

Chapter 7: Who Gets Well? Health as a Social Problem

My deepest gratitude goes to Kim Puttman, who helped guide me as I wrote this chapter during a tumultuous period of my life. She was a thoughtful tutor and mentor, and this chapter wouldn't have been written without her. - Kate Burrows

7.1 Chapter Overview



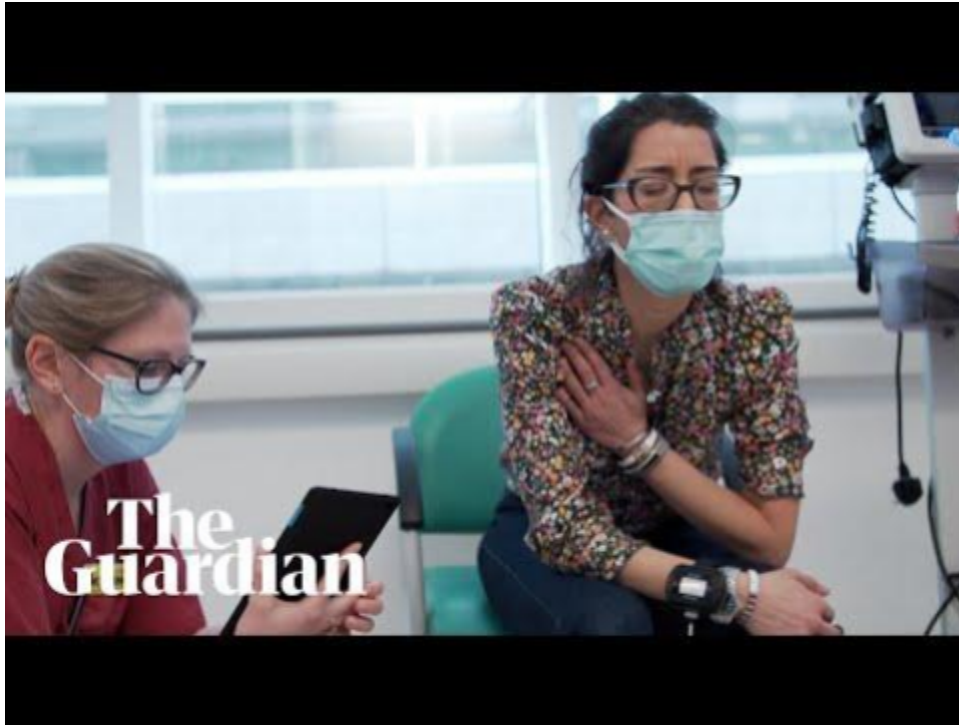


Figure 7.1 These two videos tell the story of people with long haul COVID-19. As you watch, please consider how these experiences might create a social problem. Opening Question: How did you and your family experience COVID-19?

By now, we probably all can tell a story about how **COVID-19** has impacted our lives. Some of us have had family members or friends pass away. Some of us are still experiencing lingering symptoms from a COVID-19 infection (called long-haul or long COVID, figure 7.1). Some of our kids just felt achy or tired for a day and then got better. Some of us may not know anyone who was personally affected by COVID-19. Pause for a moment to think about your own COVID-19 health story, and consider the many ways that this disease has affected society in the United States and worldwide .

My personal COVID-19 story has many layers. My wife and I quarantined, masked, and stayed socially distant for over two years. We isolated ourselves stringently because both of us have underlying health conditions which would make surviving COVID-19 difficult. My four parents followed these same protocols, missing visits with grandchildren, graduations, and family holidays. My dad had his 80th birthday party on Zoom, an event that we never could have predicted. My brothers and their families quarantined as requested early in the pandemic. They

attended school from home, just as many governors ordered. One sister-in-law still went to the hospital to deliver babies and care for patients sick with COVID-19.

Luckily, no one in my close family had to be hospitalized for COVID-19, and no one passed away. People in my close family got sick, but everyone has recovered. Luck might have kept my family well, but equally important to consider is my social location. My family had safe, warm, comfortable housing where we could quarantine. We could order food and supplies online, and people would deliver them to our door. Many of us were able to complete our work remotely, or at least adjust our work schedules. Although we had to wait until our age groups were eligible, our family had relatively easy access to vaccines. While these advantages don't guarantee health, they gave us options to respond effectively during the pandemic.

This story highlights how health itself becomes a social problem, not just a medical one. Common sense tells us that since COVID-19 is a disease, it should affect all people equally. You would think that a virus wouldn't discriminate.

However, we have learned that some social groups are more likely to be infected, hospitalized, and even die as a result of contracting COVID-19. The table in figure 7.2 shows rates of cases, hospitalizations, and deaths due to COVID-19 by race and ethnicity. As you can see, non-Hispanic Black people die from COVID-19 at a rate twice that of White people. Please take a moment to look at the other differences related to race and ethnicity in this table.

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases ¹	1.5x	0.8x	1.1x	1.5x
Hospitalization ²	2.8x	0.8x	2.2x	2.1x
Death ^{3,4}	2.1x	0.8x	1.7x	1.8x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers.

Figure 7.2: Rates for COVID-19 Infection, Hospitalization and Death y Race/Ethnicity, as of July 28, 2020. Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to related occupations, e.g. frontline, essential and critical infrastructure workers

Image Description: Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity

Rate rations compared to White, Non-Hispanic Persons	American Indian or Alaskan Native, Non-Hispanic Persons	Asian, Non-Hispanic Persons	Black or African American, Non Hispanic Persons	Hispanic or Latino Persons
Cases	1.5x	0.8x	1.1x	1.5x
Hospitalization	2.8x	0.8x	2.2x	2.1x
Death	2.1x	0.8x	1.7x	1.8x

Perhaps you notice that the data show a gap between European Americans and American Indian/Alaskan Native, Asian, Black people, and Latinx people. As you can see in the table, cases, hospitalizations, and deaths for all ethnic groups except for Asians are substantially higher than for Whites. This experience of inequality demonstrates that health and illness can be social problems.

In this chapter, we will explore the social elements of **health**, a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. We will look more deeply at why health is a social problem. We will look at how sociologists make sense of health and illness by considering how these understandings develop over time. We will explore collective and individual models of the social determinants of health. As we deepen our understanding of the social determinants of health, we will include the experience of individual and generational trauma as a factor in health outcomes. Like many other social problems, government policies and practices influence access to health resources and health outcomes. We will look at the differences in health systems internationally, and decide if these systemic

differences support health for everyone. Finally, we will come back to our own COVID-19 stories. The pandemic has both exposed and worsened existing inequalities. The pandemic is also inspiring creative action from individuals, communities, and governments. These generous responses demonstrate our interdependence.

7.1.1 Focusing Questions

The questions that encourage our curiosity include:

1. How is health a social problem?
2. How do sociologists make sense of health and illness? How have our definitions changed over time?
3. What are social determinants of health, and how do they influence health outcomes for individuals and communities?
4. In what ways do social values and government policies impact health systems and health outcomes in the U.S. and worldwide?
5. How has COVID-19 provided an opportunity to assess and improve healthcare delivery and health outcomes?

Let's get started!

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Figure 7.1 a “[Anyone can get Long COVID:Isaiah](#)” © Resolve to Save Lives. License Terms: Standard YouTube License.

Figure 7.1 a “[Inside a Long Covid clinic: "I look normal, but my body is breaking down"](#)” © The Guardian. .License Terms: Standard YouTube License.

Figure 7.2: [Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity](#) Center for Disease Control (CDC). [Public Domain](#)

7.2 Health as a Social Problem



Figure 7.3 Medical providers must use universal precautions such as masks and gloves when treating patients with communicable diseases such as Ebola and COVID-19.

Even with our brief explanation of COVID-19 statistics in the introduction of this chapter, we see that people experience unequal health outcomes based on their race and ethnicity. This is just one dimension of inequality in health outcomes. What else makes health and illness a social problem?

Health and illness in society go beyond individual experience. We usually think of health, illness, and medicine in individual terms. When a person becomes ill, we view the illness as a medical problem with biological causes. A physician treats the individual accordingly. A sociological approach takes a different view. Unlike physicians, sociologists and other public health scholars do not try to understand why any one person becomes ill. Instead, we typically examine rates of illness to explain why people from certain social backgrounds are more likely than those from others to become sick. Our social location in society—our social class, race and ethnicity, gender, and other dimensions of difference—makes a critical difference.

Medical sociology is the systematic study of how societies manage issues of health and illness, such as diseases and disorders, healthcare access, as well as the larger picture of physical, mental, and social components of health and illness. Major topics for medical sociologists include the doctor/patient relationship, the structure and socioeconomics of healthcare, and how

culture impacts attitudes toward disease and wellness. In the next section, we'll look at what medical sociologists find when they look at how experiences of health and illness can differ by social location.

How we get sick and how we stay healthy reveal our interdependence. As an example, residents of Flint, Michigan, experienced higher than normal levels of lead toxicity, hair loss, rash, and other health issues when the local municipal government changed the water supply in 2013. Although government officials knew that the Flint River was contaminated with pollution from manufacturing, they decided to use this water for city residents because it was cheaper. Decisions at several interdependent layers of government resulted in this harmful decision. Local citizens connected with doctors, health officials, and journalists to tell the story of the contaminated water and support a change. Eventually, the Michigan Civil Rights Commission cited systemic racism as the fundamental cause for the questionable decisions. Recovery required both individual agency and collective action. If you would like to learn more, [Flint Water Crisis: Everything You Need to Know](#) provides more details.

Conflict between values can cause social problems to arise. How would you describe the



difference in values between the social groups represented in figures 7.4 and 7.5?

Figure 7.4 Pandemic lockdown protesters hold signs that say that lockdown is an issue of tyranny and freedom.



Figure 7.5 Pandemic protesters hold signs that promote using science to end the pandemic.

The protesters in figure 7.4 explicitly state that the COVID-19 lockdown is an example of government tyranny. The protesters in figure 7.5 are promoting vaccinations, asserting that scientific knowledge and research should be used to ensure our health. You may know people who support vaccines and social distancing as a way to manage the pandemic. You may know other people who think that vaccines are dangerous and that state-mandated quarantining is “un-American.” This conflict in values creates the conditions in which a social problem is likely to arise.

Many conversations on social media in the United States focused on a perceived loss of personal freedoms caused by quarantining, social distancing, and wearing face coverings. Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases and the Chief Medical Advisor to the President, became a symbol of strength for those supporting vaccination and following guidelines, while at the same time becoming the feature of many t-shirts and bumper stickers for those who were critical of the federal government’s implementation of World Health Organization (WHO) guidelines for reducing the spread of COVID-19.

Our ideas about what is healthy, what is illness, and what actions we should take to be healthy and treat illness, are socially constructed. The fact that our social backgrounds affect our health may be difficult for many of us to accept. We all know someone, and often someone we love, who has died from a serious illness or currently suffers from one. There is usually a physical or biological cause of this person’s illness, and physicians do their best to try to cure it and prevent

it from recurring. Sometimes they succeed; sometimes they fail. Whether someone suffers a serious illness is often a combination of life events and the biological traits that we inherit from our parents (Cockerham 2009). The exact details of how one's social, cultural, ethnic, and genetic profile impact your health and likelihood of contracting diseases is a rapidly evolving research area. The study of how our behaviors and environment can cause changes that affect the way our genes work is called **epigenetics**. The medical and sociology communities are not shy in sharing that our social backgrounds affect our health, but many genetic studies erroneously correlate health outcomes with racial identity.

A sociological approach also emphasizes that a society's culture shapes its understanding of health and illness and practices of medicine. In particular, culture shapes a society's perceptions of what it means to be healthy or ill, the reasons to which it attributes illness, and the ways in which it tries to keep its members healthy and cure those who are sick (Hahn & Inborn 2009). Knowing about a society's culture, then, helps us to understand how it perceives health and healing. By the same token, knowing about a society's health and medicine helps us to understand important aspects of its culture. We'll look more deeply into cultural constructions of health and illness in section 7.4.

We can also look at health and illness through the lens of the social problems process, using COVID-19 as an example. As we discussed in Chapter 1, the social problems process is a model to explain social phenomena and predict what might happen next. The response to COVID-19 is an unusual example because government action was often the first step in response to a social problem, rather than the more common starting places of protest and activism. We start our cycle then at Step 4: Policymaking. Governments worldwide responded to the pandemic differently, resulting in a variety of social consequences.

While some countries managed the spread of the virus far better than others, it affected everyone. Highly industrialized countries, such as China, Italy, and the United States, were early centers of the outbreak. Brazil and India had later increases, as did the U.K. and Russia. Most countries took measures that were considered extreme by Americans—closing borders, forcing schools and businesses to close, and requiring face coverings to be worn when leaving one's home. Other nations went further, completely shutting down at the discovery of just a few cases. And some

countries had mixed responses, typically resulting in high rates of infection and overwhelming losses of life. In Brazil and the United States, for example, political leaders and large swaths of the population rejected measures to contain the virus. By the time vaccines became widely available, those two countries had the highest numbers of COVID-19 deaths worldwide.

Prior to the United States facing the worst COVID-19 outbreak in the world, the federal government restricted travel, as did many countries in Europe. Shutting down travel, instituting social distancing, and closing down schools were examples of Step 5 Social Problems work, the creation of actual practices and behaviors that implement government policies.

With the implementation of these policies, we begin to see Step 6, Policy Outcomes. Government action was focused on “flattening the curve,” or decreasing the amount of people who needed hospitalization at any one time. We continue to measure and report the outcomes of these policies and will continue to interpret them.

In the meantime, the cycle continues. We see new claims being made, Step 1, and the related media coverage of those claims, Step 2. Conflicting messages about mask wearing and social distancing became political weapons amid the country's 2020 Presidential election, and localized outbreaks and spikes of deaths were continually traced to gatherings that occurred against scientific guidance. Brazil's President actively disputed medical opinions, rejected any travel or business restrictions, and was in conflict with many people in his own government (even his political allies). With Brazil's slower pace of vaccination compared to the U.S., it saw a steep increase in cases and deaths just as the United States' numbers started to decline.

Both those opposed to heavy restrictions and those who used them to fight the disease acknowledge that the impacts went far beyond physical health. Families shattered by the loss of a loved one had to go through the pain without relatives to support them at funerals or other gatherings. Many who recovered from the disease had serious health issues to contend with, while other people who were forced to delay important surgical and other medical treatments faced financial, emotional, and mental health challenges because of COVID-19 restrictions implemented at all levels of government. Fear, isolation, and strained familial relationships led to emotional problems. Many families lost income. Learning was certainly impacted as educational

practices went through sudden shifts. The true outcomes will likely not be fully understood for years after the pandemic is under control.

So now, after the height of the COVID-19 pandemic, what does *health* mean to you? Does your opinion of it differ from your pre-COVID attitudes? Many people who became severely ill or died from COVID had other health issues such as hypertension and obesity. Do you know people whose attitudes about their general health changed? Do you know people who find themselves suspicious of the intentions of the government, or less likely to listen to doctors or scientists? What do you think will be the best way to prevent illness and death should another pandemic strike? Each of these questions highlights a topic related to the social construction of the social problem of health and illness.

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Figure 7.3 Navy Medicine/flickr from

<https://openstax.org/books/introduction-sociology-3e/pages/19-introduction>

Figure 7.4 [An anti-lockdown protest at Queen's Pa... | Flickr](#)

Figure 7.5 Yes to Science protesters Photo by [Mitchell Luo](#) on [Unsplash](#)

7.3 Epidemiology in the U.S.: Health Disparities by Social Location

Doctors and medical professionals focus most on the health of an individual person. Sociologists and public health professionals focus on the health of groups. This specialty is called **epidemiology**, the study of disease and health, and their causes and distributions. Epidemiology can focus on the differences between neighborhoods, states, or even countries. As we look at health in the United States, we see a complex and often contradictory issue. On the one hand, as one of the wealthiest nations, the United States fares well in health comparisons with the rest of

the world. However, the United States also lags behind almost every industrialized country in terms of providing care to *all* its citizens. This gap between the shared value of health and unequal outcomes makes health and illness a social problem.

Sociologists and others who study human health have a detailed model that helps them make sense of health in groups. This model is called the social determinants of health. More specifically, the **social determinants of health** are the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. While ethnicity may seem to correlate with these elements, it is misleading to assume that all members of a specific racial group will experience the same health outcomes (Jones & Whitemarsh 2010). These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

7.3.1 Diversity and Inequality: Social Determinants of Health



Figure 7.6 Social determinants of health (SDOH), provided by the CDC.

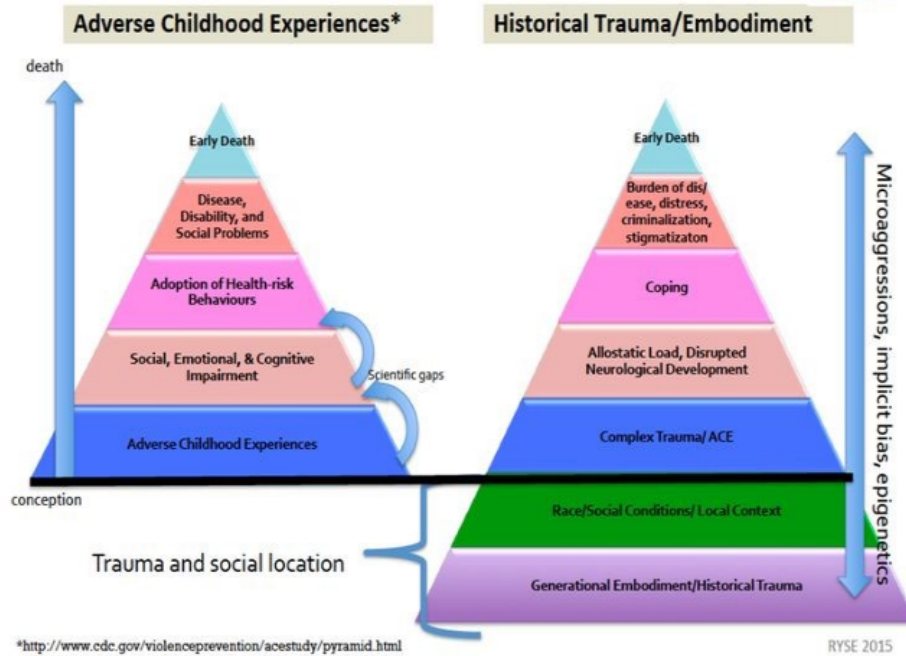
Image Description: Social determinants of health surround the individual including: 1) health care access and quality, 2) neighborhood and built environment, 3) social and community context, 4) economic stability, 5) education access and quality.

Social scientists and health professionals use this model of social determinants of health to describe the social factors that influence the health or lack of health of different social groups. The Center for Disease Control (CDC) created the model in figure 7.6. We see that access to quality health care influences how healthy you might be. Whether your neighborhood is located next to an oil refinery, as described in Chapter 5, changes your health outcomes. You might be surprised to see that education access and quality also impacts your health. However, you might remember from Chapter 3 that education and wealth are correlated. When you know more, you might choose to make different health decisions.

The way organizations and institutions create models for the social determinants of health can change what we see. If you'd like to explore this question more deeply, here is a model from the [World Health Organization](#) and a [SDOH model from the Canadian First Nations Peoples](#). Why might these models be different from each other?

In a slightly different model, researchers look at why how trauma over time makes a difference in health outcomes:

Trauma and Social Location



Source: Centers for Disease Control and Prevention. (2016). Violence prevention: *The ACE pyramid* (adapted by RYSE Youth Center). <https://www.cdc.gov/violenceprevention/acestudy/about.html>

[ACEs_social_location_2015.pdf](#)

Figure 7.7 Trauma and Social Location

The Centers for Disease Control and Prevention provides the pyramid model in figure 7.7 on the left. This pyramid starts with **Adverse Childhood Experiences**, more commonly known as ACEs. These adverse or traumatic experiences may include growing up in a family with mental health or substance abuse issues, child abuse, or other experiences of violence. Because a person who experiences these events is more likely to experience some impairments in childhood, they are more likely to adopt risky behaviors as an adult. If left untreated, the related diseases and disabilities can lead to early death.

When children get help from caring adults, are connected with others, or receive competent professional support, they can recover from this early trauma. Also, many people experience at least one Adverse Childhood trauma in their lifetime. However, a more marginalized social

location may create risks for experiencing more ACEs. For a deeper look at how ACEs work, you could watch this TED Talk, “[How Childhood Trauma Affects Health Across a Lifetime.](#)”

The pyramid on the right, created by The RYSE Youth Center center adds a deeper context to the causes of Adverse Childhood Experience (ACEs). They identify **historical trauma**, pointing out that trauma can be repeated through generations and across history, and that long-term, strained social conditions can increase the incidence of ACEs in specific populations. The more ACEs an adult has can predict that person’s risk of developing health problems such as diabetes, heart disease, and cancer. This addition helps us to understand even more deeply that disease and health are interdependent social problems.

Diversity and Inequality Social Determinants of Health Licenses and Attributions

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Figure 7.6 [Social Determinants of Health Model](#): Source: Center for Disease Control (CDC). [Public Domain](#)

Figure 7.7 Trauma and Social Location [ACEs_social-location_2015.pdf](#)

7.3.2 Health Inequalities by Race and Ethnicity

When looking at the social epidemiology of the United States, it is easy to see the disparities among races. The discrepancy between Black and White Americans shows the gap clearly. In 2018, the average life expectancy for White males was approximately five years longer than for Black males: 78.8 compared to 74.7 (Wamsley 2021). (Note that in 2020 life expectancies of all races declined further, though the unprecedented COVID-19 pandemic was a significant cause.)

Mortality is the measure of how many people die at a particular time or place. When we look at how many babies die, or infant mortality, we see similar disparities. The 2018 infant mortality rates for different races and ethnicities are as follows:

Infant Mortality Rates by Race and Ethnicity, 2018

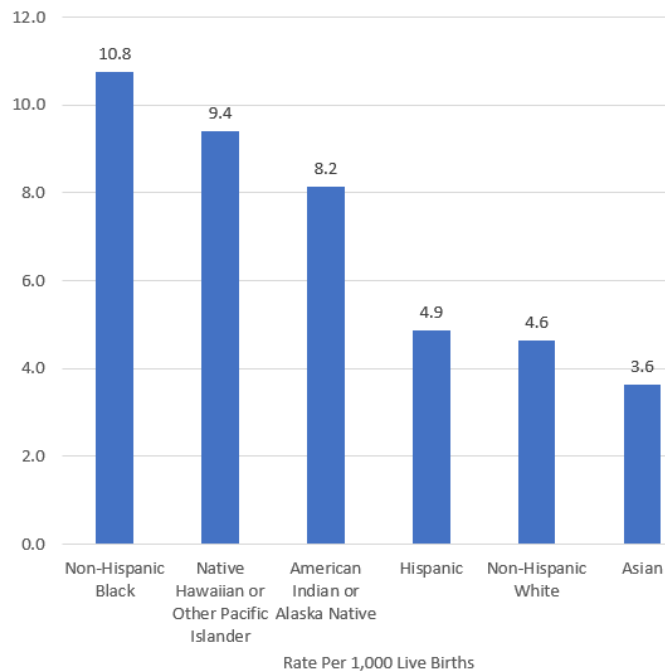


Figure 7.8 Infant Mortality by Race and Ethnicity, 2018

Image Description: Rate per 1,000 live births; 1) Non-hispanic Black, 10.8, 2) Native Hawaiian or other Pacific Islander, 9.4, 3) American Indian or Alaskan Native, 8.2, 4) Hispanic, 4.9, 5) Non-Hispanic White, 4.6, 6) Asian, 3.6.

According to a report from the Henry J. Kaiser Foundation (2007), African Americans also have higher incidence of several diseases and causes of mortality, from cancer to heart disease to diabetes. In a similar vein, it is important to note that ethnic minorities, including Mexican Americans and Native Americans, also have higher rates of these diseases and causes of mortality than White people.

Lisa Berkman (2009) notes that this gap started to narrow during the Civil Rights movement in the 1960s, but it began widening again in the early 1980s. What accounts for these perpetual

disparities in health among different groups? Much of the answer lies in the level of healthcare that these groups have access to. The National Healthcare Disparities Report shows that even after adjusting for insurance differences, Black, Indigenous, and people of color receive poorer quality of care and less access to care than dominant groups. The report identified these racial inequalities in care:

- Black people, Native Americans, and Alaska Natives receive worse care than Whites for about 40 percent of quality measures, which are standards for measuring the performance of healthcare providers to care for patients and populations. Quality measures can identify important aspects of care like safety, effectiveness, timeliness, and fairness.
- Hispanics, Native Hawaiians, and Pacific Islanders receive worse care than White people for more than 30 percent of quality measures.
- Asian people received worse care than White people for nearly 30 percent of quality measures but better care for nearly 30 percent of quality measures (Agency for Healthcare Research and Quality, 2020).

Although the reasons for these disparities are complex, a simple illustration may help make the point. Medical professionals and public health workers are asking why Black and Brown people are more likely to die of COVID-19. One medical study examined the pulse oximetry measurements of Black people and White people who were in the hospital. If you've been to the hospital, you likely have had to put your finger into a little device that tells the medical professionals how much oxygen is in your blood, or oximetry. The authors of the study examined how often these measurements were accurate for White patients and Black patients. They found that Black patients were three times more likely than White patients to have shortages of oxygen in the blood that the monitor didn't pick up. Because COVID-19 mainly attacks the lungs and reduces oxygen, the discrepancies in the measurements of this device may lead to more medical complications in Black patients (Sjoding et al. 2021). Although there are multiple complex reasons, this example can help illustrate part of the reason. Sometimes medical devices work more effectively for people with white skin. An example of this is [research](#) that suggests that pulse oximeters work less effectively for darker-skinned people, and as a result, may actually cause more harm than good.

7.3.3 Health Inequalities by Socioeconomic Status

The social location of wealth or poverty often influences health outcomes (Patel 2020). Marilyn Winkleby and her research associates (1992) state that “one of the strongest and most consistent predictors of a person's **morbidity** [incidence of disease] and **mortality** [death] experience is that person's socioeconomic status (SES). This finding persists across all diseases with few exceptions, continues throughout the entire lifespan, and extends across numerous risk factors for disease.” In other words, having a lower SES makes you more likely to get sick or die of disease than people with a higher SES.

In Ijaoma Oluo's [blog](#) post, “So You Want to Talk About Race,” the author describes her experience as a child in Japan, and how being poor changes both a current healthcare crisis for her mother and her own ability to eat without pain. She writes that when you are poor, the only option you have when a tooth goes bad is to get it pulled. Even if you get richer as an adult, your mouth tells the story of your poverty, because it is full of gaps. (Oluo 2022).

Economics is only part of the SES picture. Research suggests that education also plays an important role. Phelan and Link (2003) note that many behavior-influenced diseases like lung cancer (from smoking), coronary artery disease (from poor eating and exercise habits), and HIV/AIDS initially were widespread across SES groups. However, once information linking habits to disease was disseminated, these diseases decreased in high SES groups and increased in low SES groups. This illustrates the important role of education initiatives regarding a given disease, as well as possible inequalities in how those initiatives effectively reach different SES groups.

To find data related to why people of low SES are more likely to contract and die from COVID-19, we look outside the United States to a study conducted in England. The study finds that people who are poor are more likely to live in overcrowded or substandard housing. These conditions make it challenging for the people who live there to quarantine effectively or maintain social distancing.

According to this study, people who are poor are more likely to be essential workers - servers, grocery clerks, delivery drivers, and other service workers. These essential workers have been

required to keep their jobs and continue their interactions with lots of other people, again increasing their risk of exposure to the virus.

Finally, because people with a lower socioeconomic status experience financial insecurity, they can be more stressed. This stress often translates into weakened immune systems, which makes it difficult to fight the virus. Finally, because poorer people have less access to quality healthcare, they may delay going to the hospital. Because they waited “until the last minute” to get medical attention, their symptoms are more severe, and it is more difficult for them to recover.

7.3.4 Health Inequalities by Biological Sex

The Pandemic has finally opened our eyes to the fact that health is not driven just by biology, but by the social environment in which we all find ourselves and gender is a major part of that.

– Professor Sarah Hawkes, Co-Director of GH5050

Figure 7.9 Gender and COVID-19 Quote

Exposure, sickness, and death due to COVID-19 do not only reflect structural inequalities for People of Color but are also influenced by one’s gender. In this video, [A Gender Perspective on COVID-19](#), the Georgetown Institute for Women, Peace, and Security highlights some of the ways that females may experience COVID-19 differently than males. They explain that during the pandemic, women are more likely to be caregivers for family members and work as frontline health workers compared to men, increasing their risk of exposure. At the beginning of this crisis, the video focuses on “front-line first” encouraging support for the most vulnerable populations. Over time, though, worldwide data is showing that women and men are getting infected with COVID-19 at near equal rates. Stereotypes regarding the types of occupations and tasks taken on by women did not hold water once the statistics were known. In fact, men are more likely to die from a COVID-19 infection than women.

Fig 3. Number of Global COVID-19 Deaths where the Sex is Known, January 2021 - November 2021

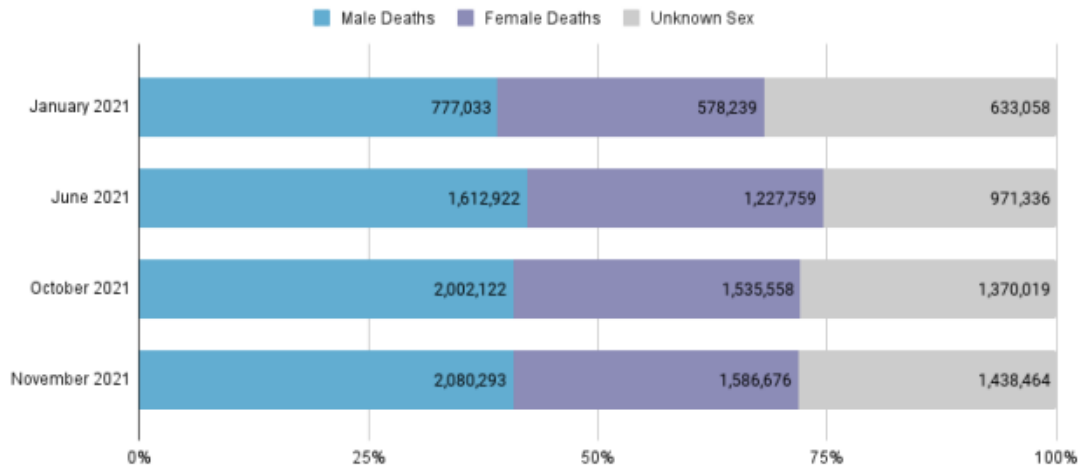


Figure 7.10 Number of Global COVID-19 Deaths Where Sex is Known, as of 2021. Men die more frequently.

The Sex, Gender, and COVID-19 Project works to collect all kinds of COVID-19 numbers, and dis-aggregate, or separate, the statistics by male, female or non-binary gender. In the chart in figure 7.10, the chart demonstrates that more men are dying from COVID-19 than women.

To understand why this is so, the social scientists from this project highlight both biological sex characteristics and socially constructed gender. They note that men have higher levels of an enzyme called ACE2. This enzyme allows viruses to enter cells more easily, which might tend to make men sicker than women. In addition to biological differences, the evidence highlights differences in behavior and in social structures. In general, men tend to engage in more risky health behaviors such as drinking and smoking. These behaviors lead to poorer overall health and more risk of early death. Also, men tend to seek treatment later than women. The scientists write:

However, experience and evidence thus far tell us that both sex and gender are important drivers of risk and response to infection and disease. For example, even in the case of ACE2 (the enzyme that helps the virus enter the body's cells), there are generally more ACE2 receptors in the heart cells of someone with pre-existing heart disease. And heart disease itself is associated with gender. In many societies today it is men who are more

likely to suffer from heart disease and chronic lung disease as they are more frequently smokers, drinkers or working in occupations that expose them to risk of air pollution.

Other gender-based drivers of inequality may include men's generally lower use of health services, including preventive health services – which might mean that men are further along in their illness before they seek care, for example. In the case of ebola, men typically presented at hospital 12 hours later in the course of the disease than women did – and men's death rate was [higher](#). (Donnelly et al. 2016)

We are reacting to the COVID-19 pandemic and trying to understand complex links between the causes of pandemic sickness and death at the same time, so our scientific conclusions may change as we learn more. Even if the final analysis changes, gender is one dimension of difference that helps to explain unequal health outcomes during COVID-19.

Gender is also a key variable in understanding health with a wider lens. Women are affected adversely both by unequal access to and institutionalized sexism in the healthcare industry. According to a recent report from the Kaiser Family Foundation, women experienced a decline in their ability to see needed specialists between 2001 and 2008. In 2008, one-quarter of women questioned the quality of their healthcare (Ranji & Salganico 2011). Quality is partially indicated by access and cost. In 2018, roughly one in four (26 percent) women—compared to one in five (19 percent) men—reported delaying healthcare or letting conditions go untreated due to cost. Because of costs, approximately one in five women postponed preventive care, skipped a recommended test or treatment, or reduced their use of medication due to cost (Kaiser Family Foundation 2018).

We can see an example of institutionalized sexism in the way that women are more likely than men to be diagnosed with certain kinds of mental disorders. Psychologist Dana Becker notes that 75 percent of all diagnoses of Borderline Personality Disorder (BPD) are for women according to the *Diagnostic Statistical Manual of Mental Disorders*. This diagnosis is characterized by instability of identity, of mood, and of behavior, and Becker argues that it has been used as a catch-all diagnosis for too many women. She further explains the stigma of the diagnosis, saying that it predisposes many people, both within and outside of the profession of psychotherapy, against women who have been so diagnosed (Becker n.d.).

Many critics also point to the medicalization of women's issues as an example of institutionalized sexism. **Medicalization** refers to the process by which previously normal aspects of life are redefined as deviant and needing medical attention to remedy. Historically and contemporaneously, many aspects of women's lives have been medicalized, including menstruation, premenstrual syndrome, pregnancy, childbirth, and menopause. The medicalization of pregnancy and childbirth has been particularly contentious in recent decades, with many women opting against the medical process and choosing natural childbirth. Fox and Worts (1999) find that all women experience pain and anxiety during the birth process, but that social support relieves both as effectively as medical support. In other words, medical interventions are no more effective than social ones at helping with the difficulties of pain and childbirth. Fox and Worts further found that women with supportive partners ended up with less medical intervention and fewer cases of postpartum depression. Of course, access to quality birth care outside the standard medical models may not be readily available to women of all social classes.

7.3.5 Health Inequalities by Gender Identity

Gender identity and sexual orientation may also impact how a person experiences health and illness. However, understanding these unequal experiences based on sociological data is challenging. Because it has been illegal to be queer or transgender until recently in the United States, many people do not disclose their unique identities. The agencies that collect data about gender identity and sexual orientation have only recently begun to re-tool their data collection methods so that people can report their gender identity or sexual orientation. Despite these limitations, though, we notice inequality.

For example, when the Centers for Disease Control and Prevention (CDC) examined risk factors for COVID-19 illness or death, they found that gay, lesbian, and bisexual people had challenging underlying health conditions more often than straight people (figure 7.11). The report points primarily to economic causes as a core cause of the difference, indicating that lesbian, gay, and bisexual people, particularly if they are Black or Brown, experience less economic stability (Heslin & Hall 2021).

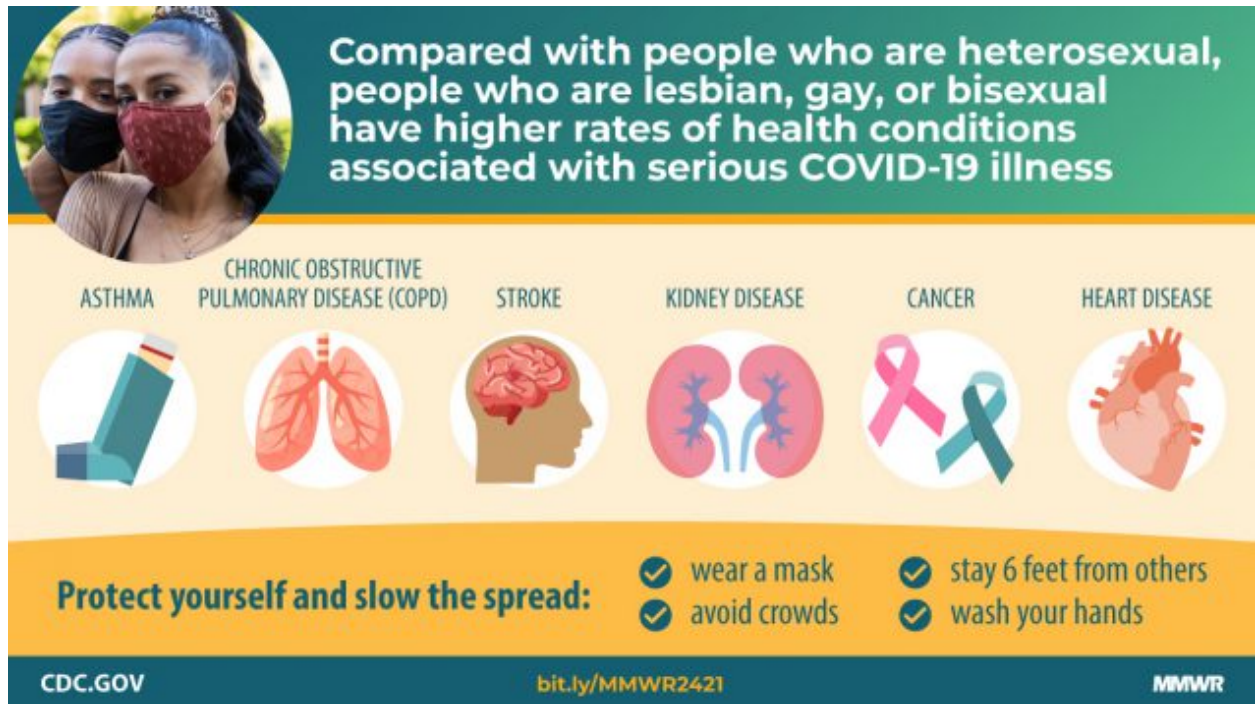


Figure 7.11 CDC Infographic COVID and LGBTQIA+ health (Heslin & Hall 2021)

Image Description: Compared with people who are heterosexual, people who are lesbian, gay, or bisexual have higher rates of health conditions associated with serious COVID-19 illness including: Asthma, Chronic Obstructive pulmonary disease (COPD), stroke, kidney disease, cancer, heart disease.

When examining the overall health of lesbian, gay, bisexual, and transgender people, the American College of Physicians finds similar issues. They also highlight the connections between laws, discrimination, and rejection that result in poorer health outcomes for LGBTQIA+ people:

These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse. (Daniel 2015)

Transgender people have unique health concerns that are rarely addressed well by current practices. Although transgender people differ in their desires regarding medical support for their

physical transitions, many of the procedures are not covered by insurance. When examining health outcomes for transgender people, the report states:

Transgender persons are also at a higher lifetime risk for suicide attempt and show higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than nontransgender persons. A 2011 survey of transgender or gender-nonconforming persons found that 41 [percent] reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault. (Daniel 2015)

In this episode of [All Things Considered: Health Care System Fails Many Transgender Americans](#), the journalist notes that simple things, like having forms that indicate only male and female, become barriers to accessing health care services. Transgender people are more likely to experience health conditions that are preventable because it is difficult to find medical providers that will treat them with respect. The videos that are linked to this episode explore issues related to transgender health in more detail.

Perhaps this doesn't need to be said, but it is not the gender identity or sexual orientation per se that causes poorer health outcomes. Instead, it is the social structure embedded with stigma, discrimination, and violence that makes life riskier and shorter for LGBTQIA+ people.

7.3.6 Health and Disability



Figure 7.12 The handicapped accessible sign indicates that people with disabilities can access the facility. The Americans with Disabilities Act requires that access be provided to everyone.

Disability refers to a reduction in one's ability to perform everyday tasks. The World Health Organization makes a distinction between the various terms used to describe handicaps that are important to the sociological perspective. They use the term **impairment** to describe the physical limitations a person may face, while reserving the term disability to refer to the social limitations, such as the fact that people with disabilities are far less likely to be employed than people without disabilities.

Before the passage of the Americans with Disabilities Act (ADA) in 1990, people in the United States with disabilities were often excluded from opportunities and social institutions many of us take for granted. This occurred not only through employment and other kinds of discrimination but also through casual acceptance by most people in the United States of a world designed for the convenience of the able-bodied. Imagine being in a wheelchair and trying to use a sidewalk without the benefit of wheelchair-accessible curbs. Imagine a blind person trying to access information without the widespread availability of Braille. Imagine having limited motor control and being faced with a difficult-to-grasp round door handle. Issues like these are what the ADA tries to address. Ramps on sidewalks, Braille instructions, and more accessible door levers are all accommodations to help people with disabilities.

People with disabilities can be stigmatized by their illnesses. The sociological concept of stigma can be applied widely to people who are marginalized because of poverty, race, citizenship status, and other factors. Stigmatization means their identity is spoiled; they are labeled as different, discriminated against, and sometimes even shunned. Erving Goffman, who is the mid-century sociologist who pioneered stigma theory, used the words "spoiled identity" to refer to stigmas, however, this language is not commonly used by sociologists to describe stigma today, as it in itself can be stigmatizing. People with disabilities may be labeled (as an interactionist might point out) and ascribed a master status (as a functionalist might note), becoming *the blind girl* or *the boy in the wheelchair* instead of someone afforded a full identity by society. This can be especially true for people who are disabled due to mental illness or disorders.

Many mental health disorders can be debilitating and can affect a person’s ability to cope with everyday life. This can affect social status, housing, and especially employment. According to the Bureau of Labor Statistics (2011), people with a disability had a higher rate of unemployment than people without a disability in 2010. This unemployment rate refers only to people actively looking for a job. In fact, eight out of ten people with a disability are considered “out of the labor force;” that is, they do not have jobs and are not looking for them. The combination of this population and the high unemployment rate leads to an employment-population ratio of 18.6 percent among those with disabilities. The employment-population ratio for people without disabilities was much higher, at 63.5 percent (U.S. Bureau of Labor Statistics 2011).

Epidemiology in the U.S.: Health Disparities by Social Location

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[19.3 Health in the United States](#) CC-BY 4.0 Added additional details related to infant mortality rates, COVID-19 and outcomes for LGBTQIA+ populations.

Figure 7.8 Infant Mortality by Race and Ethnicity, 2018

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

Figure 7.9 and related text on COVID-19 and Gender: The Sex, Gender and COVID-19 Project

<https://globalhealth5050.org/the-sex-gender-and-covid-19-project/men-sex-gender-and-covid-19/> CC-BY [Creative Commons Attribution-NonCommercial 4.0 International License](#)

Figure 7.10 Number of Global COVID-19 Deaths Where Sex is Know. (

<https://globalhealth5050.org/wp-content/uploads/November-2021-data-tracker-update.pdf> Nov 2021) CC-BY [Creative Commons Attribution-NonCommercial 4.0 International License](#)

Figure 7.11 CDC Infographic COVID and LGBTQ health (Heslin & Hall, 2021)

Figure 7.12 The handicapped accessible sign indicates that people with disabilities can access the facility. The Americans with Disabilities Act requires that access be provided to everyone. (Credit: Ltjljtlj/Wikimedia Commons)

7.4 Sociological Theories of Health

Like all social problems, the concepts of health and illness are socially constructed. The definition of the social construction of illness experience is based on the idea that there is no objective reality, only our own perceptions of reality. The theories surrounding the **social construction of health** emphasize the social and cultural aspects of the discipline's approach to physical, objectively definable phenomena. This section examines a comprehensive framework that focuses on the cultural meaning of illness, the social construction of the illness experience, and the social construction of medical knowledge (Conrad & Becker, 2010).

7.4.1 *The Cultural Meaning of Illness*

Most medical sociologists contend that illnesses have both a biological and an experiential component and that these components exist independently of each other. Our culture influences the way we experience illness, dictating which illnesses are stigmatized, which are considered disabilities or impairments, and which are contestable as opposed to definitive (Conrad & Barker, 2010). **Contested illnesses** are those that are questioned or questionable by some medical professionals. Disorders like fibromyalgia or chronic fatigue syndrome are real physical experiences, but some medical professionals contest whether these ailments are definable in medical terms. This causes a problem for a patient with symptoms that might be explained by a contested illness - how to get the treatment and diagnosis they need in the face of a medical establishment that does not believe their symptoms are real.

Individual and cultural perceptions of exertion and pain can make it difficult for healthcare workers to treat illnesses since they cannot be measured using a device. Instead, assessment tools like the Rating of Perceived Exertion (RPE) Scale attempt to measure exertion at the individual level using accessible language and visual cues. This RPE chart includes the Wong-Baker FACES pain assessment tool, which is used often in healthcare settings because it works for a variety of ages, ability levels, and can be understood by those whose primary language is not English. This Rating of Perceived Exertion (RPE) gives a more complete view of an individual's actual exertion level, since heart rate or pulse measurements may be affected by medication or other issues (Centers for Disease Control 2011a).







<i>Rating of Perceived Exertion</i>			
	0 - Very light activity	Minimal exertion, but more than sleeping or stationary activity.	Heart rate, breathing, and physical comfort level are baseline.
	2 - Light activity	Feels like you can maintain the activity for several hours.	Breathing is normal. Heart rate higher than baseline.
	4 - Moderate activity	Feel comfortable, but cannot maintain the activity for more than two hours.	Can speak a few minutes before getting winded. Heart rate is elevated.
	6 - Vigorous activity	Feel uncomfortable with multiple physical signs that your body is working hard.	Can speak a sentence before becoming winded. Heart rate is elevated.
	8 - Very hard activity	Difficult to maintain activity intensity for more than a few minutes.	Can speak a few words before becoming winded. Heart rate is high.
	10 - Maximum effort activity	Feels impossible to maintain activity intensity for more than a few minutes.	Completely out of breath, unable to talk. Heart rate is very high.

Figure 7.13: Rating of Perceived Exertion (RPE) Scale combined with the Wong-Baker FACES pain assessment tool.

7.4.2 Sick role and functionalist perspective

Health is vital to the stability of the society, so *illness* is often seen as a form of deviance. Talcott Parsons (1951), an American sociologist who was the first to systematize the study of social systems, and is considered one of the *fathers* of American mid-century sociology, was the first to discuss this in terms of the **sick role**: patterns of expectations that define appropriate behavior for the sick and those who take care of them. Having a physician certify that the illness is genuine is an important symbolic step in taking on the sick role. It also reveals the strong power and

authority differential between the patient and physicians. An example of the power differential between a patient and the physician is if a physician calls the patient on the phone and leaves a voice message, the social norm and expectation is that the patient will call the physician back as soon as possible. However, if the patient calls the physician, the expectation is that it may take several days, or even a week, for the call to be returned. In this example, the physician's priorities are different from that of the patient's, and the patient has more social expectations to do what the physician says, and the physician has fewer social norms compelling them to respond to the patient. A long-term illness can have the effect of making our world seem smaller, more defined by the illness than anything else. An illness can be a chance for discovery, for re-imaging a new self (Conrad & Barker, 2007). Today, many institutions of wellness acknowledge the degree to which social location influences our personal understanding of health and wellness.

7.4.3 Social disparities and the conflict perspective

People with money and power, seen as the dominant group, are the ones who make decisions about how the healthcare system runs. They, therefore, ensure that they will have healthcare coverage, while simultaneously ensuring that subordinate groups stay subordinate through lack of access. This creates significant healthcare and health disparities between the dominant and subordinate groups. These ideas come straight from the conflict perspective that we've discussed in earlier chapters, which emphasizes that social class difference is the main cause of unequal outcomes, including health outcomes. Healthcare institutions include thousands of doctors, staff, patients, and administrators. They are highly bureaucratic but often struggle to serve all members of society equally due to racism, sexism, ageism, and heterosexism. When health is a commodity, the poor are more likely to experience illness caused by poor diet, living and working in unhealthy environments, and are less likely to challenge the system.

7.4.4 Medicalization and the symbolic perspective

The term **medicalization of deviance** refers to the process that changes *bad* behavior into *sick* behavior. A related process is demedicalization, in which *sick* behavior is normalized again. Both of these concepts come from the symbolic perspective of sociology, which asserts that society is created by repeated interactions between individuals and groups. Medicalization and demedicalization affect who responds to the patient, how people respond to the patient, and how

people view the personal responsibility of the patient (Conrad & Schneider 1992). So far in this chapter, we have discussed medicalization as the process in which situations and behaviors are considered medical problems, rather than social problems. In the case of the medicalization of deviance, the social problems that may be medicalized are deviant behaviors. An example of this is the medicalization of Intermittent Explosive Disorder, which is a disorder listed in the DSM-5 as a psychiatric condition, but before its listing in the DSM in 1980, people who had emotionally explosive or aggressive behavior were considered deviant, but not *sick*. The medicalization of deviance in this case shows how what was previously considered deviant is now considered a medical problem.



Figure 7.14 “King Alcohol” engraving from the 1800s. The words “poverty,” “misery,” “crime,” and “death” hang in the air behind him.

An example of medicalization is illustrated by the history of how our society views alcohol and alcoholism. During the nineteenth century, people who drank too much were considered bad, lazy people. They were called drunks, and it was not uncommon for them to be arrested or run out of a town. Drunks were not treated sympathetically because, at that time, it was thought that it was their own fault that they could not stop drinking. During the latter half of the

twentieth-century, however, people who drank too much were increasingly defined as alcoholics: people with a disease or a genetic predisposition to addiction who were not responsible for their drinking. With alcoholism defined as a disease and not a personal choice, alcoholics came to be viewed with more compassion and understanding. Thus, *badness* was transformed into *sickness*.

Another important example of medicalization is the significant differences in who delivers babies worldwide. In Great Britain, midwives deliver half of all babies, including Kate Middleton's first two children, Prince George and Princess Charlotte. In Sweden, Norway, and France, midwives oversee most expectant and new mothers, enabling obstetricians to concentrate on high-risk births. In Canada and New Zealand, midwives are so highly valued that they're brought in to manage complex cases that need special attention. The medicalization of childbirth in the U.S. is so pervasive, that most expectant mothers in the U.S. give birth in hospitals, with fetal monitors, medications, and other medical interventions that are simply unnecessary for the majority of healthy pregnancies. In fact, severe maternal complications in the U.S. have more than doubled in the last 20 years.

Shortages of maternity care have reached critical levels, with nearly half of U.S. counties without a practicing obstetrician-gynecologist. In rural areas, the number of hospitals offering obstetric services has fallen more than 16 percent since 2004. Midwives are far less prevalent in the U.S. than in other affluent countries, attending around 10 percent of births, and the extent to which they can legally participate in patient care varies widely from one state to the next. At times the cultural stigmas regarding medical practices can cause people to seek medical services that don't meet their needs. There are other aspects of the U.S. healthcare system that rise as important social problems to be addressed.

7.4.5 Indigenous and First Nations Understanding of Health



Figure 7.15 An Indigenous woman receives healthcare in the 1920s.

Like feminist sociologists, scholars studying the health of Indigenous people provide competing values, claims, and outcomes related to the social problem of health. In exploring this history, we examine the history of Indigenous nursing in Canada. Several stories coincide: stories about education, colonialism in health care, Indigenous women and work, and racism in the nursing profession, for example. But one starting point is the founding of the Registered Nurses of Canadian Indian Ancestry (RNCIA) in the mid-1970s, an important professional and political organization for Indigenous nurses in Canada.

Most of the original goals of the RNCIA had to do with moving into a central position within the federal Indian health system and extending Indigenous people's self-advocacy and authority. RNCIA nurses also sought to re-write the standard curriculum in Canadian nursing schools and insisted on Indigenous representation in workplaces serving Indigenous people. Their objectives were practical and reasonable: to improve Indigenous health by fostering education, data collection, and Indigenous nurse participation in health care programming and provision.

But in the historical context of both the twentieth century Indian health system in Canada and inequity in the health status of Indigenous people, these goals were, in fact, revolutionary. The

RNCIA wanted to transform the very nature of the relationships between Indigenous people and governments and reject the colonization of Indigenous health.



Figure 7.16 Jean Goodwill, Founder, Canadian Indigenous Nurses Association. (© [C.I.N.A.](#))

Let's take a look at one of the RNCIA's objectives to see what we can learn about Indigenous nursing history: It reads that the RNCIA aimed, "To act as an agent in promoting and striving for better health for the Indian people, that is, a state of complete physical, mental, social, and spiritual well-being." (McCallum 2017)

This goal is significant for a number of reasons. The RNCIA was the first group of Indigenous professionals in Canada to organize as an association. Most professional associations form in order to improve wages and working conditions. Instead, the RNCIA spoke about the health of Indigenous people and their goal to help to improve it.

This objective, moreover, was about action on the part of Indigenous nurses—"promoting and striving for better health." Putting Indigenous nurses and their work at the core of the analysis is key to writing this history.

Third, this objective insisted upon a definition of health that suited Indigenous epistemologies and defined health as a state of complete physical, mental, social and spiritual well-being. As such, it also spoke to a different approach to or ethic of nursing.



Figure 7.17 Two Aboriginal nursing students and a nurse examine a medical mannequin.

This objective also addresses the historical conditions of colonization. Indigenous standards of health fell enormously during and after contact. The appropriation of land and resources, successive military and cultural invasions, as well as policies that served to weaken Indigenous people, communities, and nations, all resulted in widespread poverty and dislocation. These conditions not only fostered ill health and the suppression of Indigenous medicine, but also a health care system that did not by and large serve Indigenous people very well.



Figure 7.18 Indigenous nurse Grace Manatch sees a patient.

The existence of a critically engaged Indigenous nursing workforce has resulted in not only a professional challenge to inherent inequities in healthcare but also to some of the most vehement and longstanding stereotypes about Indigenous people. In addition, Indigenous nurse history forces a discussion of the colonial nature of the health system in Canada. Many Indigenous nurses worked within the limited, hierarchical, and non-local medical and nursing services run from the nation's capital as a *moral obligation* rather than as a treaty responsibility.

Finally, one of the great contributions of Indigenous nursing history is that it puts Indigenous displacement and resistance at the center, rather than the periphery of, national history and the history of state formation. Critically, this centers racism and inequality in discussions of federal education, health and employment policy. For example, many Indigenous nurses in Canada had a compromised educational background at segregated federal Indian schools, be they residential or day schools. Until after the 1940s, they faced color bars at Canadian nursing schools, as well as a number of other substantial barriers long after. In employment, Indigenous nurses faced assumptions about their abilities and their competence as Indigenous nurses. Any successes were attributed to assimilation. The persistence of Indigenous expertise in nursing in spite of this is inspiring.

Sociological Theories of Health Licenses and Attributions

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Figure 7.13 “Rating of Perceived Exertion” by Kaitlin Hakanson (2022) is licensed under a Creative Commons Attribution 4.0 International License. Sources: Wong-Baker FACES Pain Rating Scale, Twitter post by Haydn Drake [@paramedickiwi](#); Borg Rating of Perceived Exertion Scale, CDC.gov. <https://www.cdc.gov/physicalactivity/basics/measuring/exertion.htm>

Figure 7.14 In this engraving from the nineteenth century, “King Alcohol” is shown with a skeleton on a barrel of alcohol. The words “poverty,” “misery,” “crime,” and “death” hang in the air behind him. (Credit: Library of Congress/Wikimedia Commons)

Section 7.4.9 Indigenous Nursing and the related figures 7.15, 7.16, 7.17

The How and Why of Indigenous Nursing

<https://nursingclio.org/2017/11/30/the-how-and-why-of-indigenous-nurse-history/> Added social problem language Creative Commons BY-NC-SA

Figure 7.15 An Indigenous woman receives healthcare in the 1920s

Figure 7.16 Jean Goodwill, Founder, Canadian Indigenous Nurses Association. (© [C.I.N.A.](#))

Figure 7.17 Two Aboriginal nursing students and a nurse examine a medical mannequin. ([Canadian National Archives](#))

Figure 7.18 Indigenous nurse Grace Manatch sees a patient. ([Canadian National Archives](#))

7.5 Healthcare: Policymaking Matters

As we examine the social structures of health and healthcare in the U.S. and around the world, we see that governments, in their functions of law and policy, influence health outcomes. In this *policymaking* step of the natural history of social problems, governments decide who gets insurance, how people have access to clean water, or whether to fund initiatives related to reproductive health. We'll see that laws, policies, and practices related to health care and health access affect the social problem of health.

7.5.1 U.S. Healthcare

U.S. healthcare coverage can broadly be divided into two main categories: **public healthcare**, which is funded by the government, and **private healthcare**, which a person buys from a private insurance company. The two main publicly funded healthcare programs are Medicare, which provides health services to people over sixty-five years old as well as people who meet other standards for disability, and Medicaid, which provides services to people with very low incomes who meet other eligibility requirements. Other government-funded programs include The Indian Health Service which serves Native Americans, Veterans Health Administration, which serves veterans, and the Children's Health Insurance Program (CHIP).

Private insurance is typically categorized as either employment-based insurance or direct-purchase insurance. Employment-based insurance is health plan coverage that is provided in whole or in part by an employer or union; it can cover just the employee, or the employee and their family. Direct purchase insurance is coverage that an individual buys directly from a private company.

Even with all these options, a sizable portion of the U.S. population remains uninsured. In 2019, about 26 million people, or eight percent of U.S. residents, had no health insurance. That number increased to 31 million in 2020 (Keith 2020). Several more million had health insurance for part of the year (Keisler-Starkey 2020). Uninsured people are at risk of both severe illness and also chronic illnesses that develop over time. Fewer uninsured people engage in regular check-ups or preventative medicine and rely on urgent care for a range of acute health issues.

The number of uninsured people is far lower than in previous decades, but that doesn't mean everyone has the healthcare they need. In 2013, and many of the years preceding it, the number of uninsured people was in the 40 million range, or roughly 18 percent of the population. The **Patient Protection and Affordable Care Act (ACA)**, which was implemented in 2014, allowed more people to get affordable insurance. The uninsured number reached its lowest point in 2016, before beginning to climb again (Garfield 2019). People having some insurance may mask the fact that they could be **underinsured**; that is, people who pay at least 10 percent of their income on healthcare costs not covered by insurance or, for low-income adults, those whose medical expenses or deductibles are at least five percent of their income (Schoen et al. 2011).

Why are so many people uninsured or underinsured? Skyrocketing healthcare costs are part of the issue. While most people get their insurance through their employer, not all employers offer it, especially retail companies or small businesses in which many of the workers may be part-time. Finally, for many years insurers could deny coverage to people with pre-existing conditions--previous illnesses or chronic diseases.

The Affordable Care Act (ACA), also referred to as *Obamacare*, was a landmark change in U.S. healthcare. Passed in 2010 and fully implemented in 2014, it increased eligibility to programs like Medicaid, helped guarantee insurance coverage for people with pre-existing conditions, and established regulations to ensure insurance premiums collected by insurers and care providers went directly to medical care (as opposed to administrative costs). It also included an individual mandate, which required anyone filing for a tax return to either acquire insurance coverage by 2014 or pay a penalty of several hundred dollars. Other provisions, including government subsidies, are intended to make insurance coverage more affordable, reducing the number of underinsured or uninsured people.

In 2012, the U.S. Supreme Court upheld the constitutionality of the ACA's individual mandate. 29 million people in the United States have gained health insurance under ACA (Economic Policy Institute 2021).



Figure 7.18 The Affordable Care Act has been a savior for some and a target for others. As Congress and various state governments sought to have it overturned with laws or to have it diminished by the courts, supporters took to the streets to express its importance to them. (Credit: Molly Adams)

The ACA remained contentious for several years. The Supreme Court ruled in the case of *National Federation of Independent Businesses v. Sebelius* in 2012, that states cannot be forced to participate in the ACA's Medicaid expansion. This ruling opened the door to further challenges to the ACA in Congress and the Federal courts, some state governments, conservative groups, and private businesses. The ACA has been a driving factor in elections and public opinion. In 2010 and 2014, the election of many Republicans to Congress came out of concerns about the ACA. However, once millions of previously uninsured people received coverage through the law, public sentiment and elections shifted dramatically. Healthcare was the top issue for voters going into the 2020 election cycle, and the desire to preserve the law led to Democratic gains in the election (just a short time before COVID-19 began to spread globally). The ACA, with its passage, response, subsequent changes, and new policies, demonstrates the interplay

between policymaking, social problems work, and policy outcomes, the last step of the claims-making process.

7.5.2 Healthcare In Other Nations

Clearly, healthcare in the United States has some areas for improvement. But how does it compare to healthcare in other countries? Many people in the United States are fond of saying that this country has the best healthcare in the world, and while it is true that the United States has a higher quality of care available than many nations in the Global South, it is not necessarily the *best in the world*. In a report on how U.S. healthcare compares to that of other countries, researchers found that the United States does relatively well in some areas—such as cancer care—and less well in others—such as mortality from conditions amenable to prevention and treatment” (Docteur & Berenson 2009). This conflict between values and outcomes is another example of the conditions of a social problem - that values and outcomes do not match.

Some consider the Patient Protection and Affordable Care Act (ACA) to be a slippery slope that could lead to socialized medicine, a term that for many people in the United States has negative connotations lingering from the Cold War era and earlier. Under a **socialized medicine** system, all medical facilities and expenses are covered through a public insurance plan that is administered by the federal government. It employs the doctors, nurses, and other staff, and it owns and runs the hospitals (Klein, 2009). The best example of socialized medicine is in Great Britain, where the National Health System (NHS) covers the cost of healthcare for all residents. Despite some U.S. citizens’ knee-jerk reaction to policy changes that hint at socialism, the United States Veterans Health Administration (VA) is administered in a similar way to socialized medicine in other countries.

It is important to distinguish between socialized medicine, in which the government owns the healthcare system, and **universal healthcare**, which is simply a system that guarantees healthcare coverage for everyone. Germany, Singapore, and Canada all have universal healthcare. People often look to Canada’s universal healthcare system, Medicare, as a model for the system. In Canada, healthcare is publicly funded and is administered by the separate provincial and territorial governments. However, the care itself comes from private providers.

This is the main difference between universal healthcare and socialized medicine. The Canada Health Act of 1970 required that all health insurance plans must be “available to all eligible Canadian residents, comprehensive in coverage, accessible, portable among provinces, and publicly administered” (International Health Systems Canada, 2010).

Heated discussions about the socialization of medicine and managed-care options seem frivolous when compared with the issues of healthcare systems in developing or underdeveloped countries. In countries with low incomes, meeting basic health care needs is difficult. Care that people in wealthy countries take for granted—like hospitals, healthcare workers, immunizations, antibiotics, other medications, and even sanitary water for drinking and washing—are unavailable to much of the population. Organizations like Doctors Without Borders, UNICEF, and the World Health Organization have played an important role in helping these countries get their most basic health needs met.

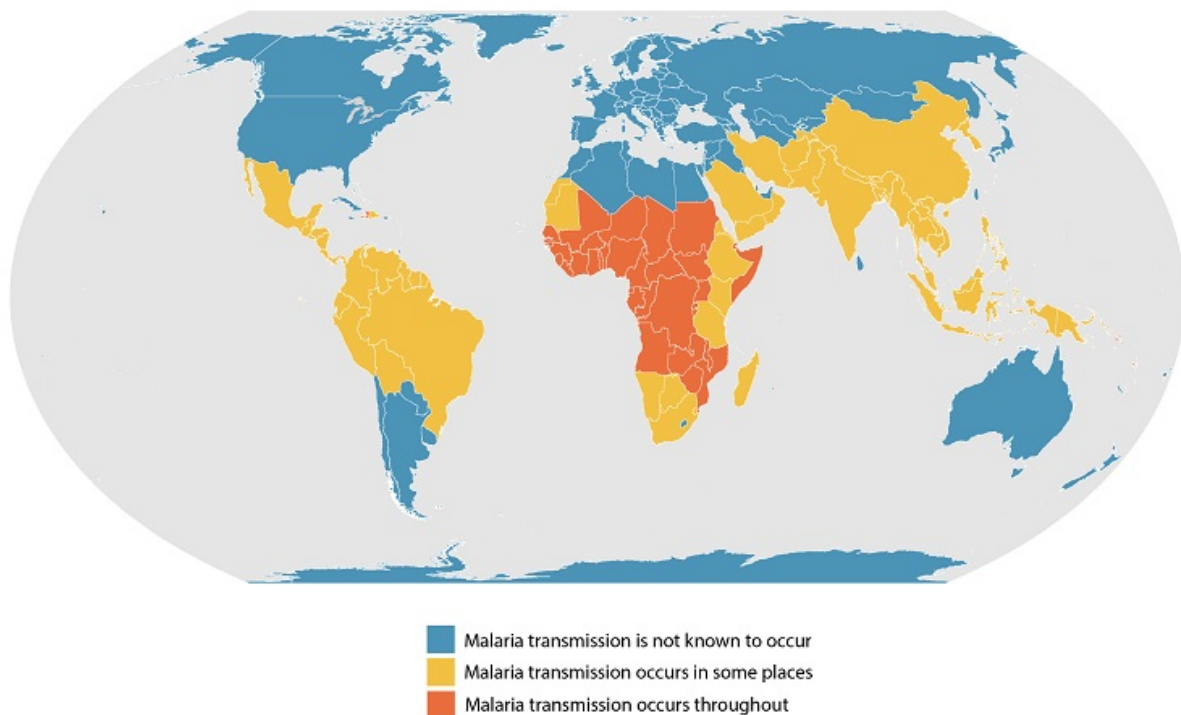


Figure 7.19 Malaria, a life-threatening blood-borne disease transmitted by mosquitoes and other insects, affects different regions of the world at different rates. This map shows which nations are

impacted the most by malaria infections. Malaria is most common in tropical and subtropical regions near the equator.

The United Nations set goals in 2016 with the goal of transforming our world. Some of these goals reflect familiar descriptions of social location, such as Goal 5. Gender Equality, Goal 11 Sustainable Cities and Communities, and Goal 4, Quality Education.



Figure 7.20. United Nations Global Sustainability Goals

Image Description: Sustainable development goals- 17 goals to transform our world; 1) no poverty, 2) zero hunger, 3) good health and well-being, 4) quality education, 5) gender equality, 6) clean water and sanitation, 7) affordable and clean energy, 8) decent work and economic growth, 9) industry, innovation, and infrastructure, 10) reduced inequalities, 11) sustainable cities and communities, 12) responsible consumption and production, 13) climate action, 14) life below water, 15) life on land, 16) peace, justice and strong institutions, 17) partnerships for the goals.

Many of these goals relate more directly to health outcomes, like Goal 3 itself, Good Health and Wellbeing, Goal 6 Clean Water and Sanitation, and Goal 2, Zero Hunger.

Prior to COVID-19 infant mortality rates and maternal deaths were decreasing worldwide. However, the World Health Organization reports that "Children in sub-Saharan Africa are more than [15 times more likely to die before the age of five](#) than children in high-income countries." (World Health Organization, 2020). Most of these deaths could be prevented by access to sufficient food, clean water, and regular immunizations. The United Nations also reports that [94 15 times more likely to die before the age of percent of all maternal deaths](#) occur in low and lower-middle-income countries. (Unicef, 2019). With COVID-19, over 6 million people have died of COVID-19 worldwide. The resources that are being used to contain the virus are limiting access to other health services, particularly in areas of high poverty. The response to the virus will resonate as we look at health and health outcomes for decades to come.

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Figure 7.18 The Affordable Care Act has been a savior for some and a target for others. As Congress and various state governments sought to have it overturned with laws or to have it diminished by the courts, supporters took to the streets to express its importance to them. (Credit: Molly Adams) (NOTE: Need Open Source Picture)

Figure 7.19 Malaria, a life-threatening blood-borne disease transmitted by mosquitoes and other insects, affects different regions of the world at different rates. This map shows which nations are impacted the most by malaria infections. Malaria is most common in tropical and subtropical regions near the equator. <https://www.cdc.gov/malaria/about/distribution.html>

Public Domain

Figure 7.20. United Nations Global Sustainability Goals

https://www.google.com/search?q=united+nations+sustainability+goals+image&sxsr=ALiCzsabnB840s6QMTI-SVvIHHQtUU_5Zw:1661986915686&source=lnms&tbm=isch&sa=X&ve

7.6 Health, Interdependence, and Change

When you read about the numbers of people dying of COVID-19, the inequalities in meeting basic needs, or the reasons why children die more often in poorer countries, it is normal to feel overwhelmed by the depth and breadth of the social problems of health.

At the same time, our collective response to COVID-19 is highlighting our interdependence, and the ability of each of us to create change. Even before COVID-19, health professionals were highlighting how health for all requires acknowledging our interdependence. For example, in the article “The power of interdependence,” the authors write that connecting people, providers, and systems is essential:

Promoting optimal health outcomes for diverse patients and populations requires the acknowledgment and strengthening of interdependent relationships between health professions, education programs, health systems, and the communities they serve. (Van Eck et al. 2021)

Researchers have already started looking at understanding the spread, treatment and eventual recovery from COVID-19 can help us get better at solving social problems worldwide. In the article “System Thinking in COVID-19 recovery,” the authors point out first that COVID-19 is targeting our most vulnerable people:

The effects of the COVID-19 pandemic have been experienced differently globally, regionally, and within countries. Rather than equalizing societies, the COVID-19 pandemic has exacerbated existing inequalities on an unprecedented scale. The effect of the pandemic on vulnerable people is already, and will continue to be, devastating, especially in regions with particularly challenging economic landscapes, such as in Latin America, which has the highest levels of inequalities globally, and in sub-Saharan Africa, which has the highest levels of poverty. The U.N. stated that just 25 weeks of the pandemic derailed 25 years of human development. (Omukuti 2021)

They further argue that women and girls are disproportionately impacted:

Lockdowns have led to increases in domestic violence and femicide and although all women are at risk of gender-based violence, women of poorer backgrounds have less resources to flee violent homes, whereas women who are older, disabled, migrant, Indigenous, Black, or minority ethnic are less likely to have access to protection services or obtain justice. Social distancing measures have put more women and girls out of paid work and education in comparison to their male counterparts due to gendered factors, such as prioritizing boys' education or forcing girls into child or early marriages.

(Omukuti 2021)

Unexpectedly though, the authors do not argue for public health interventions. The first strategy that they propose is reducing the debt loads of lower-income countries so that more of the money can go to public health and infrastructure projects. The intricate interconnections of money and power connect countries together. By changing the accessibility of money, the authors argue, the circumstances of women and girls during the pandemic can be improved long term.

Closer to home, we see how individual agency and collective action can give us hope. In another bit of good news, some young people across the country are using their tech-savvy skills to help older people get Covid vaccines, which can be difficult to schedule and require a certain amount of tech savviness. 12-year-old Samuel Kuesch, a video game lover, has helped over 1200 older Americans get COVID vaccine appointments (Herzog 2021). His project expanded to his extended family, and teens and preteens in his family are now all pitching in to give older Americans a “shot at the shot.” Other examples abound of neighbors taking food to quarantine friends, food kitchens adding staff to provide more boxed meals and delivery to people who couldn't leave home, and school art studios using 3-D printers to create PPE for understaffed hospital workers. Each individual action supported the collective good, improving health for all of us.

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7.7 Conclusion

In this section, we have explored the different explanations for health, wellness, and illness. We have looked at what sociologists care about when they study health and medicine. We have seen that people of color, and people who are poor, are more likely to have health challenges, as well as disparate access to quality healthcare—and we have seen that this is probably both an effect of being poor, as well as a cause. When we started our chapter, these were the questions that focused our curiosity. Now that we have examined health and illness throughout the world, how would you answer them?

7.7.1 Key Terms

Adverse Childhood Experiences (ACEs): potentially traumatic events that occur in childhood (0-17 years)

contested illness: an illness that is questioned or considered questionable by some medical professionals

COVID-19: an infectious disease caused by the SARS-CoV-2 virus.

disability: a reduction in one's ability to perform everyday tasks; the World Health Organization notes that this is a social limitation

epidemiology: the study of disease and health, and their causes and distribution

health: a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

epigenetics: the study of how your behaviors and environment can cause changes that affect the way your genes work.

historical trauma: multigenerational trauma experienced by a specific cultural, racial or ethnic group. It is related to major events that oppressed a particular group of people because of their status as oppressed, such as slavery, the Holocaust, forced migration, and the violent colonization of Native Americans.

impairment: the physical limitations a less-able person faces

medical sociology: the systematic study of how humans manage issues of health and illness, disease and disorders, and healthcare for both the sick and the healthy.

medicalization: the process by which aspects of life that were considered bad or deviant are redefined as sickness and needing medical attention to remedy

medicalization of deviance: the process that changes “bad” behavior into “sick” behavior

morbidity: the incidence of disease

mortality: the number of deaths in a given time or place

Patient Protection and Affordable Care Act (2010): a law that provides numerous rights and protections that make health coverage more fair and easy to understand, along with subsidies (through “premium tax credits” and “cost-sharing reductions”) to make it more affordable.

private healthcare: health insurance that a person buys from a private company; private healthcare can either be employer-sponsored or direct-purchase

public healthcare: health insurance that is funded or provided by the government

sick role: patterns of expectations that define appropriate behavior for the sick and for those who take care of them.

social determinants of health: social features of a person or group, such as race, class, gender, ability, rural/urban status, etc that partially determine the health and wellness of the person or group; Also defined by WHO as The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics

socialized medicine: when the government owns and runs the entire healthcare system

underinsured: people who pay at least 10 percent of their income on healthcare costs not covered by insurance

universal healthcare: a system that guarantees healthcare coverage for everyone

7.7.2 Discussion Questions

1. What was you and your families experience during COVID-19? Now that you have learned more, has your understanding changed?
2. How could you apply the social problems process to a health related topic: smoking, alcohol use, eating disorders, etc?
3. What does it mean to you to "be healthy"? Have your health habits changed during the COVID-19 pandemic?
4. How do sociologists make sense out of health and illness? How have our definitions changed over time?
5. Why might we have multiple models of the Social Determinants of Health?
6. How do protective factors make a difference in responding to Adverse Childhood Events (ACEs)?
7. How could we improve the healthcare system in the United States?

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