In 2006, the Centers for Disease Control and Prevention (CDC) released a report of health trends for the year. In “Health, United States, 2006” (National Center for Health Statistics 2006), the CDC reported that life expectancy reached a record high of 77.9 years, with gaps between Blacks and Whites and men and women narrowing (see Table 10.1). In addition, the CDC reported improvements in many other aspects of our health:

- Heart disease remains the leading killer, but deaths from heart disease fell 16 percent between 2000 and 2004, and deaths from cancer—the number 2 killer—dropped 8 percent.
- Infant mortality fell to 6.8 deaths per 1,000 live births in 2004, down from 6.9 deaths per 1,000 live births in 2003.
- Americans are increasingly using many types of preventive or early detection health services.

Yet, the study concludes,

Even as progress is made improving life expectancy, increased longevity is accompanied by increased prevalence of chronic conditions and their associate pain and disability. In recent years, progress in some arenas—declines in infant and cause-specific mortality, morbidity from chronic conditions, reduction in prevalence of risk factors including smoking and lack of exercise—has not been as rapid as in earlier years or trends have been moving in the wrong direction … improvements have not been equally distributed by income, race, ethnicity, education and geography. (National Center for Health Statistics 2006:3)
Before we discuss health inequalities and challenges, let's use our sociological imagination to better understand the relationship between health, illness, and society.

Table 10.1

<table>
<thead>
<tr>
<th></th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>1900</td>
<td>46.3</td>
<td>48.3</td>
<td>46.6</td>
</tr>
<tr>
<td>1950</td>
<td>65.6</td>
<td>71.1</td>
<td>66.5</td>
</tr>
<tr>
<td>1960</td>
<td>66.6</td>
<td>73.1</td>
<td>67.4</td>
</tr>
<tr>
<td>1970</td>
<td>67.1</td>
<td>74.7</td>
<td>70.7</td>
</tr>
<tr>
<td>1980</td>
<td>70.0</td>
<td>77.4</td>
<td>70.7</td>
</tr>
<tr>
<td>1990</td>
<td>71.8</td>
<td>78.8</td>
<td>72.7</td>
</tr>
<tr>
<td>2000</td>
<td>74.3</td>
<td>79.7</td>
<td>74.9</td>
</tr>
<tr>
<td>2003</td>
<td>74.8</td>
<td>80.1</td>
<td>75.3</td>
</tr>
</tbody>
</table>

Source: National Center for Health Statistics 2006.

Before we discuss health inequalities and challenges, let's use our sociological imagination to better understand the relationship between health, illness, and society.

Sociological Perspectives on Health, Illness, and Medicine

If you are thinking that this is going to be a discussion about human physiology, theories about germs and viruses, full of medical terms, you'd be wrong. Although medicine can identify the biological pathways to disease (Wilkinson 1996), we will need a sociological perspective to address the social determinants of health. “Health is a result of an individual’s genetic makeup, income and educational status, health behaviors, communities in which the individual lives, and the environments to which he or she is exposed” (Lurie and Dubowitz 2007:1119).

Consider the gross inequalities in health between and within countries. For example, life expectancy at birth is highest for a child born in Japan (81.9 years) and lowest for one born in Sierra Leone (34 years). Within the United States, there is a 20 year gap in life expectancy between most and least advantaged populations (Marmot 2005). There is no biological reason why life expectancy should be 48 years longer in Japan than Sierra Leone or why there is a gap in life expectancy about the rich and poor in America. To better understand the connection between our social structure and health, we must investigate how our political economy, our corporate structure, and the distribution of resources and power influence health and illness (Conrad 2001a).

The sociology of health and illness includes the field of epidemiology. Epidemiology is the study of the patterns in the distribution and frequency of sickness, injury, and death and the social factors that shape them. Epidemiologists are like detectives, investigating how and why groups of individuals become sick or injured (Cockerman and Glasser 2001). They don’t focus on individuals; rather, epidemiologists focus on communities and populations,
addressing how health and illness experiences are based on social factors such as gender, age, race, social class, or behavior (Cockerman and Glasser 2001). Epidemiology has successfully increased public awareness about the risk factors associated with disease and illness, leading many to quit smoking, to participate in more physical exercise, and to eat healthier diets (Link and Phelan 2001). For example, Type 2 diabetes, the most common form of the disease, occurs when the body does not produce enough insulin or the cells ignore the insulin. An estimated 16 million Americans have Type 2 diabetes. However, the disease can be effectively managed with healthy behaviors like meal planning, exercise, and weight management (American Diabetes Association 2003). Modernization, fast foods, and physical inactivity have led to significant increases in the number of Type 2 diabetes cases in countries such as Brazil and India. Indian public health officials project that in 20 years, there may be 78 million diabetics in their country. A disease that usually affects the old is affecting the younger Indian population primarily because they have adopted a modern life-style and diet (Kleinfield 2006).

What Does It Mean to Me?

All of us practice healthy behaviors we believe or were told can prevent or cure illness or disease. Brushing our teeth is one practice that we routinely do without really remembering why we do it. What other healthy behaviors do you practice? Why do you do them? Where did you learn them?

Epidemiologists use three primary measures of health status: fertility, mortality, and morbidity. These data are routinely collected by the National Center for Health Statistics, Centers for Disease Control. **Fertility** is the level of childbearing for an individual or population. The basic measure of fertility is the crude birthrate, the number of live births per 1,000 women ages 15 to 44 in a population. The U.S. crude birthrate for 2005 was 14 births per 1,000 women (Hamilton, Martin, and Ventura 2006). Related to this is the measure of **fecundity**, the maximum number of children that could be born (based on the number of women of childbearing age in the population).

In the early 1900s, a woman could expect to give birth to about four children, whereas a woman during the Great Depression of the 1930s could expect to have only two (U.S. Census Bureau 2002). The lowest number of births per woman was 1.8 children in the mid-1970s. Since then, the rate has averaged around two births per woman (U.S. Census Bureau 2002). Fertility is determined by a set of biological factors, such as the health and nutrition of childbearing women. But innovations in medicine, in the form of
infertility treatments, have also made childbirth possible for women who once considered it impossible. Fertility is also determined by social factors, such as our social values and definitions of the role of women, the ideal family size, and the timing of childbirth.

**Mortality** is the incidence of death in a population. The basic measure of mortality is the crude death rate, the number of deaths per 100,000 people in a population in a given year. For 2004, the U.S. death rate was 800 deaths per 100,000 (Miniño et al. 2006). In the United States, it is unlikely that we'll die from acute infectious diseases, such as an intestinal infection or measles. Rather, the leading causes of death are attributed to chronic conditions such as coronary heart disease, cancer, stroke, or chronic lower respiratory disease, all of which have been linked to heredity, diet, stress, and exercise. The leading causes of death vary considerably by age. The leading cause of death of college-age Americans is unintentional injuries, followed by homicide and suicide. Among the elderly, mortality caused by chronic diseases (heart disease, cancer, chronic bronchitis, diabetes) is more prevalent.

**Infant mortality** is the rate of infant death per 1,000 live births. For 2004, the infant mortality rate was 6.79 per 1,000 (Miniño et al. 2005). The three leading causes of death among U.S. infants were congenital birth defects, low birth weight, and sudden infant death syndrome. Infant mortality is considered a basic indicator of the well-being of a population, reflecting the social, economic, health, and environmental conditions in which children and their mothers live. Though infant mortality rates in the United States have declined, rates are disproportionately higher for minority children. In 2003, infant mortality rates were highest for infants of non-Hispanic Black mothers (13.6 deaths per 1,000 live births), American Indian mothers (8.7 per 1,000), and Puerto Rican mothers (8.2 per 1,000). Infant mortality rates were lowest for infants of Cuban mothers (4.6 per 1,000) and Asian or Pacific Islander mothers (4.8 per 1,000) (National Center for Health Statistics 2006).

The U.S. infant mortality rate is historically higher than other industrial societies. In its 2007 report, the Save the Children organization identified Iceland as the country with the lowest infant mortality rate with a rate of 2 deaths per 1,000 births. (Refer to Table 10.2 for a complete list of the top 24 countries.) When comparing U.S. infant mortality rates to those of other countries, researchers noted that maternal health care is more widely and uniformly available in other countries with national health care programs.

### Table 10.2

<table>
<thead>
<tr>
<th>Country</th>
<th>Newborn Mortality Rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iceland</td>
<td>2</td>
</tr>
<tr>
<td>Finland, Japan, Sweden</td>
<td>3</td>
</tr>
<tr>
<td>Czechoslovakia, Denmark, Germany, Norway, Iceland</td>
<td>4</td>
</tr>
<tr>
<td>Australia, Austria, Canada, Cyprus, Israel, Luxembourg, Malta, Netherlands, Republic of Korea, Switzerland, United Kingdom</td>
<td>5</td>
</tr>
<tr>
<td>Croatia, Slovakia</td>
<td>6</td>
</tr>
<tr>
<td>United Arab Emirates, United States</td>
<td>7</td>
</tr>
</tbody>
</table>

*Source: Save the Children 2007.*
Morbidity is the study of illnesses and disease. Illness refers to the social experience and consequences of having a disease, whereas disease refers to a biological or physiological problem that affects the human body (Weitz 2001). Epidemiologists track the incidence rate, the number of new cases within a population during a specific period, along with the prevalence rate, the total number of cases involving a specific health problem during a specific period (Weitz 2001). For example, the 2005 incidence rate for diabetes was 1.5 million people age 20 years or older; the prevalence rate was 20.8 million or 7 percent of the population (Centers for Disease Control 2006). Incidence rates help measure the spread of acute illnesses, which strike suddenly and disappear quickly, like chicken pox or the flu. The prevalence rate measures the frequency of long-term or chronic illnesses, such as diabetes, asthma, or HIV (Weitz 2001). The National Center for Health Statistics publishes the Morbidity and Mortality Weekly Report, a weekly summary of surveillance information on reported diseases/deaths.

In addition to epidemiological analyses, sociologists have also applied theoretical perspectives to better explain the social problems of health and illness.

**What Does It Mean to Me?**

Based on data from the National Center for Health Statistics, determine the current rates of fertility and mortality (adult and infant) in your state. Log on to Study Site Chapter 10. How do these rates compare with overall national figures (as reported in earlier paragraphs) or with neighboring states?

**Functionalist Perspective**

Émile Durkheim conducted the first empirical analysis of suicide in the late 1800s. Before Durkheim’s work, scientists attributed suicide primarily to psychological or individual factors. However, Durkheim treated suicide as a social fact and identified the relationship between suicide and the level of social attachment or regulation between an individual and society. His research is the first true epidemiological analysis, but most importantly revealed the relationship between illness and the larger social structure.

The stability of society is paramount from a functionalist’s perspective. Consider for a moment what happens when you become sick. When are you sick enough not to attend class? How do others begin to treat you? According to the functionalist perspective, illness has a legitimate place in society. The first sociological theory of illness was offered by Talcott Parsons (1951), addressing how individuals are expected to act and to be treated while sick (Weitz 2001). This set of behaviors is part of Parsons’ theory of the sick role.

The sick role has four parts. In the first, sick people are excused from fulfilling their normal social role. Illness allows them to be excused from work, from chores around the house, or even from attending class! Second, sick people are not held responsible for the illness. The flu that’s going around is no one’s fault, so you aren’t personally blamed if you catch it. (Although your roommates may blame you if they catch what you have.) Third, sick people must try to get well. Illness is considered a temporary condition, and sick people are expected to take care of themselves with appropriate measures. In relation to this, Parsons offers the last part, that sick people are expected to visit medical authorities and to follow their advice.

Although Parsons legitimized the social role of illness, he also identified a critical source of the problem in health care today. In the fourth element, Parsons identified the authority
and control of the physician. Even though you’re the one who is sick, the doctor has the ultimate power to diagnose your condition and tell you that you’re “really” sick. Doctors play a prominent role in managing our illnesses, but they don’t do it alone. Doctors, along with nurses, pharmaceutical corporations, hospitals, and health insurers, form a powerful medical industry. The medical industry has served us well with its technological and scientific advances, offering a wider array of medical services and treatment options. However, this industry has also created a set of problems, or dysfunctions, as functionalists like to refer to them. Medicine has shifted from a general practitioner model (a family doctor who took care of all your needs) to a specialist model (where one doctor treats you for a specific ailment). You are receiving quality care, but at a price (and you are paying to be treated by many different doctors, instead of just one). As a result, health care costs have become less affordable, leaving many without adequate coverage and care. The system intended to heal us does not treat everyone fairly. We will explore this further in the next perspective.

Conflict Perspective

According to conflict theorists, patterns of health and illness are not accidental or solely the result of an individual’s actions. Conflict theorists identify how these patterns are related to systematic inequalities based on ethnicity/race or gender and on differences in power, values, and interests.

The experience of AIDS treatment in Africa highlights the inequality of health care delivery and access. The World Health Organization (WHO) reports that though antiretroviral treatments for AIDS are available, most HIV-positive children from poor countries are not receiving these drugs. An estimated 2.3 million children under the age of 15 are infected with HIV and 800,000 of them need antiretroviral drugs to stay alive, yet only 60,000 to 100,000 are being treated. Fewer than 10 percent of pregnant women with HIV in poor or middle-income countries are receiving medication to prevent the transmission of the virus to their newborns. So why have rich(er) countries been able to virtually eliminate pediatric AIDS? Observers note that the disease would and could have been eradicated earlier if there were stronger health systems in African countries, a stronger commitment from the global community, and more money to be made helping these poorer countries (Altman 2006).

Conflict theorists may take a traditional Marxist position and argue that our medical industry is based on a capitalist system, founded not on the value of human life, but on a pure profit motive. Studies consistently identify that those in upper social classes have better health, health insurance, and medical access than men and women of lower socioeconomic status. A conflict theorist argues that instead of defining health care as a right, our capitalist system treats health care as a valuable commodity dispensed to the highest bidder. The alternative would be a dramatic change in the medical system, ensuring that health care is provided to all regardless of their race, class, or gender.

In Kampala, Uganda, a nurse (left) provides counseling to a patient (right) who is affected by cancer as a result of HIV. The nurse is a volunteer trained by The Aids Support Organization (TASO). Uganda has been called a pioneer in the battle against AIDS in Africa, reducing the prevalence of the disease in the country from a high of 18.3 to 6.2 percent in 2005.
Instead, what we have in place is a medical system responsive to middle- or upper-class patients and their needs. According to Ken Silverstein (1999), 6.1 million people died worldwide of malaria or acute lower-respiratory infections because there were no drugs available to treat these illnesses. Silverstein notes that pharmaceutical companies have pursued drugs that maximize their profitability, focusing less on diseases of the poor or drugs that are commercially unviable. As he explains, the interest is in lifestyle drugs, “remedies that may one day free the world from the scourge of toenail fungus, obesity, baldness, face wrinkles, and impotence” (p. 14).

The medical system itself ensures that those already in charge maintain power. In health care, no other group has greater power than medical physicians and their professional organization, the American Medical Association (AMA), established in 1847. On its Web site, the AMA identifies itself as “the nation’s most influential medical organization.” In his book, *The Social Transformation of American Medicine*, Paul Starr (1982) explains how the AMA’s authority over the medical profession and education was secured in the early 1900s, with a series of events that culminated with the Flexner Report. The 1910 report was written by Abraham Flexner and was commissioned by the Carnegie Foundation and supported by the AMA. Through the report, Flexner and the AMA were able to pass judgment on the quality of each medical school, based on an assessment of its curriculum, facilities, faculty, admission requirements, and state licensing record. This report eventually led to strict licensing criteria for all medical schools, which led to the closure of schools that could not meet the new standards. Starr (1982) reveals that although the increased standards and school closures may have improved the quality of medical training and care, they also increased the homogeneity and cohesiveness of the profession. From 162 schools in 1906, the number of medical schools dropped to 81 by 1922. Some of the closed schools were exclusively for African Americans and women. According to Rose Weitz (2001), with the increasing cost of education and higher educational prerequisites, fewer minorities, women, immigrants, or poor students could meet the requirements. As a result,

Fewer doctors were available who would practice in minority communities and who understood the special concerns of minority or female patients. At the same time, simply because doctors were now more homogenously White, male, and upper class, their status grew, encouraging more hierarchical relationships between doctors and patients. (Weitz 2001:327)

The AMA (2003) continues its lobbying and legislative efforts today, pursuing several legislative goals including medical liability reforms (asking for limits on punitive or noneconomic damages), preserving Medicare physician payments, expanding health insurance options, and obtaining regulatory relief from Medicare administration.

**What Does It Mean to Me?**

The consumer movement has shifted some of the power in the doctor-patient relationship to the patient. Drug ads, previously reserved for professional medical journals, are now commonly featured in popular magazines and in television advertisements. Pharmaceutical companies routinely take two or three full-page ads, featuring drug warnings, side effects, and precautions, along with a description of their drug and its benefits. It sometimes is difficult to figure out what the drug is for. How do you think this popular diffusion of pharmaceutical information has redefined the relationship between doctor and patient? Between your doctor and you?
Feminist Perspective

According to Peter Conrad (2001b), illness and how we treat it can reflect cultural assumptions and biases about a particular group. Take, for example, the case of women and their medical care. Conrad explains that throughout history, there are examples of medical and scientific explanations for women's health and illnesses that reflect dominant and often negative conceptions of women. Since the 1930s, women's natural physical conditions and experiences, such as childbirth, menopause, premenstrual syndrome, and menstruation, have been medicalized. Medicalization refers to the process through which a condition or behavior becomes defined as a medical problem (Weitz 2001). Although the medicalization of these conditions may have been effective in treating women, various feminist theorists see it as an extension of medicine's control of women (Conrad 2001b), specifically normal female experiences linked with the female reproductive system (Markens 1996), inappropriately emphasizing the psychological, biomedical, or sociocultural origins (Hamilton 1994). Once a condition is defined as a medical problem, medicine, rather than the woman herself, gains control of its diagnosis and treatment.

Menopause, a natural physiological event for women, was defined in the medical community as a “deficiency disease” in the 1960s when commercial production of estrogen replacement therapy became available (Conrad 2001b; Lock 1993). Although a few medical writers refer to menopause as a natural process, many continue to describe it as a “hormonal imbalance” that leads to a “menopausal syndrome” (Lock 1993). Although estrogen replacement treatment was presented as a means for women to retain their femininity and to maintain good health, feminists argued that menopause was not an illness; actually, estrogen therapy may not be necessary and may actually be dangerous (Conrad 2001b). A recent study indicated that although estrogen is an effective short-term treatment for hot flashes or night sweats, estrogen does little to improve the quality of older women's lives (Haney 2003).

Studies have suggested that the meanings and experiences of menopause may also be bound by cultural definitions. In North America, where women are defined by their youth and beauty, aging women are set up as a target for medicalization. In Japan, however, public attention focuses on a woman's life course experience. For a middle-aged Japanese woman, what matters is how well she fulfills her social and familial duties, especially the care of elderly family members, rather than her physical or medical experiences. The Japanese medical community has a different perspective on menopause than their American colleagues do: Most doctors in Japan define menopause as natural and an inevitable part of the aging process (Lock 1993).

What Does It Mean to Me?

Do you know what a “mommy job” is? Mentioned on ABC’s Brothers and Sisters program and featured on print and television advertisements, a mommy job is a cosmetic surgical procedure that may include a breast lift, a tummy tuck, and liposuction to reduce the stretch marks, slackened skin, and excess fat that result from pregnancy and child birth. Targeting women of childbearing age, the marketing of mommy makeovers has been described as an attempt to “pathologize the postpartum body, characterizing pregnancy and child birth as maladies with disfiguring aftereffects that can be repaired with the help of scalpels . . .” (Singer 2007:E3).

From a sociological perspective, is a mommy job a surgical necessity or invention? What do you think?
Interactionist Perspective

From the interactionist perspective, health, illness, and medical responses are socially constructed and maintained. In the previous sections, we discussed how health issues are defined by powerful interest or political groups. We just reviewed how the medicalization of women's conditions reflects our cultural assumptions or biases about women. Each example demonstrates how social, political, and cultural meanings affect our definition and response to health and illness.

A patient's experience with the medical system can be disempowering (Goffman 1961), but the experience can be mediated by social meaning and interpretations (Lambert et al. 1997). According to S. Peterson, M. Heesacker, and R. Schwartz (2001), when people contract a disease, they define their illness according to a socially constructed definition of the disease, which includes a set of images, beliefs, and perceptions. Patients use these definitions to create a personal meaning for their diagnosis and to determine their subsequent behavior. The authors argue that these social constructs have a greater influence on the patient's actions and decisions about his or her health than recommendations from health professionals do.

Sociologists also examine how the relationship between doctors and their patients is created and maintained through interaction. In particular, sociologists focus on how medical professionals use their expertise and knowledge to maintain control over patients. Research indicates that doctors' power depends on their cultural authority, economic independence, cultural differences between patients and doctors, and doctors' assumed superiority to patients (Weitz 2001). Studies consistently demonstrate the systematic differences in the level of information provided by physicians to their patients. Although differences might be attributed to the doctor responding to a patient's particular communication style, researchers argue that information varies according to the doctor's impressions of a patient (e.g., intelligence) or according to subjective judgments about what information the patient needs (Street 1991). Educated and younger patients tend to receive more diagnostic information, as do patients who ask more questions and express more concerns; doctors are likely to communicate as equals with their educated, older male patients (Street 1991). African Americans, Asian Americans, and Hispanics are more likely than are Whites to experience difficulties in communicating with their doctors. The difficulties include not understanding their doctor, not feeling that the doctor listened to them, or having questions for their doctor that they did not ask (Collins et al. 2002).

Interactionists and social constructionists also investigate how a disease is socially constructed. This doesn't mean that disease and illness do not exist. Rather, the focus is on how illness is created and sustained according to a set of shared social beliefs or definitions. In his essay, “The Myth of Mental Illness,” Thomas Szasz (1960) argues that mental disorders are not actually illnesses. He considered mental illness a convenient myth to cover up the “everyday fact that life for most people is a continuous struggle” (p. 118). The disease of mental illness is constructed and maintained through a set of medical, legal, and social definitions. The social construction of disease has also been applied to anorexia nervosa (Brumberg 1988), black lung disease (Smith 1987), and chronic fatigue syndrome (Richman and Jason 2001).

For a summary of sociological perspectives on disease and illness, see Table 10.3.

What Does It Mean to Me?

What are the social constructs for cancer? for AIDS? for diabetes? How would your social definitions of a disease affect your experience of the disease?
As noted in Table 10.1, women live about five years longer than men. The three leading causes of death for males and females are identical: heart disease, cancer, and stroke. Although women live longer than men, women experience higher rates of nonfatal chronic conditions (Waldron 2001; Weitz 2001). Men experience higher rates of fatal illness, dying more quickly than women when illness occurs (Waldron 2001; Weitz 2001).

These differences in mortality have been attributed to three factors: genetics, risk taking, and health care (Waldron 2001). Biological differences seem to favor women; more females than males survive at every age (Weitz 2001). Because of differences in gender roles, men are more likely to engage in risk-taking behaviors or potentially dangerous activities: driving too fast or incautiously, using legal or illegal drugs, or participating in dangerous sports (Waldron 2001). The workplace offers more dangers for men. More men than women are employed, and men’s jobs tend to be more hazardous (Waldron 2001); about 9 of every 10 fatal workplace accidents occur to men (Men’s Health Network 2002). Finally, because women obtain more routine health examinations than men do, their health problems are identified early enough for effective intervention (Weitz 2001). Typically, women eat healthier diets and smoke and drink less alcohol than men do (Calnan 1987).
According to the Men’s Health Network (2002), “No effective program exists which is devoted to awareness and prevention of the leading killers of men.” Although men die of cancer at twice the rate of women by the age of 75, there is little education for men in cancer self-detection and prevention. Whereas there is a popular national campaign for breast cancer, there is no national educational campaign teaching men how to self-examine for testicular cancer, a leading killer of men from 15 to 40 years of age. In addition, there are no quality educational programs regarding prostate cancer, a cancer that strikes one in five men (Men’s Health Network 2002).

**Social Class**

Regardless of the country where a person lives, social class is a major determinant of one’s health and life expectancy (Braveman and Tarimo 2002). The link between class and health has been confirmed in studies conducted in Australia, Canada, Great Britain, the United States, and Western Europe (Cockerman 2004). Although no factor has been singled out as the primary link between socioeconomic position and health, scholars have offered many factors—standard of living, work conditions, housing conditions, and the social and psychological connections with others at work, home, or the community—to explain the relationship (Krieger, Williams, and Moss 1997).

Weitz (2001) offers several explanations for the unhealthy relationship between poverty and illness. The type of work available to poorly educated people can cause illness or death by exposing them to hazardous conditions. Poor and middle-class individuals who live in poor neighborhoods are exposed to air, noise, water, and chemical pollution that can increase rates of morbidity and mortality. Inadequate and unsafe housing increases the risk of injury, infections, and illnesses, including lead poisoning when children eat peeling paint. The diet of the poor increases the risk of illness. The poor have little time or opportunity to practice healthy activities like exercise, and because of life stresses, they may also be encouraged to adopt behaviors that might further endanger their health. Finally, poverty limits individual access to preventative and therapeutic health care.

The relationship between health and social class afflicts those most vulnerable, the young. Children in poor or near-poor families are two to three times more likely not to have a usual source of health care than are children in non-poor families (Federal Interagency Forum on Child and Family Statistics 2007). Access to a regular doctor or care facility for physical examinations, preventative care, screening, and immunizations can facilitate the timely and appropriate use of pediatric services for youth. Even children on public insurance (which includes Medicaid and the State Children’s Health Insurance Program) were more likely not to have a usual source of care than were children with private insurance. Children in families below the poverty level had lower rates of immunization and yearly dental check ups (both basic preventative care practices) than did children at or above the poverty level (Federal Interagency Forum on Child and Family Statistics 2007). More than 9 million U.S. low-income children are uninsured (Kaiser Family Foundation 2007a).

**Education**

A similar relationship has been documented between education and health—the higher your education, the better your health (no matter how it is measured—mortality, morbidity, or other general health measures). Schooling might be a more important correlate to good health than is one’s occupation or income (Grossman and Kaestner 1997).
Recent studies on the effects of compulsory education in Sweden, Denmark, England, and Wales consistently identify that a longer educational experience leads to better health (Kolata 2007). Michael Murphy and his colleagues (2006) identified mortality trends by educational level for Russian men and women between 1980 and 2001. Murphy et al. concluded that better educated men and women had a significant mortality advantage over less educated men and women. In 1980, life expectancy at age 20 for university educated men was 3 years greater than for men with only an elementary education. By 2001, however, the gap between university and elementary educated men had increased to 11 years. Similar differentials were also noted among Russian women.

Researchers suggest that education helps individuals choose and practice a healthier lifestyle regarding diet, exercise, and other health choices. Highly educated men and women are likely to visit their primary physicians more often and regularly and may be more willing to use new medical technologies or medicines. Knowledge about the health consequences of smoking and drinking has been shown to decrease smoking and excessive alcohol consumption. Educated parents will also transmit their healthier lifestyle to their children (Grossman and Kaestner 1997).

Researchers have demonstrated the link between education and future orientation. Future-oriented individuals attend school for longer periods. Educated individuals are able to link their current actions to their future, not only for their education, but also for preventative health care practices. For example, a future-oriented person will say, “I’m going to college now so that I can have a good job when I graduate.” Applied to health behaviors, the same person will say, “I won’t start smoking because I know there are long-term health consequences of smoking.” Studies have shown that men and women who discount the future are more likely to become addicted to alcohol or other drugs (Becker and Mulligan 1994).

The Rising Cost of Health Care

The United States spends about 15 percent of its gross domestic product (GDP) on health care—the largest expenditure in this category among industrialized countries. (A GDP comparison with other countries is presented in Figure 10.1.) In 2005, total health care spending reached $2 trillion, with an average of $6,697 spent per person in health expenses (Centers for Medicare and Medicaid Services 2006). Analysts note that for 2005, health care spending grew at the slowest pace in six years, partly because of the increasing use of generic drugs. Overall health care spending increased 6.9 percent in 2005, lower than the 7.2 percent increase in 2004. In 2005, home health care spending increased more than any other category. More than 30 percent of health care spending went to hospitals in the same year. (Refer to Table 10.4 for a summary of health insurance plans.)

Even though the U.S. health system is the most expensive in the world, “Comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of [health] performance” (Davis et al. 2007:viii). The United States remains the only major industrial country without some form of universal health coverage. In their analyses of health care systems and outcomes in Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States, Karen Davis and her colleagues (2007) concluded that the United States failed to achieve better health outcomes and scored last on the dimensions of
Chapter 10

U.S. Health Insurance and Health Care Delivery Systems

Most Americans receive health insurance from their employers. This type of insurance is referred to as group insurance or as employment-based private insurance. Employers buy into a health insurance program, paying for part or all of the cost of the insurance premiums. A premium is a monthly fee to maintain your health coverage.

Most college students are probably covered by their parents’ insurance plan. That handy insurance card in your wallet identifies your insurance provider, the amount of your deductible (payment due at the time of service), and the amount of coverage for prescription drugs or emergency services.

There are many different types of group insurance programs:

- **Fee for service plan.** Under this plan, also known as an indemnity health plan, insurance companies pay fees for services provided to the people covered by the policy. This type of program emphasizes patient choice and immediate patient care.

- **Health maintenance organization (HMO).** These organizations operate as prepaid health plans. For your premium, the HMO provides you and your family comprehensive care. This plan is also known as managed health care, a plan that controls costs by controlling access to care. You’ll be assigned to a primary care provider who will provide most of your medical care, but if necessary, that doctor will refer you to specialists within the HMO practice or to providers contracted by the HMO. Under the plan, there is limited coverage for any treatment outside the HMO network.

- **Preferred provider organization (PPO).** A PPO is a combination of the fee for service and HMO plan. With a PPO, you can manage your own health care needs by selecting your own doctors. These specialists will be on a preferred provider list supported by the PPO plan. If you use a provider outside of your plan, you may have to pay a larger percentage of your health care expenses.

- **Federal health plans.** Medicare is available to Americans 65 years or older or those with disabilities, whereas Medicaid pays for medical and long-term care for the poor; low-income children, pregnant women, and elderly; the medically needy; and people requiring institutional care.
access, patient safety, efficiency, and equity despite spending the most per capita on health care. Given our lack of universal health care coverage, when compared with these other nations, more Americans are uninsured or underinsured and are more unlikely to seek necessary care because of costs. Germany ranked first on access to health care and the United Kingdom ranked first for health care equity. The United States ranked last on both measures.

Policymakers and consumers have been keeping an eye on the cost of prescription drugs, one of the fastest-growing sectors of medical care. Increases in drug costs are expected to outstrip the overall growth in health care spending for the next 10 years. Spending for prescription drugs in 2004 totaled $188.8 billion, about 4.5 times more than the $40.3 billion spent in 1990 (Kaiser Family Foundation 2006).

The cost of prescription drugs remains a significant burden for elderly Americans. The American Association of Retired People (AARP) annually examines prices for 193 brand-name prescription drugs used by Americans 50 years of age or older. AARP reported that from 2005 to 2006, manufacturer prices increased 6.2 percent (an increase more than one and half times the rate of general inflation for the same period, 3.7 percent). Eighty-one drugs most commonly used by older Americans had price increases of more than 5 percent during the first nine months of 2006. In 2006, the typical older American, who takes four prescription drugs daily, spent $270.24 more for brand-name (non-generic) drugs than in the previous year. For 2005, the cost increase was lower at $189.72 (Binder et al. 2007).

Inequalities in Health Insurance

Access to health care is unevenly distributed across the U.S. population (Conrad and Leiter 2003). Data from the U.S. Census Bureau reveal that 46.6 million or 15.9 percent of Americans had no health insurance at anytime during 2005, an increase of 1.3 million from 2004 (DeNavas-Walt, Proctor, and Lee 2006). (Refer to U.S. Data Map 10.1.) Although most Americans receive health insurance through their employers, many uninsured individuals are either employed or are dependents of employed people (House Energy and Commerce Subcommittee on Health and Environment 1993). Nearly four in five of those without health insurance were in the labor force or had at least one parent who was employed (Families USA 2003). From 2000 to 2006, the number of companies offering health insurance fell from 69 to 61 percent (Kaiser Family Foundation 2007b). Most of the working poor are not eligible for public assistance medical programs (e.g., Medicaid) even though their employers do not provide health insurance (Seccombe and Amey 2001). Among households with incomes less than $25,000, only 75.6 percent received health insurance (DeNavas-Walt et al. 2006).

Several social factors are related to health coverage. About 11.2 percent or 8.3 million children under the age of 18 did not have health insurance (DeNavas-Walt et al. 2006). When parents lose jobs, children lose health insurance coverage. Children in poverty, with an uninsured rate of 19.0 percent, were more likely to be uninsured than was the population of all children. Children 12 to 17 years old were more likely to be uninsured than were those younger than 12 years old (DeNavas-Walt et al. 2006).

Among all minority groups, Hispanic Americans are most likely not to have insurance. Nearly half (45 percent) of Hispanics younger than age 65 and two-thirds
(65 percent) of working-age Hispanics with low incomes were uninsured for all or part of 2000 (Commonwealth Fund 2003a). Twenty-two percent of Hispanic children did not have any health insurance compared with 7.2 percent for non-Hispanic White children (DeNavas-Walt et al. 2006). Hispanic American women, compared with White women, are three times more likely to lack health insurance (NWHIC 2002). Most Hispanic women obtain health insurance through their employers; however, lower-income or part-time workers are less likely to be offered health coverage through their employment (NWHIC 2002). According to Michelle Doty (Commonwealth Fund 2003a), “Lack of insurance, unstable coverage, language barriers, and low income all contribute to the growing health care crisis among Hispanics.”

However, losing health insurance is also becoming a middle-class issue, according to the Employee Benefit Research Institute. In 2001, about 800,000 people had incomes in excess of
$75,000 but no health insurance (Broder, Pear, and Freudenheim 2002). More than one-third of those uninsured in 2007, about 17 million Americans, have family incomes of $40,000 or more (Pear 2007a). They either lost their jobs in high-wage industries, were employed but unable to afford health insurance premiums (Broder et al. 2002), work as independent contractors (e.g., real estate agents), or would not be covered by insurers because of a preexisting health condition (Pear 2007). Advocates for the uninsured are hopeful that policymakers will respond to a more effective lobbying coalition of high-wage workers, the unemployed, the poor, and minorities (Broder et al. 2002). Annual premiums for employer-sponsored health insurance for 2006 averaged $4,242 for single coverage and $11,480 for family coverage (Kaiser Family Foundation 2007b).

**What Does It Mean to Me?**

Policy analysts, advocates, and health care professionals sharply criticized President George W. Bush for stating in 2007, “People have access to health care in America. After all, you just go to an emergency room.” From a sociological perspective, what is wrong with the president’s statement? Does his statement address access as discussed in the previous section? Why or why not?

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**Community, Policy, and Social Action**

**Health Care Reform**

During his first administration, President Bill Clinton said problems connected with the U.S. health care system were the most pressing in the United States. In 1993, Clinton pushed for passage of the Health Security Act, an attempt at comprehensive health care reform. The act would have required all employers to provide health insurance to their employees and gave small businesses and unemployed Americans subsidies to purchase insurance. After Congress rejected Clinton’s health care plan, Americans looked to the private market to restrain health care costs and to enhance patient care and choice. U.S. medicine moved aggressively toward managed care arrangements, HMOs, and for-profit health plans (Oberlander 2002).

According to Stuart Altman and Uwe Reinhardt (1996), although Americans in general are pleased with the quality of health care they receive, they are troubled by other aspects of health care. Americans are upset primarily about the cost of health care, both out-of-pocket costs and the cost of the health care system as a whole. Second, the structure of the health insurance system is viewed as having a number of shortcomings, foremost among them being the lack of universal coverage. Finally, although the quality of health care is high, people believe it is not uniformly so.

The U.S. health care system is identified as a private health care system, but in reality, it is a mixed system of public and private insurance (Oberlander 2002). Health care reform did not die with the defeat of the Health Care Act. Pick up any newspaper or listen to the evening news and you’ll hear stories about insurance reform, prescription drugs, or quality care. The issue was debated among 2008 presidential candidates and received a boost with
the release of *Sicko*, Michael Moore’s documentary film comparing health care in Canada, Cuba, Great Britain, and the United States. Although there have been no other presidential proposals for universal health coverage, political attention on the issue has been more limited in scope and at a slower pace (Begley et al. 2002), focused on improving the medical experiences of those already insured by regulating managed care and expanding existing programs (Oberlander 2002).

### State Health Care Reforms

The federal government has failed to reach a compromise on comprehensive health coverage, so the burden of health care reform falls to the states (Beatrice 1996). Several states have aggressively moved forward on health reform, and several—Florida, Hawaii, Massachusetts, Minnesota, Oregon, and Washington—are committed to providing health coverage for all of their citizens. Following are summaries of three state plans.

Hawaii was one of the first states to act on health care reform. In 1974, the state passed the Hawaii Prepaid Health Care Act, requiring employers to provide health insurance for all employees working more than 20 hours per week and to pay at least 50 percent of the cost. Hawaii is the only state that requires employer payments to medical insurance under a congressional exemption of the Employee Retirement and Income Security Act (ERISA). ERISA bars states from requiring all employers to offer health insurance, from regulating or taxing self-insured plans, and from mandating the specific benefits to be covered by employer health plans (Beatrice 1996). Hawaii’s plan also limits employees’ share of the insurance premium expenses to no more than 1.5 percent of their income. Recently, there has been a call to repeal or at least revise the Prepaid Health Care Act because of increasing health care costs. The percent of uninsured Hawaiians is 9.5 percent (DeNavas-Walt et al. 2006).

The MinnesotaCare Act became law in Minnesota in 1992. Also known as the HealthRight Act, the legislation included a variety of laws aimed at reducing costs and expanding access to health care for the uninsured (Beatrice 1996). MinnesotaCare is funded through a tax on health care providers and through enrollee premiums (based on family size, number of people covered, and income) (Sacks, Kutyla, and Silow-Carroll 2002). The act set price controls for health care spending (repealed in 1997), set statewide managed care guidelines, initially mandated that all non-HMO physicians follow a state fee structure (repealed in 1995), placed all HMOs under the regulation of the Commission of Health, and mandated that HMOs be nonprofit (Citizens Council on Health Care 2003). The act also subsidized health insurance to low- and middle-income uninsured families and individuals. Minnesota expanded Medicaid eligibility to 275 percent of the federal poverty guidelines (e.g., a family of four with $45,000 income would be eligible) and placed all MinnesotaCare recipients into HMOs (Beatrice 1996; Citizens Council on Health Care 2003). A small number of Minnesotans, about 9 percent, are uninsured (DeNavas-Walt et al. 2006).

Massachusetts became the first state to provide universal health care coverage to all its residents in 2006. The plan is estimated to insure half a million people within three years, about 95 percent of the state’s uninsured population. Called a “moderate plan,” the plan will allow the state to provide sliding scale coverage, low-cost coverage, and free insurance coverage to uninsured residents depending on their income, age, or employment status. Individuals who can afford health insurance will be penalized on their state income taxes if they do not purchase it. The plan will cost $1.2 billion over three years, using a combination of federal and state (existing and new) monies.
State Children’s Health Insurance Program

The State Children’s Health Insurance Program (SCHIP) was adopted in 1997 as an amendment to the Social Security Act, Title XXI. The program is administered under the Centers for Medicare and Medicaid Services (CMS). SCHIP enables states to implement their own children’s health insurance programs for uninsured low-income children 18 years old or younger and targets the children of working parents or grandparents. For example, a family of four that earns as much as $34,100 a year is eligible. The insurance plan would pay for regular check-ups, immunizations, prescription medicines, and hospitalizations. SCHIP uses comprehensive outreach materials and educational programs to recruit eligible children and their families, especially through elementary and secondary schools. In many states, as SCHIP enrollments began, so did Medicaid enrollments. By June 2005, the number of children enrolled in SCHIP had reached a record high of more than 4 million. Enrollment growth exceeded 22 percent in four states—Delaware, Oregon, Virginia, and Wyoming. State officials expected SCHIP enrollment increases to continue.

During its 2007 meeting, the National Governors Association asked the Bush administration to provide more federal funds to support the SCHIP program. Responding to increasing need, many states have expanded program coverage and eligibility. Governors reported that they were running out of federal funds to support the popular program. States would be short $13 billion to run the program if they continued with their current program eligibility rules and benefits through 2012 (Pear 2007b). Michael O. Leavitt, Secretary of Health and Human Services, responded by saying that the administration would work with Congress to find a short-term solution to their funding problem, but also recommended that states should better manage their SCHIP programs (Pear 2007c). Based on his concern that SCHIP expansion would be too costly and would be a step toward universal health coverage, in fall 2007, President Bush vetoed the House bill that proposed coverage for more than 10 million children as well as expansion of coverage to include dental services, mental illness, and pregnant women with low incomes. SCHIP advocates accused the president and his congressional supporters of misplaced their concerns for socialized medicine over the necessary expansion of health coverage for children. With the House unable to override the president’s veto, the administration promised to work with Congress on a bill compromise.

State Prescription Drug Plans

In an effort to control drug costs for their residents, several states have offered innovative cost-control models. Pennsylvania is second to Florida in the proportion of its population that is 65 years or older (Pear 2002). More than 300,000 people in Pennsylvania are enrolled in Pharmaceutical Assistance Contract for the Elderly (PACE). Men and women 65 years or older can enroll in the program if they have annual incomes less than $14,000 for an individual or
Gemma Frost (age 9) is pictured with her mother Bonnie during a news conference promoting the State Children’s Health Insurance Program (SCHIP), along with Representative Steny Hoyer (D-MD) and House Speaker Nancy Pelosi (D-CA). Gemma received health care benefits through the program, after suffering injuries in a car accident. In 2007, President George W. Bush vetoed a bill that would have reauthorized and expanded the SCHIP program, after suffering injuries in a car accident. In 2007, President George W. Bush vetoed a bill that would have reauthorized and expanded the SCHIP program.

Photo 10.4

$17,200 per couple. The program costs patients a $6 co-payment per filled prescription and is financed largely from state lottery proceeds. The program requires the use of low-cost generic drugs, which account for about 45 percent of all filled prescriptions. PACENET, an assistance program available for elderly individuals with household incomes between $14,500 and $23,500 or between $17,700 and $31,500 per couple (with a $40 deductible and an $8 co-payment).

In 2003, Pennsylvania joined eight other states and the District of Columbia to form a nonprofit consortium to buy drugs in bulk, passing on the savings to their citizens (Freudenheim 2003). The consortium will include a drug benefit manager who will help states maximize their drug benefits by receiving full price discounts and rebates, determining the most cost-effective and appropriate drugs, and including coverage for mail order prescriptions and for importing drugs from Canada. The program is supported by the Heinz Family Philanthropies, a charitable organization.

U.S. laws prohibit the importation of Canadian drugs into the United States, unless their safety is certified by the U.S. Department of Health and Human Services. Despite this law, Boston, Massachusetts, and the state of New Hampshire announced in 2003 that they would begin buying prescription drugs from Canada. Springfield, Massachusetts, was the first city...
Taking a World View

Health Care in Canada

Imagine a world where you never see a doctor’s bill, an insurance statement, or any other paperwork related to health care (Weitz 2001). That place exists: Canada. Canada has a publicly financed, privately delivered health care system known as Medicare. Their national health insurance system provides all Canadians access to universal, comprehensive coverage for medically necessary hospital, inpatient, and outpatient care.

Although we tend to think of the Canadian insurance program as one program, there are actually 13 federally supported programs, each administered by one of its 10 provinces and 3 territories (Taylor 1990). The legislative foundation of Canada’s national health insurance program comes from the 1957 Hospital Insurance Act and the 1966 Medical Care Insurance Act. In 1984, both acts were consolidated into the Canada Health Act, which in addition outlawed extra billing by physicians and user fees by facilities and guaranteed a one-tier system of health insurance (Livingston 1998). Although the federal government is responsible for setting national standards of health care, each province or territory is responsible for the management and delivery of health care services and some aspects of prescription care and public health (Health Canada 2003). The federal government supports a province’s health insurance program as long as it is universal (covering all citizens), comprehensive, accessible (with no limits on services), portable (each province must recognize each other’s coverage), and publicly administered (under the control of a public nonprofit organization) (Marmor and Mashaw 2001).

The insurance system is funded by a progressive federal tax: Those who earn more money pay a higher proportion of their income in taxes (Weitz 2001). Overall, Canada spent less per capita on health care than the United States did. For 2005, Canada spent $3,326 compared with $6,401 in the United States (refer to Figure 10.1). The total budgets of hospitals and the level of physicians’ fees are determined by annual negotiations between provinces and the health care providers (Marmor and Mashaw 2001). Budgets are adjusted each year, accounting for inflation, new programs, and changes in service volumes (Marmor and Mashaw 2001). Most Canadian physicians are paid according to a fee-for-service plan (Taylor 1990).

Administrative costs are much lower in Canada than in the United States. Because doctors and hospitals receive their payments from one source, they do not have to keep track of multiple insurance plans or file for insurance reimbursement (Marmor and Mashaw 2001). This benefit is also passed on to patients: Canadians do not have to file claim forms or pay out of pocket for uncovered expenses. In addition, Canadian doctors have lower malpractice insurance costs. The Canadian Medical Association formed the nonprofit Canadian Protective Association in 1912. All member physicians were first charged a flat fee for malpractice insurance; currently, there are six fee categories organized according to medical specialty (Taylor 1990).

According to Clifford Krauss (2003), growing complaints about health care services have begun to erode public confidence in Canada’s health care system. Although Canadians continue to support their health system, many worry about its effectiveness, particularly its service delivery. Krauss cites many Canadian studies that reveal how the health system is overworked and understaffed and that patients wait impatiently for their health services. A recent Canadian government study reported 4.3 million Canadian adults or 18 percent of those who saw a doctor in 2001 had difficulty in seeing a doctor or getting a test completed in a timely fashion (Krauss 2003).
A report prepared by Canada’s Fraser Institute revealed that in 2006, Canadian patients experienced an average waiting time of 17.8 weeks between receiving a general practitioner’s referral and undergoing treatment and 9.0 weeks between specialist consultation and treatment. Compared with 1993, overall waiting time is about 91 percent longer (Esmail and Walker 2006). Such long wait periods are considered symptomatic of a failing and overburdened health care system as well as a serious threat to patient health. The authors of the report, Nadeem Esmail and Michael Walker, conclude, “The promise of the Canadian health care system is not being realized. On the contrary, a profusion of research reveals that cardiovascular surgery queues are routinely jumped by the famous and politically connected, that suburban and rural residents confront barriers to access not encountered by their urban counterparts and that low-income Canadians have less access to specialists…” (2006:5).

**In Focus**

**Bird Flu Pandemic**

Human cases of the bird flu or avian influenza were first recorded in 1997. The disease is an infection that occurs naturally among birds. Many wild birds carry the virus, but remain unaffected by it. However, the virus can cause disease or death among domesticated birds, such as chickens, turkeys, and ducks.

The influenza virus can be spread to humans from contact with domesticated infected poultry or surfaces contaminated with secretions from infected birds. The specific virus that has been found in human patients is called Avian Influenza A (H5N1). Illness resulting from human to human infection has been reported but is rare, according to the Centers for Disease Control.

Outbreaks of H5N1 have been reported in the Republic of Korea, Vietnam, Japan, Thailand, Cambodia, the Lao People’s Democratic Republic, Indonesia, China, and Malaysia. Of these, Japan, the Republic of Korea, and Malaysia have controlled their outbreaks and are now considered free of the disease according to the World Health Organization (WHO). Since 2003, 186 (of 307) deaths have been documented as a result of the disease. There have been no reported cases of the bird flu in the United States.

Scientists and medical experts have been concerned about the potential for a bird flu pandemic (worldwide spread of the virus), primarily because of the uncontrollable aspect of the primary carriers of the virus, wild birds. Migratory birds visit lands and waters also used by domesticated animals and their humans. WHO explains that poverty in these countries exacerbates the problem, for example, families will consume poultry even when death or signs of illness appear in the flock. Though ill or dying, these birds are the primary source of food for many poor people. Butchering and food preparation potentially can expose more humans to the disease. Additionally, it is difficult for rural farmers to accurately assess the source of illness among their poultry, delaying reporting to health authorities.

Second, health officials are concerned about H5N1 mutating to enable human to human infection. All flu viruses change (consider how each year there is a new flu shot to be given during flu season), so according to the CDC, if H5N1 can be spread by person-to-person contact, because the bird flu virus does not commonly infect humans, we have little or no immune protection. In April 2007, the Federal Drug Administration approved the first human H5N1 vaccine.
to import Canadian drugs for city employees in 2003. Boston plans to do the same for its city employees and retirees, estimating a savings of about $1 million annually. For example, 90 pills of Lipitor, a popular cholesterol drug, cost $183.97 in the United States, but the Canadian price is $136.70, a savings of $47.27 per prescription (Testa 2003). The Nevada State Board of Pharmacy approved regulations in 2006 that would allow its residents to purchase online prescriptions filled by state-approved Canadian pharmacies.

In 2004, the Health and Human Service Taskforce on Drug Importation concluded that savings on foreign drugs were not as much as consumers would expect and warned about significant risks to consumers purchasing imported drugs. The report questioned the safety and effectiveness of foreign made drugs. At the release of the report, consumer and health advocates weighed in, criticizing the taskforce for failing to address the fundamental problem of providing affordable prescriptions drugs to those who cannot afford it.

Voices in the Community

Victoria Hale

In 2005, Victoria Hale was named by *Esquire* magazine as its business woman of the year. She is the director and founder of OneWorld Health, the first nonprofit pharmaceutical company in the United States.

Hale worked as an analyst for the U.S. Food and Drug Administration’s Center for Drug Evaluation and Research and then at Genentech (a biotechnology firm) when she first envisioned her company. Her position in the pharmaceutical industry allowed her to see how drugs were being set aside simply because they were not making enough money. The industry dedicates less than 10 percent of its total research and development budget to eradicate diseases of the developing world, which account for 90 percent of the world’s total infections (Heffernan 2005). Of the more than 1,500 drugs marketed worldwide between 1974 and 2004, only 21 or 1.3 percent of these drugs were used to treat diseases of the developing world (Buse 2006).

She established OneWorld Health to accomplish what she believed the industry should be doing—investing in the development and distribution of drugs that could be used to eradicate diseases in the developing world. Says Hale, “We deliberately chose neglected diseases that others were not working on…. There has been little research done on these diseases, and limited money for research or development. We don’t choose projects because money is available, we choose projects and then we go find funding” (Roth 2006:2). OneWorld Health is funded by charitable contributions.

Hale’s strategy was simple. She searched for drugs whose patents had expired or were not being used because of low profit margins. The first drug OneWorld Health invested in was paramomycin, an antibiotic that cures a parasitic disease called visceral leishmaniasis, also known as black fever or Kala Azar. The disease afflicts a half a million people annually worldwide, particularly in Bangladesh, Brazil, India, Nepal, and Sudan. Hale discovered that the development of paramomycin had been shelved before completing its clinical trials. After continuing and completing clinical trials with the drug, Hale found a company, Gland Parma, based in Hyderabad, India, that agreed to produce paromomycin and sell it for $10 per full course of treatment, affordable for the poor people of India.
The use of paromomycin was approved in India in late 2006. The government publicly announced its goal of eradicating the disease by 2010. Eradication dates have also been set in Bangladesh and Nepal for 2015. After dealing with the initial skepticism of the pharmaceutical industry and its executives, Hale’s OneWorld Health has been heralded as an innovative socially minded organization. Hale’s work will continue, “You can’t take care of all two billion of the world’s poorest poor at one time. But you can go disease by disease and determine which one you can succeed with” (Roth 2006:2). OneWorld Health is working on three additional drugs—for malaria (the most severe parasitic disease), diarrhea (the number two killer of children in the developing world), and Chagas disease (a parasitic illness of Central and South America).

For more information about OneWorld Health, go to Study Site Chapter 10.

Work-Based Health Clinics

In an effort to manage and control the cost of their health care expenses, more U.S. corporations are providing on-site medical care. Since 2005, Cigna, Sprint Nextel, and Credit Suisse have opened on-site health clinics. More than 100 of the nation’s largest 1,000 employers now provide primary care clinics or preventative health services on-site for their employees (Freudenheim 2007). One such company, Pepsi Bottling Group, operates 11 employee clinics in the United States with plans to add more in the future. Toyota’s San Antonio, Texas, primary care center is open for workers and their families, complete with two full-time doctors, a blood test lab, and an X-ray center.
On-site clinics are a “modern model that is ... proving to be cost-effective ... Not only does it pick up health issues earlier, but it doesn’t require time away from work and at the same time creates a culture of caring,” says Sean Sullivan, president of the Institute for Health and Productivity Management (Wells 2006:48). The health care savings from these clinics is estimated between 5 and 20 percent. The range of services includes routine physical examinations, allergy and flu shots, routine monitoring for chronic diseases, prescriptions, and advice on weight loss or smoking cessation (Freudenheim 2007; Wells 2006). On-site medical facilities and staff can be outsourced or company managed and hired; both models allow companies to customize their clinics and range of services to meet the needs of their workforce (Wells 2006).

**Community-Based Health Care for Minorities**

Regardless of their health insurance status, minority Americans are more likely than Whites to be disconnected from the health care system and a regular doctor (Commonwealth Fund 2003b). Unique community-based health care approaches have emerged to serve these groups.
Community health centers (CHCs) were based on neighborhood health clinics first established during the War on Poverty in the 1960s. CHCs are operated by a variety of non-profit organizations, health departments, religious or faith-based organizations, or medical organizations or schools. Costs are covered through a variety of sources, ranging from private insurance to government contracts or grants. These centers have been called the most effective tool to reduce health disparities and can increase access to health care to an estimated 14 million individuals, two-thirds of whom are minority group members (Hargreaves, Arnold, and Blot 2006).

One example of a community health center is the Project Brotherhood Black Men’s Clinic, located on Chicago’s South Side. The clinic was created to address the disproportionate disease burden and shorter life expectancy for Black men (Tanner 2003). Eric Whitaker, cofounder of the clinic, explained how many men avoid traditional health care providers because they never find doctors who look and talk like them. Focus groups indicated that Black men need a reason other than their health to go to the clinic, so program administrators latched on to a cornerstone of Black cultural life: the barbershop.

Project Brotherhood opened a barbershop alongside the community health clinic, where men are able to get free haircuts and listen to informal presentations by the clinic staff on HIV, heart disease, and cancer. In addition, the clinic offers job search and resume writing information and parenting classes. As Whitaker describes it, “It’s a place where information is exchanged, it’s a place of familiarity…. We just transported that idea to the clinic setting” (Tanner 2003:A12). He explains, “We want to learn how to listen to our community and discover its own perception of needs and assets” (Phalen 2000). In 1999, the clinic averaged about 4 medical visits per week; by 2005, the average number of medical visits increased to 27 per week (Project Brotherhood 2006).

Using the same strategy of bringing care to community members, the American Diabetes Association (ADA) has enlisted the help of African American churches to educate their parishioners about the disease (American Diabetes Association 2003). Recognizing the importance of the African American church as a source of community support and vehicle for communication, “Diabetes Sunday” began in 1996. Diabetes Sunday is often held during Black History Month. Church pastors discuss diabetes and distribute education materials. Certified diabetes educators are on hand to answer questions after the service. Similar community-based programs target Latino, Asian Pacific Islander, and immigrant populations.

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Main Points

- Although medicine can identify the biological pathways to disease, we need a sociological perspective to address the social determinants of health. Research continues to demonstrate the relationship between the individual and society and the structural effects on health: how our health is affected by our social position, work, families, education, and wealth and poverty.
- **Epidemiology** is the study of the patterns in the distribution and frequency of sickness, injury, and death and the social factors that shape them. Epidemiologists focus on communities and populations, addressing how health
and illness experiences are based on social factors such as gender, age, race, social class, or behavior.

- According to the functionalist perspective, illness has a legitimate place in society.
- Conflict theorists believe that patterns of health and illness are not accidental or solely the result of individuals’ actions. Theorists identify how these patterns reflect systematic inequalities based on ethnicity/race or gender and differences in power, values, and interests.
- Although the medicalization of such conditions as premenstrual syndrome or menopause may have been effective in treating women, various feminist theorists see this trend as an extension of medicine’s control of women.
- From an interactionist’s perspective, health, illness, and medical responses are socially constructed and maintained.
- Women live longer than men, but women experience higher rates of nonfatal chronic conditions. Men experience higher rates of fatal illness. These differences in mortality have been attributed to three factors: genetics, risk taking, and health care.
- Data consistently support the notion that those with higher education, income, or occupational prestige have lower rates of morbidity and mortality. No factor has been singled out as the primary link between socioeconomic position and health; however, scholars have offered many factors—standard of living, work conditions, housing conditions, and the social and psychological connections with others at work, home, or the community—to explain the relationship.
- Another problem with health is access to health care and insurance; many groups do not have insurance or access to it, and now the middle class is also experiencing problems in retaining health insurance. Illegal immigrants also do not have insurance and often use the emergency room as their place of primary care.
- The United States spends about 15 percent of its gross domestic product (GDP) on health care—the largest expenditure in this category among industrialized countries. The rising cost of health care has been attributed to various factors: increases in the application of high technology for medical treatment and diagnosis, the aging population of the United States, the overall demand for health care, the amount of uncompensated care, and the cost of prescription drugs (the fastest-growing spending category and a particular problem for the elderly).
- Health care reform has been a topic of debate in Congress and the White House for several years. Recent federal health care initiatives include Medicare reform, the State Children’s Health Insurance Program, and the Patient’s Bill of Rights. But as health care continues to be debated at the federal level, some states are taking action to make reforms. Communities and organizations are also becoming involved.

On Your Own

Log on to the Web-based student study site at www.pineforge.com/leonguerrero2study for interactive quizzes, e-flashcards, journal articles, Community and Policy Guides, a Service Learning Guide, the end-of-chapter Web exercises, and additional Web resources.
Internet and Community Exercises

1. Based on the American Medical Association’s Web site, review the organization’s mission statement, history, and legislative initiatives. Log on to Study Site Chapter 10. Is there evidence to demonstrate how the AMA maintains its power and influence on the medical profession?

2. Select a specific disease or illness that you believe affects college-age men and women. Identify several Internet Web sites and support groups related to the disease or illness. How is the disease defined? Are there objective and subjective aspects of the disease? Does it vary by gender? by ethnicity/race?

3. Select one local hospital or health care system in your area or state. Through the Internet (or by visiting the hospital), identify the organization’s mission statement, its patient bill of rights, and community-based programs. How does this organization define care? Does its definition appear to be consistent with the community’s population and needs? Why or why not?

4. The United Nations’ Human Development Report tracks several health indicators: life expectancy at birth, infant mortality rates, and health expenditure per capita. Log on to Study Site Chapter 10 for the UN link and compare the United States with Canada, Germany, Mexico, Sweden, and the United Kingdom.