



Medical Sociology and Health Services Research: Past Accomplishments and Future Policy Challenges

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Abstract

The rising costs and inconsistent quality of health care in the United States have raised significant questions among professionals, policy makers, and the public about the way health services are being delivered. For the past 50 years, medical sociologists have made significant contributions in improving our understanding of the nature and impact of the organizations that constitute our health care system. In this article, we discuss three central findings in the sociology of health services: (1) health services in the U.S. are unequally distributed, contributing to health inequalities across status groups; (2) social institutions reproduce health care inequalities by constraining and enabling the actions of health service organizations, health care providers, and consumers; and (3) the structure and dynamics of health care organizations shape the quality, effectiveness, and outcomes of health services for different groups and communities. We conclude with a discussion of the policy implications of these findings for future health care reform efforts.

Keywords:

health services, health care delivery, health care organizations, health care quality

Public and professional interest in health services has increased dramatically over the last two decades driven primarily by persistent and growing frustrations with the cost and quality of care. Medical sociologists have been interested in the structure, organization, dynamics, and impact of health services for well over 50 years. Our health care system has evolved and changed dramatically over the same period, shifting from one focused on providing acute care for immediate and emergent health problems to a more diffuse system struggling to support individuals with chronic and long-term conditions while also controlling costs (Wholey and Burns 2000). Not surprisingly, medical sociological interest in health services has followed suit and expanded to examine a wider variety of settings, conditions, and processes within the formal health care delivery system. Scholarship initially focused largely on understanding the structural and institutional underpinnings of health care systems, and later on exploring the variability in access to health care across social groups. More

recently, sociological health services research has concentrated on the structure of and dynamics within health service organizations and how these factors shape both access and clinical outcomes for different groups and communities.

In this essay, we highlight three key findings that summarize the most important contributions of medical sociology to health services research. For the purposes of this paper, we define health services as the delivery of care by socially recognized, professional health care providers that is intended to respond to perceived illness and disease or to

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improve an individual's health status. While many scholars are particularly interested in specific medical technologies, medical sociologists assert that the delivery of health services is much more than simply the application of scientific and technical knowledge. Health care services are delivered by people to people within various social environments, which can influence the way medical technology is delivered or received and, perhaps most important, the clinical outcomes for people seeking help. This review is necessarily selective. Our aims here are to summarize a half-century of sociological work and to call for a renewed interest in the sociology of health services. We conclude by outlining the policy implications of these findings for future health reform efforts.

FINDING 1. HEALTH SERVICES IN AMERICA ARE UNEQUALLY DISTRIBUTED, CONTRIBUTING TO HEALTH INEQUALITIES ACROSS STATUS GROUPS

One of the fundamental concerns of medical sociologists over the past 50 years has been to document and explain gender, socioeconomic, and racial-ethnic differentials in health outcomes (see Williams and Sternthal 2010 in this issue). Among the early explanations for these patterns were disparities in the distribution of health services among social groups, and substantial attention was devoted to documenting systematic differences in access to health care. More recently, evidence has emerged suggesting that the adverse impact of health care disparities on population health is increasing, highlighting the need for additional research (Lesser and Cunningham 1997). As a result, sociologists have taken a renewed interest and adopted a more complex and comprehensive approach to health services research, examining the nature, quality, and timeliness of care received under a variety of illness conditions.

Gender

Sociological research has documented significant gender differences in help-seeking. Women are more likely than men to visit a doctor for an array of both physical and mental health problems (Courtenay 2000; Green and Pope 1999; Kessler, Brown, and Broman 1981). They are also more apt to have a regular physician and to obtain preventative screenings (Bostick et al. 1993; Centers for

Disease Control 1998; Powell-Griner, Anderson, and Murphy 1997). However, men who do consult a health professional may receive better treatment than women for the same condition. The evidence is particularly strong in the case of heart disease. Women who present with symptoms of cardiac disease are less likely to be referred for diagnostic tests, given cardiac drugs, or instructed to make lifestyle changes. Conversely, they are three to five times more likely to be sent home without any treatment (Lockyer and Bury 2002; McKinlay 1996). These patterns delay diagnosis and contribute to higher mortality rates among women with heart disease relative to men.

Socioeconomic Status

Decades of research by sociologists suggests that people with less income and education face greater obstacles accessing health services than their more well-off counterparts, despite having higher health care needs (Dutton 1978; Katz and Hofer 1994). Disparities are particularly marked in the area of primary care (Rundall and Wheeler 1979). For example, adults and children of lower socioeconomic status (SES) are less likely to have routine physical examinations and screening procedures, such as prenatal care, immunizations, mammograms, and colonoscopies (Goldman and Smith 2002; Lantz, Weigers, and House 1997; McDonald and Coburn 1988). Moreover, they are less likely to receive medical intervention in a timely manner, and they often receive less intensive and lower quality treatments (Williams 1990). Together, these patterns result in poorer long-term outcomes and higher emergency room and hospitalization rates for conditions that would not normally require them (Padgett and Brodsky 1992; Pappas et al. 1997).

Race and Ethnicity

Because income and educational attainment are so closely linked to race and ethnicity in America, patterns of health care inequality observed in racial-ethnic minority groups are similar to those found in low-SES populations (Williams and Collins 1995). That is, racial-ethnic minorities generally have less access to health services, in particular primary and preventative care, and they also tend to receive delayed treatment and lower quality acute and long-term care than whites (Blendon et al. 1989; Smedley, Stith, and Nelson 2003; Williams 1990). Though these patterns are better established in African American populations, studies

suggest they also extend to Latinos, Asian Americans, and Native Americans (Angel and Angel 2006; Collins, Hall, and Neuhaus 1999; Fiscella et al. 2002). While much of the disparity in health services use can be explained by SES differentials, race-ethnicity tends to exhibit a modest, independent effect on health services use. These effects have been attributed to racial discrimination by health services providers and racial segregation of minorities into communities with less access to high-quality health services (Polednak 1993; Williams and Collins 1995).

Do Health Services Inequities Explain Group Differences in Health?

For many decades, equalizing access to quality health services was held up as the most promising solution to reducing health disparities (Mirowsky, Ross, and Reynolds 2000). However, the national health insurance systems in the United Kingdom and Canada, which provided universal access to care, fell short of high expectations for equalizing health care utilization (Black et al. 1988; Marmot, Kogevinas, and Elston 1987; Roos and Mustard 1997). In the 1970s, sociologists began to assert that access explains only a small proportion of the differences in morbidity and mortality across social groups, and many of them began to turn away from health services research (Marmot, Kogevinas, and Elston 1987; Miller and Stokes 1978; Monteiro 1973; Ross and Wu 1995). Instead, medical sociologists pioneered efforts to focus on persistent determinants of health and illness that are more distal in the chain of causation, i.e., “fundamental social causes” (Link and Phelan 1995).

Yet some caution that it may be too early to throw the proverbial baby out with the bath water where health services are concerned (Robert and House 2000). There has very recently been a resurgence of interest in health services among medical sociologists, who are now using improved measures to reexamine the role of health care systems in health inequalities. For instance, health is increasingly being conceptualized in terms of functional status and quality of life rather than only by morbidity or mortality (Bunker, Frazier, and Mosteller 1994; Levine 1987). There has been a greater focus on the impact of chronic conditions and disease management on daily living. Thus, while health services disparities may account for relatively little of the inequality in rates of disease onset, they might still explain a large proportion of the variation in

illness experiences and outcomes among members of different social groups making contact with a stratified medical system (Kahn et al. 1994).

This point is illustrated by the case of type two diabetes, a disease whose incidence as well as resulting mortality and complications are related to SES (Cowie and Eberhardt 1995; Phelan et al. 2004). Health services disparities probably contribute little, relative to diet and exercise, to the overall risk of developing diabetes. Low SES affects risk for diabetes onset through a variety of dynamic, intervening mechanisms that reflect access to resources. For instance, living in working class neighborhoods without safe recreational facilities and stores that carry fresh fruits and vegetables makes it more difficult to exercise regularly and eat a balanced diet. In contrast, subsequent to onset, differences in mortality rates and the incidence of complications secondary to diabetes (e.g., blindness, amputations, kidney damage, etc.) are directly related to glucose management and the diabetes regimen developed by health care providers and implemented by patients (i.e., medication, diet, and glucose monitoring). Remarkably, according to an ethnography conducted by sociologists Lutfey and Freese (2005), SES shapes the outcomes of diabetes services at every point in the treatment career: including access to particular kinds of services, the organization of care, patterns of health services utilization, the success of patient-provider communication, and the types and quality of treatments received – even among those who consistently have access to long-term diabetes care. In short, to the degree that health services are a critical component of disease management and recovery, social status differences in health care are a primary mechanism of health inequalities, particularly given the demographic shift in the United States toward chronic diseases requiring long-term intervention by medical professionals.

FINDING 2. SOCIAL INSTITUTIONS REPRODUCE HEALTH CARE INEQUALITIES BY CONSTRAINING AND ENABLING THE ACTIONS OF HEALTH SERVICE ORGANIZATIONS, HEALTH CARE PROVIDERS, AND CONSUMERS

A unique strength of the sociological perspective is the focus on underlying social structural mechanisms

of phenomena that ostensibly occur at the individual level (McKinlay 1996). Sociologists have long conceptualized medicine as a social institution, highlighting the influence of macro factors on help-seeking and the practice of health care in everyday life (Freidson 1970; Mechanic 1975; Parsons 1951). The institution of medicine is characterized by a powerful set of social norms, rules, values, and practices that provides a blueprint for the behavior of individuals and organizations (e.g., physicians, patients, hospitals, HMOs, etc.), and systematically structures the relationships between them. Sociologists have contributed much to our understanding of the ways that culturally and historically shaped institutional forces constrain the behavior of health care providers and consumers, reproducing health care inequalities across social groups (Light 2004).

Sociologists have been instrumental in documenting changes in the institution of medicine over the twentieth century. In what Scott and colleagues (2000) call the era of professional dominance (1945–1965), the motivating ideology in medicine was commitment to quality care. Additionally, there was a strong sense of obligation to provide health care to all, regardless of a person's ability to pay for it (Klarman 1963). Accordingly, the poor received free care from physicians and hospitals, and the population at large paid on a sliding scale according to their means. In the era of federal involvement (1966–1982), concern with equitable access prevailed, but the government increasingly took over responsibility for funding and regulating the fair distribution of health care (Scott et al. 2000). At the same time, health services expenditures began to increase rapidly, and concerns about cost containment began to overshadow the long-standing commitment to quality care and equity that had characterized the institution of medicine since its inception (Brown 1979).

In the current era of managerial control and market mechanisms (Scott et al. 2000), the health care sector is conceptualized as an industry, or economic system, and efficiency and profit are central motivating values. Changes in health policy (and ultimately practice) enacted by the Reagan administration began as part of a broader political movement characterized by welfare state retrenchment and by the shifting of government control to competitive market forces (O'Connor 1998). These events, described in greater detail by Mechanic and McAlpine (2010, in this issue), culminated in the corporatization of health care and the managed care ethos that pervades the institution of medicine today.

Managed Care and Medical Decision-making

One of the most significant consequences of institutional change for everyday medical practice has been that most physicians are now rewarded for providing fewer services at lower cost. This has caused concern among sociologists about the impact of third-party payers on equitable access and quality of care (Mechanic 2001, 2004). Managed care increases the use of primary care, preventative medicine, and outpatient treatment, but it reduces hospitalizations, visits to specialists, and more intensive, costly procedures (Wholey and Burns 2000). In fact, there is evidence that managed care changes the way that individual doctors practice medicine. For instance, physicians in health maintenance organizations (HMOs) are significantly less likely than those in a hospital or private practice settings to diagnose the exact same case of chest pain as cardiac disease, a diagnosis with high-cost implications (McKinlay, Potter, and Feldman 1996). A critical role of sociologists has been to identify how managed care unintentionally influences physicians and organizations to treat individual patients in ways that reinforce broader patterns of structural inequality.

Using a controlled experimental design, sociologist John McKinlay and colleagues (1996) demonstrate that the resource environment in which a physician operates interacts with patients' sociodemographic characteristics to shape physicians' decisions about how to diagnose and treat signs and symptoms of illness. For instance, ample evidence indicates that medical practitioners provide lower quality care to older patients relative to younger ones, i.e., they are less likely to make referrals to a specialist, prescribe expensive medications, and perform costly tests and procedures (Wenger et al. 2003). However, sociologists emphasize that these biases are exacerbated by cost considerations. Among patients over the age of 65 presenting with chest pain, having health insurance coverage is a strong predictor of receiving a diagnosis of cardiac disease rather than a condition requiring less expensive medical interventions (McKinlay et al. 1996). Conversely, health insurance has no significant effect on patterns of diagnosis in younger patients. Along these same lines, physicians practicing in a fiscally conscious, managed care environment are over nine times as likely to attribute women's chest pain to psychiatric problems (e.g., panic disorder, generalized anxiety, etc.) relative to men reporting the exact same symptoms, and they are nearly seven

times as likely to diagnose African Americans' symptoms as gastrointestinal in origin compared to whites. Importantly, the diagnoses more commonly applied to lower-status groups are associated with less costly and time-intensive medical tests and treatments. In short, when cost containment forces physicians to make difficult decisions and ration care, they frequently rely on biases that, while probably unconscious, nonetheless result in inferior care and poorer health for vulnerable social groups.

Separate and Unequal: The Public and Private Health Care Sectors

Some sociologists have also criticized managed care and competition as a socioeconomic environment that draws resources away from sectors of the health care system that are less profitable but nonetheless critical (Cunningham et al. 1999; Mechanic 1994). Again, this trend has important implications for the types and quality of care received by lower-status groups. For instance, managed care organizations minimize risk by denying coverage to sicker, less profitable patients and spreading the risk out among a large consumer group that contains both healthy and sick individuals. These practices shift much of the financial responsibility for indigent care (i.e., those who are unable to pay for services) to physician groups and hospitals, pressuring them to balance their budgets by cutting costs associated with uninsured or publicly insured patients. At the same time, professional resources and government funds are increasingly being diverted to the profitable private sector (Waitzkin 2000). This has forced many public health facilities to close their doors, shrinking the public sector and widening the health gap between the rich and the poor. Sociologists have demonstrated that the result of this profit-driven funding environment is essentially two divergent health care systems, public and private, characterized by radically different experiences and outcomes (Dutton 1978; Lutfe and Freese 2005; Smedley et al. 2003).

Supporters of the for-profit sector have argued that those without private insurance can still access private health services through Medicare and Medicaid reimbursements. On the contrary, sociologists have identified numerous barriers that minimize use of the private sector by the publicly insured: (1) Medicare and Medicaid often pay less than private market value for a given service, forcing the patient to pay the difference in cost; (2) Medicare and Medicaid policies are notoriously complex, prompting confusion and fear of incurring fees in the private

sector; (3) Community and geographic barriers may restrict access to private facilities and providers, even when patients are publicly insured (Macintyre, MacIver, and Sooman 1993; Williams and Collins 2001); (4) Finally, private facilities and providers may overtly or subtly discourage publicly-insured (and uninsured) patients from using their services (see Mechanic and McAlpine 2010 in this issue). At even greater risk for slipping through the cracks of our health care system are the working poor and lower middle class –those whose incomes neither qualify them for public insurance nor allow them to afford private coverage (Secombe and Amey 1995). Indeed, public emergency room departments have effectively become the safety net for America's marginally poor, compensating for changes in eligibility criteria and cuts in government funding for other social services (Billings, Parikh, and Mijanovich 2000; Dohan 2002). However, most agree that emergency room services are an ineffective, inefficient, and costly solution to gaps in coverage.

Inequality between private and publicly available health services and facilities is growing (Andrulis 1998). The resource environment associated with managed care is partially responsible, but rationing care does not inevitably lead to inequality. Rather, this trend is consistent with American political, economic, and cultural ideologies, biases, and practices characterized by individualism and the privatization and dismantling of the social safety net. Unlike in every other industrialized nation, health care in the United States is a commodity rather than a right, and rationing of health services is based on socioeconomic status rather than clinical need (Jost 2003). Thus, health care available to the uninsured and publicly insured is inferior to the care received by individuals with employer-based or other private insurance, exacerbating health disparities in underserved groups (Institute of Medicine 2004).

FINDING 3. THE STRUCTURE AND DYNAMICS OF HEALTH CARE ORGANIZATIONS SHAPE THE QUALITY, EFFECTIVENESS, AND OUTCOMES OF HEALTH SERVICES FOR DIFFERENT GROUPS AND COMMUNITIES

Seeking to understand the implications of organizational structure and dynamics in health services settings, a number of medical sociologists have

focused more narrowly on organizations. Indeed, much of the classical work in medical sociology during the 1960s and 1970s explored various aspects of health care organizations, especially the general, acute-care hospitals (Coe 1978; Goss 1963; Wilson 1963), as well as medical schools, physician offices, and psychiatric hospitals (Coe 1978; Freidson 1970; Strauss et al. 1963). With advances in technology and economic opportunities in the health care sector, and with the epidemiological shift from acute to more chronic and long-term health conditions, the types and varieties of health care organizations expanded dramatically from the 1960s onward. Nevertheless, these early studies had enormous descriptive value and contributed to a fundamental understanding of our emerging health system. They also highlighted a myriad of organizational challenges in delivering health services, including the depersonalization and devaluing of patients (Coe 1978); the interpersonal dynamics between doctors and patients (Freidson 1970; Glaser and Strauss 1965; Goffman 1961) the power relationships and conflicts among health professional groups (Goss 1963); and the tendency toward bureaucratic medical decision-making and treatment (Freidson 1970; Goss 1963; Strauss et al. 1963). Most importantly, this body of work sensitized a generation of medical sociologists to the nature of medical work and established a reference point that continues to inform the field. In more recent years, medical sociologists have examined critical organizational changes that have had implications for how and what types of care are delivered, as well as how effective the care is for various social groups.

Complex Health Care “Systems”

Changes in the institution of medicine and its funding environment in the latter half of the twentieth century, described above, have dramatically reshaped health care organizations. Before managed care, hospitals operated largely as autonomous units. Today, most are evolving to become the nuclei of wider, regionally focused health networks formed through the acquisition or merger of specialty and allied health care agencies and the development of new ambulatory care facilities (e.g., urgent care centers, outpatient surgery centers) and specialty branch hospitals (e.g., children’s, cardiac, orthopedic hospitals; Andersen and Mullner 1989; Cuellar and Gertler 2003; Weinberg 2003). Sociologists have been instrumental in highlighting the challenges associated with integrating care, as well

as the inter- and intra-organizational dynamics that are occurring within increasingly complex health care systems (Flood and Fennel 1995; Light 2004; Scott et al. 2000).

Understanding these organizational changes is critical because they reflect fundamental shifts in the nature of medical work and the delivery of health services. As health care organizations have become more highly specialized, internally differentiated, technologically oriented, and more tightly integrated (Scott et al. 2000), the professional boundaries of medical work have blurred. Initially, medical sociologists suggested that these organizational changes had the potential to lead to the “deprofessionalization” of medicine (Haug 1973) and to undermine physicians’ professional dominance within the health care system (Light 2004). Indeed, the greater emphasis on the “business of health care” and the rise of health administrators clearly have changed the traditional role of physicians by reducing or restricting their authority over clinical decision-making (Hafferty and Light 1995). Today’s complex health systems represent fundamentally new configurations of an increasingly broad array of professional expertise that is altering the long-standing system of professional boundaries of technical expertise and knowledge.

Consequences of Organizational Structure and Dynamics for Clinical Outcomes

Sociological health services research emphasizes the central role that structural arrangements and organizational dynamics play in shaping the quality, effectiveness, and outcomes of health services. Eliot Freidson (1970), in his classic book *The Profession of Medicine*, laid the sociological foundation for this line of research. While Freidson’s focus was on the work of physicians, he was among the first to theorize that performance was largely determined by structural and organizational factors.

Since 1990, interest in more applied research on the organizational context of health services has expanded dramatically. Burns and Wholey (1991), for example, demonstrated that structural and organizational features of hospitals—including size, type, and whether a hospital is part of a formal system (e.g., public vs. private, teaching vs. nonteaching, urban vs. rural)—are associated with length of stay and mortality. Similarly, Aiken and colleagues have highlighted the impact of the organization of care and the degree of autonomy in

nursing on various health outcomes (Aiken, Clarke, and Sloane 2002; Aiken et al. 1999; Aiken, Smith, and Lake 1994). Finally, sociologists have examined how organizational features, such as leadership centralization, differentiation, hierarchy, and size, can influence both outcomes and the extent and nature of the adoption of effective medical technologies in hospitals and health systems (Fennell and Warnecke 1988; Flood 1994; Flood, Scott, and Shortell 1994; Scott 1990).

In more recent years, social theory has been incorporated into health services research, moving the field toward a better understanding of complex mechanisms underlying organizational effectiveness. For example, the fragmented and unstable nature of today's health care organizations has led to the rapid adoption of clinical care teams to integrate services. Health services researchers have described and studied these teams using sociological theories of group processes and social interaction, ranging from social network conceptualizations of teams (Pescosolido, Wright, and Sullivan 1995) to more process-related dynamics (Wright et al. 2006). Similarly, sociological theory is central to research on the social dynamics of provider-patient interaction, focusing on how organizational factors influence providers' attitudes toward patients and the approaches they take in communication and services delivery (Waitzkin 1991). Indeed, it has been argued that interactional and organizational characteristics of public and private health care providers and settings may contribute to the aforementioned health and health services disparities across gender, socioeconomic, and racial-ethnic groups and communities (Luthey and Freese 2005; Malat and Hamilton 2006; Williams 1990).

From a broader sociological perspective, research and theory linking organizational dynamics and processes to clinical outcomes represent an effort to open up the black box of health services. Fifty years of medical sociology has clearly demonstrated that improving health services, while necessary, is not sufficient to improve the health of all communities and populations. In this regard, medical sociologists should help to sensitize health services researchers to factors from sources other than health care organizations that nonetheless fundamentally shape the experience of health care and, in turn, the impact that care has on individuals. Hohmann (1999) has offered a helpful multi-level framework in this regard. While developed with mental health services in mind, the framework has more general utility. The central concern is the array of system-related factors and social

externalities that influence clinical interaction. Hohmann's model acknowledges that the organizational structure and context within which clinical work occurs is essential for understanding outcomes, but her framework also highlights the external social environments, including personal networks and community contexts, which influence both the providers and recipients of health care services, as well as clinical outcomes.

HEALTH SERVICES IN THE TWENTY-FIRST CENTURY: POLICY IMPLICATIONS, FUTURE CHALLENGES, AND REFORM

In a study of consumer attitudes in five industrialized nations, Davis and colleagues (2004) found that the United States ranked lowest in efficiency, effectiveness, and equity, and most Americans believe that the health care system is in desperate need of reform (Mechanic 2004). In late March 2010, President Obama and the U.S. Congress were successful in passing major health reform. The final reform package, however, focuses primarily on expanding access to health insurance and generally avoids the deeper and more complex challenges in the structure and organization of our health service delivery system. In this regard, sociological work on health services has clear policy implications.

Policy Recommendation 1: The State and Federal Governments Should Become More Involved in Regulating the Delivery of Health Services in the United States

The persistent health inequalities across social groups and communities documented by medical sociologists raise serious doubts about the capacity of our current health system to improve the health of our nation's population. In cross-national studies the United States does not compare favorably, particularly with regard to other advanced, industrialized Western European nations (Davis 2004). Some have argued that the key to better outcomes in these countries is the strong role of central government in regulating the delivery of health services. Not only do these governments guarantee access to care through a single payer or a tightly regulated non-profit health insurance system, but they also support and manage the distribution and quality of critical health resources. As documented by Scott

and colleagues (2000), health services have operated and developed relatively independently because of the weak regulatory structure within the United States and because government agreed to take over financial responsibility for providing health care for uninsured and other vulnerable populations during the 1960s and 1970s. As a result, private health care systems have continued to make significant economic gains and have secured resources that have allowed them to resist many efforts to impose stricter regulations (Quadagno 2004). More importantly, the broader U.S. health care system remains a fragmented, uncoordinated patchwork of remarkably independent organizations driven largely by the pursuit of immediate organizational and economic interests, not by the longer-term health care needs of the country.

Expanding government's regulatory role in the delivery of health services must necessarily be accompanied by a better marriage of research and policy. In recent years, policy makers have called for more "comparative effectiveness" research, specialized research that compares the cost and clinical efficacy of treatments for particular conditions. Recent efforts to improve care have gravitated toward performance measurement and linking payment to concrete outcomes. While a focus on outcomes is undoubtedly valuable, existing research has barely scratched the surface of the broad and complex social and organizational factors that shape efficiency and effectiveness. In this regard, sociological research is important because it underscores that quality care is determined not only by what services are provided, but also *how* they are delivered, *by whom*, and *to whom*.

In sum, increasing state and federal regulation requires that the government be optimally informed about the best new directions for health policy and practice. While many argue against an expanded role of government in health care because of fears of limiting access and innovation, government already pays for nearly half of our national health care expenditures (Sisko et al. 2009). History tells us that reducing state and federal regulation in the health care marketplace will only result in limiting access to health services for the most vulnerable, expanding health inequalities and ultimately weakening the foundations of our democratic society.

Policy Recommendation 2: Federal and State Governments Should Invest in Public Health Service Systems that Reach out to the Most Structurally-disadvantaged Members of

Society

Sociological contributions to health services research reviewed in Findings 1 and 2 above emphasize ways that the existing medical system privileges some social groups at the expense of others, and thus reproduces broader structural inequalities rooted in gender, race-ethnicity, and socioeconomic status. In short, profit motivation in the private health care sector and underfunding in the public sector influence physicians and organizations to make medical decisions that in effect ration care on the basis of social status rather than on health care needs. Because it seems unlikely that the United States will move away from a partially privatized system (see Mechanic and McAlpine 2010 in this issue), and because these sectors are inherently profit-driven, the most promising area for instituting real policy change may be the underfunded public sector. As argued in Finding 3, many of our nation's low-income and racially segregated communities are being served by a public system that is struggling to maintain the organizational structure, culture, and leadership afforded to the private sector by government investment.

Current proposals for health care reform will work to improve access to private services among the publicly insured and underserved. However, the public/private stratification of our existing health services system necessitates a two-pronged strategy. Equally critical is the need to move beyond access issues to consider qualitative differences in the health services being utilized by those on the margins of society—the most sick, impoverished, and structurally disadvantaged individuals (Mechanic 1994). As described above, existing sociological research suggests that members of structurally disadvantaged groups face myriad obstacles to utilizing efficient, cost-effective, and health-promoting preventative and primary health services, even when they ostensibly have access to these through public insurance (Dutton 1978; Lutfey and Freese 2005; Macintyre et al. 1993). Thus, it is necessary to focus on improving the quality and organization of services and facilities that benefit, for example, those with severe and persistent mental illness, those in remote rural areas, individuals near or below the poverty line, and members of disadvantaged racial-ethnic minority groups. The goal, then, is not only to provide universal access to the private sector, but also to lift the public sector up to the standards of the private.

Such a strategy requires careful planning. Policy makers should identify locations for building

facilities, increasing funding, and augmenting services and providers that are optimally useful and attractive to those in underserved communities. Likewise, it is necessary to consider how the uninsured and underinsured currently utilize those services that are available, and how to bring people at the margins into the health care system. For instance, incentivizing the use of primary, preventative, and follow-up health care among those currently relying on emergency room services may be an effective strategy. In all, we may simultaneously reduce the cost of health care and improve the health of U.S. citizens by *thoughtfully* investing in groups and communities that need it most, rather than by allocating them on the basis of profit and stakeholder interests.

CONCLUSION

Over the past 50 years, medical sociology has improved our understanding of the U.S. health care system and the wide array of providers and organizations that comprise it. More important, this body of research has put a spotlight on how the distribution and delivery of health services contributes to fundamental social inequalities and health disparities across many social groups and communities. The extraordinary fragmentation and lack of coordination suggests a need for more centralized management, something that the health care market has not been able to achieve on its own. When taken as a whole, sociological research on health services highlights the need for a stronger role of government in coordinating and managing the U.S. health care system.

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