Lecture Notes

# Chapter 11: Health Care: An Anatomy of Health and Illness

## Learning Objectives

1. Provide examples of health at the societal level.
2. Illustrate how health issues impact us at the micro-, meso-, and macro-levels.
3. Use the symbolic interaction perspective to show that illness is a social construction.
4. Describe the role of the sick person.
5. Explain modern hospitals as complex organizations with bureaucratic features.
6. Describe how globalization influences health care issues at micro-, meso-, and macro-levels.

## Chapter Overview

Chapter 11 explains the institution of medicine from micro-, meso-, and macro-levels. The chapter begins with an interesting discussion of euthanasia, and then explains the reasons why health is a social issue to begin with, rather than a purely biological problem. Symbolic interactionist and labeling theories of illness are discussed. Then, the functionalist perspective is described with a focus on the sick role. Conflict and feminist theories of illness are articulated, including the social factors that influence access to health care and treatment of people within the health care system. Meso-level descriptions of health care systems in general and hospitals in particular are defined. Finally, a macro-level analysis of health care in the United States, in selected other countries, and globally is addressed.

## Lecture Outline

I. Introduction

*A. Active euthanasia* – aiding the dying individual by prescribing or administering a lethal dose of drugs to patients who request it, usually under legally-controlled conditions

i. The majority of deaths to terminally ill people are planned and sometimes hastened by medical interventions

ii. Arguments in favor of euthanasia

1. Physicians should be able to help patients die in comfort

2. Terminally ill individuals have the right to decide how and when they die

3. Just three U.S. states give competent, terminally ill adults the legal right to commit suicide

4. Legal safeguards will prevent physician abuse of assisted suicide

5. Terminally ill people already have high suicide rates

6. A majority of the public favors legalizing euthanasia

7. Extending life with no hope of recovery is costly to the health care system, individuals, and families

8. Elder care could be reduced by allowing people to die at home or in a hospice setting

iii. Arguments against euthanasia

1. Physicians are responsible for sustaining life and relieving suffering

2. The pain of terminally ill people can be relieved

3. Religious beliefs argue life is sacred

4. Some terminally ill people may feel pressured into suicide to save family resources or are depressed

5. Allowing terminally ill people to commit suicide may make suicide a more acceptable option for those who are depressed, disabled, elderly or retarded

iv. How and when we die and if we have a choice are based on cultural beliefs, values, and laws

II. Why is Health a Social Issue?

A. *Health* – a state of physical, mental, and social well being or the absence of disease

B. *Illness* – the lack of health

C. Health at the Micro-Level

i. How does our health impact our ability to carry out our other responsibilities

ii. Everyday lives are shaped by our own state of health or illness and that of our loved ones and close associates

D. Health at the Meso-Level

i. The institution of health care provides for the well-being of citizens, including prevention, diagnosis, and treatment of illness and the regulation and dispensing of medication

1. The institution of health care affects and is affected by other institutions

E. Health at the Macro-Level

i. Societies are interested in keeping their citizens healthy because health impacts the economy

1. Beliefs about who is ill, for how long, and with what illness are culturally determined

2. Global health – focuses on pandemics, distribution of drugs and immunizations, and bio-terrorism

a. *Pandemic* – a disease that is prevalent throughout and entire country and may infect a continent or reach around the world

III. Theoretical Perspectives on Health and Illness

A. Micro-Level Theoretical Perspectives

i. *The symbolic interaction perspective and labeling theory* – illness is whatever the powerful (in this case, doctors) define (or label) it as

1. The way that conditions are labeled can result in social stigma or various policies to treat problems

2. As new phenomena are labeled as “diseases”, physician power expands

3. Alternatively, labeling some behaviors as illnesses can be a step toward treatment

ii. *Medicalization and labeling* – the shift from handling some forms of deviance and normal human functions at home or in the legal or religious arenas to the health care system

1. The way something is labeled determines how the person with the “disease” is treated, whether they are blamed for their behavior or illness, and the physician’s role

2. Some behaviors (such as homosexuality) have been demedicalized

B. Meso- and Macro-Level Theoretical Perspectives

i. *The functionalist perspective* – social norms define what counts as illness and how to treat it; the health care system maintains the social structure and a balance between individuals and institutions; illness is not functional for society

1. The sick role is sometimes seen as deviant since it “robs” society of normal role functioning

ii. *The conflict perspective* – people’s economic and social positions in society affect their access to health care and the types of illnesses from which they suffer

1. People in poor countries die from illnesses that are curable in rich countries

2. Many governments see health care as a basic right, but not all have the means to meet the needs of their citizens

3. Globally, large companies attempt to make the biggest profit, and sometimes cut wages or health and safety standards at their plants in order to do so

4. Physicians who work in global urban areas and well-known clinics, treating those who can pay for private care receive more prestige than those who treat the indigent or elderly

iii. *Feminist theory* – the patriarchal control of women carries over to health care systems and reinforces dependence, submission, and definitions of what is “illness” for women

1. Western women are seen more often and their procedures are more expensive than men’s

2. Women’s bodies have been used historically to “prove” their inferiority and keep them out of some social positions

3. Women’s normal menstrual life cycles have become medicalized

4. A difficult problem for young girls who give birth at a young age is obstetric fistula

IV. The Status and Roles of the Sick Person: Micro-Level Analysis

A. There are no universal standards of what constitutes illness—illness is socially constructed

B. Certain socially defined standards must be met in order for the health care system, schools, and the workplace to define the person as legitimately ill

C. *The sick role* – the position that ill persons occupy in society

i. Sick people are deviant in failing to carry out their responsibilities

ii. The role is not punished, but tolerated as long as the sick individual cooperates and acts to overcome illness, returning as soon as possible to fulfill their usual social roles

iii. *Parsons’ functional theoretical model of the sick role* – the rights and responsibilities expected for ill persons

1. The sick person is excused from normal social responsibility in order to get well

2. The illness is not the sick person’s fault

3. The sick person should not enjoy being sick

4. The sick person is expected to seek competent medical help in getting well

iv. The sick role can legitimize failure by providing an excuse for failing to meet obligations, but if too many people do this society will be unable to function properly

v. Social and economic factors as well as denial of illness affect who gets health care and when

D. Social Factors in Illness and Health

* + 1. Individual beliefs, experiences, and decisions about health and illness may be deeply rooted in meso- and macro-level structural factors that shape availability of medicines and health services as well as factors that shape one’s lifestyle and attitudes toward health care

ii. Cultural belief systems and health

1. The methods of treatment of illness are culturally determined

2. Definitions of mental illness vary from culture to culture

3. Pain is universal, but the way it is perceived, explained, and reacted to is culturally determined

iii. Social Predictors in Individual Health and Illness

1. Age – older people need more preventative and acute care

2. Gender – Western women report more health problems than men, receive more preventative care, and take more medications; men use emergency services more

3. Ethnic groups – African-Americans are less likely to be able to access health care and are less likely to use hospitals and clinics; infant mortality is much higher among minorities

a. Minority women receive less prenatal care than other women

b. High infant mortality rate in the United States compared to other countries stems largely from the lack of adequate health care to low-income Americans and racial minorities

4. Social status – wealthier individuals are more likely to seek health care, in part because they can afford treatment, especially preventative treatment

5. The “working poor” tend to delay care

a. One in 4 adults lacks health care

b. More Americans are signing up for the Affordable Health Care Act insurance

V. Modern Health Care Systems: Meso-Level Analysis

A. The Organization of Health Care Systems

i. Citizen’s access to health care depends on the cultural values concerning the government’s role in providing care, whether health care is seen as a right for all, the amount and source of funding for health care, and type of health care available

ii. Types of national health care systems

1. *Affordable Care Act* (the United States)-individuals who do not have a group plan or are low income can acquire health insurance through exchanges

2. *Socialized medicine* – government-sponsored consumer service with equal access to all citizens; private care is available for an extra fee

3. *Decentralized national health programs* – the government regulates health care but does not operate it

4. Developing countries often cannot provide health insurance or security and rely on a combination of Western and indigenous medicine

iii. Hospitals as Complex Organizations

1. *Hospitals* – places for the care and treatment of the sick and injured, providing centralized medical knowledge and technology for treatment of illnesses and accidents

2. Urbanization and industrialization led to new health problems from lack of sanitation and overcrowding. Rational, systematic approaches to treatment were necessary

3. Hospitals have the same characteristics as other bureaucracies – hierarchical structures, rules and regulations, positions (doctors, nurses) based on competency and training, hiring and promotion based on merit, “gatekeepers” (primary care physicians) and contracts for work performed.

4. Health care systems are major employers in most developed nations

5. There is division within hospitals between physicians and administrators

B. Changing Professional Status of Employees in the Health Care System

i. Hospitals differ from other formal organizations

1. Divisions of labor are more extensive and specialized than other formal organizations

2. Well established hierarchical system of stratification

a. Patterns of authority very clear

b. Even clothing denotes the differences between statuses

c. Physicians have very high status in society and have been professionally recognized by the American Medical Association

i. The predominantly female health care area such as midwifery and other holistic approaches such as osteopathy, chiropractic medicine, and homeopathy were delegitimized by the powerful new AMA

1. Only *allopathy* (medical treatment supported by the AMA involving remedies that are based on directly countering a patient’s symptoms with drugs or surgery)

ii. New physicians face several challenges

1. Health care is now a system shaped by the purchasers of care and competition for profits,

2. decline in the public trust of physicians, and

3. emphasis on specialization and subspecialization over primary care,

4. the increase of outpatient care, and

5. a demand by payers for detailed accounts of decision-makers, fixed prepayment rates, and less willingness to pay doctors based on their decisions about patients’ needs

d. *Deprofessionalization* is the process through which a professional occupation loses autonomy, respect, and service orientation because the professionals come to be controlled by nonprofessionals and outside forces—financial concerns, government regulation, technological changes, and administrators or management

VI. Health Care Issues at National and Global Levels: Macro-Level Analysis

A. The health care system in the United States

i. One of the best in the world in terms of quality medical care and technology

ii. One of the worst in the world in terms of cost, unequal access, inefficiency, fragmentation, and competing interests

iii. Has become a social problem, according to some researchers, because the health care system was allowed to develop without specific direction, responded to demands piecemeal, allowing practitioners, medical facilities, and insurance and drug companies to establish themselves and then protect their self-interests at the expense of the American citizens

iv. Health care advances

1. Medical research leading to better therapies through gene therapy and an understanding of the human genome

2. Achievements in public health (e.g., motor vehicle safety, safer workplaces, clean drinking water)

v. Problems in the U.S. health care system

1. Access to health care

a. Maldistribution of services – shortage of rural providers (despite incentives to encourage doctors to work in underserved areas); for profit hospitals and clinics often migrate to wealthier areas to avoid doing too much free care;

b. Lack of family practice physicians (specializations are more profitable and prestigious)

2. Health care costs and funding

a. Costs continue to escalate

i. The United States spends twice as much per year on health care as other countries

b. The United States is the only developed country in the world that does not offer national health care for all citizens

i. The first attempt failed because of public influence campaigns by insurance and drug companies

ii. *Corporatization* – the provision of health care by for-profit oriented organizations

3. Lack of health care security and the Affordable Health Care Act

a. Commonwealth fund poll showed that 1 in 4 Americans under the age of 65 were uninsured at some point in 2011, mostly due to job loss

b. Uninsured population is dropping

c. Pre-existing conditions will no longer keep people from having insurance

d. Insurance companies can deny claims for what they view as unnecessary procedures

e. Racial and ethnic differences in coverage

B. Health Care Around the Globe

i. Each society organizes its health care around its culture and the demographic needs of its population

ii. Great Britain: Socialized medicine

1. All citizens have free access to health care, but can pay for private services

2. Families choose their own primary care physician, who is paid well and acts as a referral source

3. Some complaints about older facilities and waits for visits and surgery, but recent reforms have improved public opinion

iii. Globalization of Medical Problems

1. International sale of body parts (some people who are so poor will sell lungs, kidneys, etc. to the rich, leaving them eventually even more destitute than before)

2. National markers of good health include decreased infant mortality and increased life expectancy

iv. Globalization and the Mobility of Disease

1. HIV, influenza, SARS, polio, and other diseases are resurfacing

2. The spatial distribution of people affects the number of rodents and insects, sanitation, and contact individuals have with one another

3. Circulated air (in stadiums, airplanes, etc.) has contributed to the spread of disease

4. With more people traveling globally, more diseases are being spread internationally

5. Growing tobacco use is a global issue – governments benefit from taxing and placing tariffs on tobacco but health care costs increase

VII. What Have We Learned?

A. Although health is a private, personal concern, it is also a public concern, delivered through organizations dispensing health care and government practices determining access and funding of health care

B. Whether you have insurance or money to pay doctors depends in part on the economic conditions in society and the global marketplace of health care delivery