to accept orders from doctors, hospital administrators, and their nursing superiors. This approach made it difficult for nursing as a field to fight for status, autonomy, or better working conditions. Moreover, the fact that the field was almost solely female in and of itself made it difficult for nursing to obtain the autonomy and public respect for its training and work that define a profession.

Changing the Status of Nurses

To improve the status and position of nurses, nursing's leadership has worked for decades to raise educational levels (Weitz 2010). Until the 1960s, the standard nursing credential was an RN (registered nurse) diploma, obtained through a hospital-based training program. Now, almost all RNs hold 2- or 4-year nursing degrees from community colleges or universities. In addition, a small percentage of nurses obtain graduate degrees and become nurse practitioners or nurse-midwives. These nurses enjoy considerably more autonomy, status, and financial rewards than do other nurses, including the right to prescribe specified medications in most states.

The drive to increase nurses' education and thus their status has succeeded only partially. Because many hospitals believe that associate-degree nurses receive the best practical training and make the best employees, associate-degree programs have remained more popular than higher-level training. Meanwhile, to control costs, hospitals have shifted many services to outpatient clinics where fewer RNs are needed, nurses' salaries are lower, and nursing jobs are less interesting and prestigious (Norrish & Rundall 2001). In addition, hospitals have reduced their nursing staffs and increased the workload of the remaining nurses (Gordon 2005). Finally, although more men now work as nurses, the field is still considered a "woman's profession," and for that reason, salaries and status remain relatively low.

Understanding Health-Care Systems

Ensuring that people have access to health care is one of the most basic tasks of any society. The United States offers many ways through which people can get health care: private and publicly funded insurance, private and public clinics and hospitals, or cash payments. Yet many Americans can obtain only low-quality care, many can obtain care only by making financial sacrifices, and many cannot afford care at all. How does health insurance in the United States work? Why do some people lack insurance, and what are the consequences of being uninsured? How do other countries manage to pay for health care for all their citizens, and why doesn't the United States also have a national health-care program?

Paying for Health Care in the United States

Medical care is the fastest-growing segment of the cost of living. In 1970, Americans spent an average of $372 per person (in 2006 dollars) on medical care. By 2006, they spent an average of $6,561, and by 2013 they will probably spend twice that (U.S. Bureau of the Census 2009a).

There are three primary modes of financing health care in the United States: paying out of pocket, private insurance, and government programs. The cost of health care is so high that only the very rich can afford to pay out of pocket for anything beyond minor problems. As a result, most Americans must rely on private insurance or on government insurance programs. The remainder have no insurance and often are unable to pay for health care. Even those who have insurance often find that it doesn't cover many of their bills. In total, 21 percent of Americans recently surveyed by the Gallup Poll report that they sometimes cannot afford to purchase needed medical care or drugs (Szabo & Appleby 2009). Map 10.1 shows how this varies around the United States.

Private Insurance

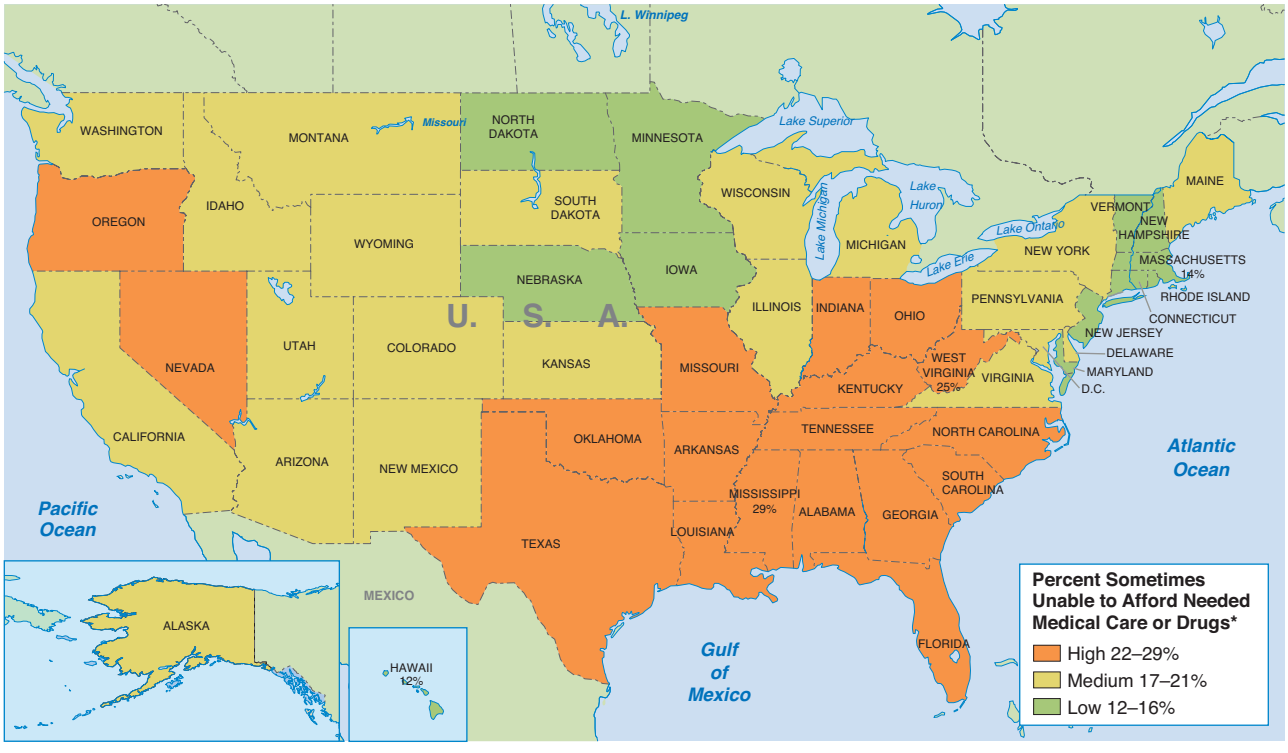
Most insured Americans hold private insurance obtained via their employers, their parents' employers, or their spouses' employers. Individuals are most likely to get insurance from their employer if they work for large corporations or government agencies

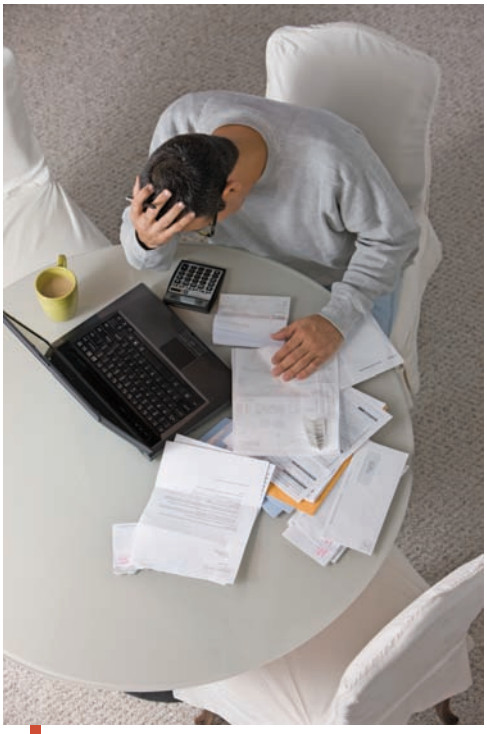
MAP 10.1: Percent Sometimes Unable to Afford Needed Medical Care or Drugs*

Twenty-one percent of Americans are sometimes unable to afford needed medical care. Rates are highest in southeastern states with many poor, African American residents and lowest in states with state-funded insurance programs, such as Hawaii and Massachusetts.

SOURCE: Szabo & Appleby (2009).

*During previous 12 months.





The rising cost of health insurance and health care is now one of the top causes of bankruptcy in the United States.

and are least likely to get such insurance if they work for small businesses or in minimum-wage jobs. In the past, the largest private insurers, like Blue Cross and Blue Shield, were nonprofit organizations that at least to some extent tried to keep costs down. These days, however, most private insurance providers are for-profit corporations. This is one reason why individual costs for health care have risen dramatically.

Government Programs

The government has several health insurance programs. The two largest programs are Medicaid and Medicare. In addition, local governments provide medical care through public health agencies and public hospitals.

Medicare is a government-sponsored health insurance program primarily for citizens older than age 65. Because of Medicare, almost all elderly Americans now have health insurance. This is not a cheap program, however: In 2006, the government paid more than $401 billion in Medicare benefits (U.S. Bureau of the Census 2009a). The costs are so high that government officials believe the program could go bankrupt by 2017 unless taxes are raised or costs are somehow reduced.

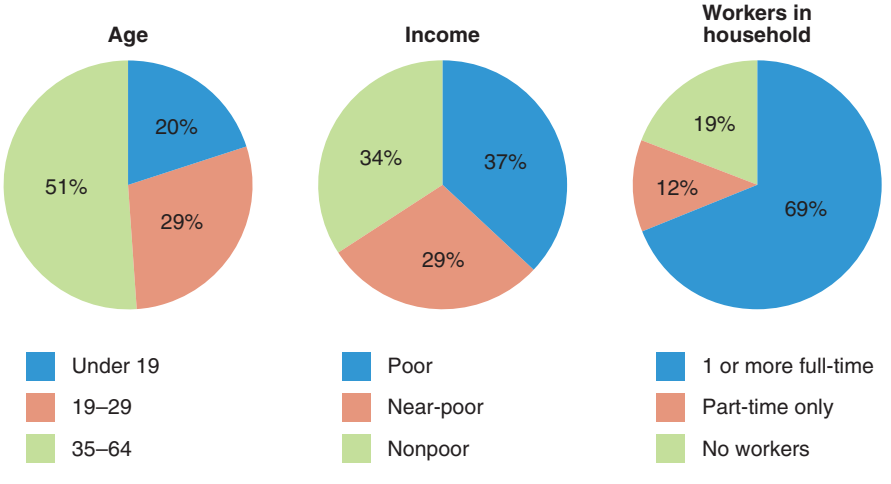
Unlike Medicare, which is available to almost everyone older than age 65, *Medicaid* provides health insurance based on need. Funds come from both the federal government and state governments. Both eligibility and services are determined by states, some of which offer much more generous medical care than others. Generally speaking, though, you won't get Medicaid unless you are both very poor and either a child or a pregnant woman.

The Uninsured in the United States

As of 2007, about 17 percent of Americans younger than age 65 lacked health insurance. More recent statistics are not yet available, but this percentage has undoubtedly risen since then, given current economic conditions.

Thanks to Medicare, nearly 100 percent of the elderly are insured. Those who fall through the cracks are primarily young or middle-aged, unemployed, working poor,

FIGURE 10.1 America's Uninsured Population
Almost 1 in 5 U.S. residents under age 65 has no health insurance. Most are working-age adults, poor or near poor, and live in a household with at least one full-time worker.
SOURCE: Kaiser Commission on Medicaid and the Uninsured (2008).



or employees of small businesses (Kaiser Commission on Medicaid and the Uninsured 2008). Figure 10.1 provides a statistical portrait of America's uninsured.

In emergencies, people who lack insurance can get treatment at public hospitals. However, they often must wait several hours before the overworked hospital staff can see them. And once seen, they are more likely than others to receive substandard care. As a result, uninsured Americans are more likely than others with similar conditions to postpone needed medical care, to require hospitalization when they do seek care, and to die whether or not they are hospitalized (Kaiser Commission on Medicaid and the Uninsured 2008; Weitz 2010).

Health Care in Other Countries

The United States is the only industrialized nation that does not guarantee health care to all of its citizens. Instead, health care is sold like any other commodity. Like dry cleaning, you get what you can afford, and if you can't afford it, you may have to go without. In contrast, in the rest of the industrialized world, medical care is like primary education—regarded as something that all citizens should receive regardless of ability to pay. How is health care provided in these countries?

National Health-Care Systems

Different industrialized nations use different systems, but all guarantee that every citizen has affordable access to high-quality health care. Great Britain and Canada provide two useful examples.

In both these countries, health care is provided through a single-payer system. In a **single-payer system**, doctors and hospitals are paid, either directly or indirectly, from a single source: the government. In both countries, doctors who work in hospitals are paid on salary. However, British doctors who work in private offices or clinics usually receive a salary, whereas Canadian doctors who do so are paid a fee for each service they provide (Weitz 2010).

Single-payer systems reduce the cost of care in three ways (Weitz 2010; Physicians for a National Health Program 2009). First, they are very efficient: Whereas a U.S. doctor might have to bill dozens of insurers each week, a Canadian doctor need send a bill only to the government. Second, they are nonprofit: Whereas the Canadian and British health-care systems are motivated solely by the desire to provide health care, the primary aim of U.S. insurance companies is to earn a profit for their stockholders. As a result, U.S. insurance companies prefer to insure only healthy people who will have few medical bills. Finally, single-payer systems are "the only game in town": As the only purchaser of health care (including drugs), single-payer systems can pressure pharmaceutical companies to reduce drug prices, require doctors to keep down their fees, and refuse funds for hospitals to provide new services that government researchers consider unneeded, untested, or ineffective.

The downside of a single-payer system is that it reduces options for doctors and consumers. Doctors can't decide what fees they will charge and consumers can't "shop around" to obtain a treatment that the government does not support.

Good Care at Low Cost

Modern medical technology has enhanced our ability to extend and save lives. It is, however, extraordinarily expensive. So how do some less-developed nations manage to keep their populations healthy?

China provides an interesting example of how this can be done. In China, Western-style medicine has taken a back seat to prevention. The focus has been on

sociology and you

Social Policy

Like many young people, you may lack health insurance now or lose your insurance once you graduate. If you are healthy, this doesn't matter much at the moment. But what would happen if you were hit by a car? If you seemed likely to die, hospitals would be required by law to treat you. No one, however, would be required to provide you with a wheelchair, physical therapy, or follow-up surgery to improve your chances of recovering full use of your body. Thus the same accident could leave you fully recovered if you have health insurance or permanently disabled if you don't.

A **single-payer system** (of health care) is one in which doctors and hospitals receive payment solely from the government.

using less-expensive health-care providers such as midwives and nurses; improving sanitation, housing, and food; raising education levels to raise incomes; and using traditional healing practices that Western physicians are only now coming to appreciate. Because of these strategies, life expectancy is now only 5 years less than in the United States, even though China spends several times less on health care (Population Reference Bureau 2008). Other less-developed nations such as Costa Rica, Sri Lanka, Cuba, and Vietnam also have demonstrated the value of preventing illness, increasing education levels, and improving the standard of living, rather than focusing on high-technology health care (Weitz 2010).

Why Doesn't the United States Have National Health Insurance?

Why doesn't the United States have national health care? The answer, sociologists argue, lies in **stakeholder mobilization:** organized political opposition by groups with a vested interest in the outcome (Quadagno 2005).

Opposition to national health care has come from numerous sources (Quadagno 2005; Rothman 1997). In the past, labor unions opposed national health care because health insurance was one of the major benefits they could offer members. Opposition also came from the American Medical Association, which feared doctors might lose income or autonomy under a national health plan, and from middle- and upper-class Americans who had health insurance and saw no reason to pay taxes to support health care for others.

As the health-care crisis has worsened, affecting more and more middle-class Americans, support for national health care has grown among doctors, labor unions, the public, and even some major corporations who are tired of paying high prices for their employees' health insurance. The strongest opposition to national health care now comes from the pharmaceutical and health insurance industries. These industries poured millions into fighting former President Clinton's proposed health plan, outspending those who favored it by a ratio of four to one (Quadagno 2005, 189). In addition, anti-tax sentiment and distrust of "big government" have become powerful forces in U.S. politics since the 1980s, making it difficult to generate support for any governmental programs (Rothman 1997; Skocpol 1996). Nevertheless, polls consistently find that about two-thirds of Americans believe it is the federal government's responsibility to guarantee health care for all members of our society, and they are willing to pay more taxes to fund such services (Everybody In, Nobody Out 2005).

If Americans obtain national health insurance in the future, it will be because the middle class, labor unions, and corporations all find it increasingly difficult to pay their health-care bills and unite to fight against anti-tax lobbies, the health insurance industry, and the pharmaceutical companies.

Where This Leaves Us

Sociological analysis suggests that health and illness are socially structured. To paraphrase C. Wright Mills once again, when one person dies too young from stress or bad habits or inadequate health care, that is a personal trouble, and for its remedy we properly look to the character of the individual. When whole classes, races, or sexes consistently suffer significant disadvantage in health and health care, it is a social problem. The correct statement of the problem and the search for solutions require us to look beyond individuals to consider how social structures and institutions

Stakeholder mobilization refers to organized political opposition by groups with a vested interest in a particular political outcome.

have fostered these patterns. The sociological imagination suggests that significant improvements in the nation's health will require changes in social institutions—increased education, reduced poverty and discrimination, improved access to good-quality housing and food, and so on. Equalizing access to health care will also help but is considerably less important than making these social changes.

Summary

1. A major contribution of structural-functionalist theory to the study of health is the concept of a sick role. This concept explains how (some) illness can help society run smoothly and how society limits illness to keep it from interfering with that smooth flow.
2. From conflict theory we get the concept of manufacturers of illness: groups that benefit from promoting conditions that cause illness and disease. Conflict theory also helps us to understand how definitions of illness develop in the process of medicalization and how competing interest groups battle over different potential definitions of illness.
3. Symbolic interaction theory has been particularly useful for understanding the experience of illness, including why patients sometimes do not follow doctors' orders.
4. Nine factors—tobacco, poor diet and inadequate exercise, alcohol, bacteria and viruses, polluted workplaces and neighborhoods, motor vehicles, firearms, sexual behavior, and illegal drugs—underlie almost half of all preventable deaths in the United States.
5. The sick role consists of four social norms regarding sick people. They are assumed to have good reasons for not fulfilling their normal social roles and are not held responsible for their illnesses. They are also expected to consider sickness undesirable, to work to get well, and to follow their doctors' orders. The sick role model, however, fits some illnesses better than others.
6. The health belief model predicts that individuals will adopt behaviors that will protect their health if they believe they are at risk for a particular health problem, they believe the problem is serious, they believe that changing their behavior will reduce their risks, and no significant barriers keep them from changing their behavior.
7. Gender, social class, race/ethnicity, and age all help explain the patterns of health and illness in the United States. Men, racial and ethnic minorities, those with lower socioeconomic status, and the very young and old have higher mortality rates, largely due to social rather than biological forces.
8. The health disadvantage associated with lower socioeconomic status goes far beyond a simple inability to afford health care. Poorer people experience lower standards of living, more stress, lower education levels, and polluted environments, all of which increase the likelihood that they will experience poor health.
9. Women and lower-class people have higher rates of mental illness than other groups. Although the reasons are complex, differences in exposure to stress appear to be the primary cause. Men have higher rates of substance abuse and personality disorders than women.
10. Physicians are professionals; they have a high degree of control not only over their own work but also over all others in the medical world. Structural functionalists argue that physicians earn so much because of scarce talents and abilities, whereas conflict theorists argue that high salaries are due to an effective union (the AMA). Physicians have less independence than they used to due to increased corporate control, government oversight, and public criticism.
11. Nurses comprise the largest single occupational group in the health-care industry. Nurses earn much less than physicians, have less prestige, and take orders instead of giving them. The reasons for this primarily stem from nursing's position as a traditionally "female" field.
12. Most insured Americans belong to private health insurance plans. Medicare is a government program that insures almost all senior citizens, and Medicaid is a government insurance program primarily for the very poor.
13. The United States is the only industrialized nation that does not make medical care available regardless of the patient's ability to pay. Seventeen percent of U.S. residents under age 65 are uninsured. Uninsured persons are more likely than others to postpone getting needed health care, to become ill, and to die if they become ill.
14. Single-payer systems reduce the costs of health care in other countries because they are efficient, nonprofit, and able to negotiate good prices with health-care providers. However, single-payer systems reduce options for doctors and consumers.
15. The United States lacks national health insurance because of stakeholder mobilization, which currently comes primarily from pharmaceutical and insurance corporations.

Thinking Critically

1. How have "manufacturers of illness" increased deaths caused by tobacco? by alcohol? by toxic agents? by diet?
2. How have social forces and political decisions increased deaths caused by sexual behavior? caused by illicit drugs?
3. Think of the last time you or a close friend or relative was ill. Discuss each of the elements of the sick role, and whether or not it applied in this instance. Then think of someone you know who has a chronic illness, and do the same.
4. Who benefits when "male erectile dysfunction" is defined as an illness? How? Who loses? What do they lose?
5. Think of a friend of yours who smokes or engages in another unhealthy behavior. Use the health belief model to explain what else would have to change before your friend would be likely to change his or her behavior.
6. Why do so few men enter nursing? What could change this gender gap?
7. Who would gain if the United States adopted a national health-care system? Who would lose, and what would they lose? Consider economic, social, political, and psychological costs.

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