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The Role Of Sociology In Health Affairs

by David Mechanic

More than a century ago, Rudolf Virchow noted that medicine is in essence a social science, and politics nothing more than medicine on a larger scale. Virchow and many others over the past two centuries saw the extent to which disease and epidemics derived from the material conditions of living and the social stratification of society. An enormous body of research and analysis has confirmed this observation in more recent years in relation to mortality as a whole and to a wide range of diseases and disabilities. Two important government reports in the 1980s, in England (the Black Report) and in the United States (Report of the Secretary’s Task Force on Black and Minority Health), reviewed the impressive evidence of the effects of socioeconomic status and racial and ethnic differences on health and longevity.1 These reports, unfortunately, were met with disfavor or embarrassment by the national administrations in the United States and England, who did little to disseminate them.

The fortunes of sociology, as well as the other social sciences, are linked with the prevailing attitudes, values, and politics of the time. While the discipline developed an institutional base at the beginning of the century, substantial growth only occurred with the rapid expansion of higher education following World War II and postwar growth in government support for research.2 Membership in the national professional association was never much over 1,000 before the war but grew rapidly after 1945, exceeding 14,000 members by 1970. Sociology and the other social sciences suffered setbacks in the 1980s, substantially as a consequence of hostility by a conservative federal administration and of shifting concerns of the general population toward personal priorities.

Sociology In Context

Sociologists played a useful role in the World War II effort, exemplified?
by Samuel Stouffer's Research Branch of the Army's Information and Education Division and the publication of The American Soldier. Yet, the social sciences were excluded when the National Science Foundation was initially established in 1946. Nevertheless, the social research activities initiated throughout government during the war became firmly established and grew in importance in subsequent decades. Government was interested less in basic science, however, and more in the use of social science methods—particularly the social survey and scientific sampling—to answer its own informational needs. While a wide range of methodologies were introduced and found useful, including content analysis, focused interviewing, and randomized social experiments, the large-scale national survey became the launching pad for a wide array of continuing social inquiries.

With the passage of the National Health Survey Act in 1956, which supported the establishment of the Household Interview Survey, government became involved in ongoing monitoring of the nation's health and in administering the most sophisticated and comprehensive health data collection system found anywhere in the world. The range of continuing and special surveys on health care provides much of the information that allows us to assess health status and progress in relation to national objectives. In the National Center for Health Statistics and many other agencies of our government, sociologists and other social scientists oversee the design, implementation, analysis, and dissemination of the results of surveys on almost every aspect of our population, economy, and social system.

Mental health roots. Sociologists worked on health issues throughout the century, but medical sociology as an institutionalized specialty first developed a strong educational infrastructure in the 1950s and 1960s, largely with the support of the National Institute of Mental Health (NIMH). Unlike the National Institutes of Health (NIH) at that time, NIMH saw the social and behavioral sciences as central to the development of its mission. Thus, the agency broadly invested in fellowships and training programs in sociology, psychology, and anthropology. In the 1950s and 1960s, most medical sociology was focused on mental health issues and contributed many of the concepts and much of the research that helped transform mental health services in the United States from a hospital to a community endeavor. It was NIMH that supported studies in psychiatric epidemiology, stress and coping, public attitudes and stigma, labeling processes, the course of disability, and the study of hospitals. In those years, the emphasis was on mental health broadly conceived, and NIMH contributed importantly to the development of social and behavioral research, including the development of methodolo-
gies and analytic techniques. Under pressure during the Reagan years, NIMH very much narrowed its training and research support to focus more specifically on the mentally ill population, in contrast to broader mental health concerns.

By the 1980s, however, many of the NIH institutes recognized the importance of social and behavioral research for their missions and helped compensate for NIMH’s more narrow emphasis. The National Institute on Aging, with its broad agenda of studying developmental change across the life cycle, did much to promote improved methodology and high-quality data and to support substantive research across a wide range of issues affecting health, function, and well-being. Similarly, the National Institute of Child Health and Human Development supported much sociological effort in the area of population research. While the heart, cancer, and other institutes were more narrowly focused, they increasingly supported epidemiological and behavioral research relevant to their categorical missions. The heart institute was particularly instrumental in developing the field of behavioral medicine.

Some Contributions Of Medical Sociology

Medical sociological endeavors tend to follow two streams: sociology in medicine and sociology of medicine. In the former, sociologists work as applied investigators or technicians, seeking to answer questions of interest to their sponsors, whether government agencies, foundations, hospitals, or medical schools. Depending on the ingenuity of the researcher, such work can make broader contributions than the particular task may suggest, but the emphasis is on information and application. This role is familiar, encompassing those who design and execute health surveys and who study such varied topics as access to care, use of services, satisfaction, risk factors in disease, health status determinants, and many more.

Sociology of medicine, in contrast, focuses on testing sociological hypotheses, using medicine as an arena for studying basic issues in social stratification, power and influence, social organization, socialization, and the broad context of social values. Work within this tradition explores such themes as how physicians control the work of other health occupations; how lower social status and gender affect health interactions; and how political and economic interests influence the structure of care, reimbursement, and the uses of technology. At the organizational level, such studies commonly contrast rhetoric with reality, seeking to identify the motivations, incentives, and group interests that result in departures from public declarations and stated goals. Medical sociology has little theory of its own, depending on its parent discipline for its broader
perspectives. Thus, the major points of emphasis that define sociology in
general help focus the way generic questions about health and medicine
are formulated.

Medical education. Medical sociology, for example, has had long
involvement in the study of medical education, dating from the 1950s.
Educators sought assistance from sociologists in improving curricula and
in understanding better how to structure education to deal with the
stresses of training, reduce unethical behavior, improve selection pro-
cesses, and induce more thoughtful inquiring behavior on the part of
physicians in training—in short, how to transform students into better
medical professionals. Many sociologists sharing these goals with medical
educators did excellent studies on such issues as coping with uncertainty,
specialty selection, factors affecting professional socialization, and the
like.9

Other studies, however, examined medical education in terms of its
values and contradictions. They focused on the incompatibility between
educational rhetoric and the behavior of the faculty; they described the
economic and prestige incentives that deterred faculty from their pro-
fessed goals and values; and they viewed some of the less commendable
behavior of medical students as adaptive to many of the contradictory
challenges and incentives to which they were exposed.10 They questioned
whether the ethical problem was simply a matter of more careful selec-
tion to avoid a few “bad apples” as physicians often saw the issue, the lack
of a course in ethics, or the result of fundamental problems concerning
the incentives and rewards within medicine. In short, they saw the
problem not as one of simple remedies. In addition, critics of medical
education were less impressed by the claims and status of the profession.
While those closer to medicine might think of medical education in terms
of The Student Physician, those less impressed thought of them more as
Boys in White.11

Medical sociology and physicians. Work in medical sociology, more
closely tied to disciplinary interests, finds less acceptance among physi-
cians and administrators because it looks at issues of health and medicine
from the outside, commonly operating on premises that reject basic
assumptions of the medical profession. Thus, in response to one study
that described the deceptions used by house officers under pressure from
their medical chief to gain autopsy permissions, one prominent physician
lamented the preoccupation with “learning in its most ghoulish aspects”
and warned that it just opened “new veins of muck for those who make it
their business to rake the medical profession.”12 An eminent physician,
stung by a highly critical study of his service, lamented, “The authors’
combination of smugness and naivete is hard to bear by someone who
has been dealing with the realities."¹³ This is just one of many instances in which sociology from the outside was hard to take by those being studied.

Robert Petersdorf and Alvin Feinstein, in commenting on the field, note that such work “has been a troublesome domain for many clinicians, who believe their distinctive concerns for individual people are lost in collectivist beliefs about society, and whose generally conservative political views have clashed with the strongly liberal, often radical positions of many sociologists.”¹⁴ It seems clear that these commentators—and probably most of their colleagues—prefer a sociology that is adjunct to medical activity and accepting of its basic premises. Such a sociology would simply be a servant to medicine, not fulfilling its larger responsibility to understand medicine as a social, political, and legal endeavor; to challenge its curative and technological imperatives; to examine equity of care in relation to class, race, gender, age, character of illness, and geographic area; and to study the appropriate goals and objectives for health care in the context of an aging society with an illness trajectory dominated by chronic disease.¹⁵

Although the critical perspective accounts for only a part of sociological effort, it is an indispensable component. This is not to argue that such analyses are not occasionally overstated or that their failure to show understanding for the constraints under which health professionals and policymakers work sometimes undermines receptivity of the audience. Perhaps most grating to the practitioner is a tendency to view necessary restructuring less in terms of small adjustments and more in terms of major changes that, if not politically repugnant, may seem far-fetched or impractical.¹⁶ Yet such work, and the perspectives underlying it, has been enriching and over time has been accepted as part of conventional wisdom.

Consider some of the research concerns of medical sociologists that were unpopular among many physicians. Sociologists have for decades studied organized forms of group practice, including health maintenance organizations (HMOs), making efforts to understand how alternative organization and payment arrangements affect access to and use of care and its costs. Researchers have inquired how patients’ social class, race, gender, and geography affect the quality of communication with health professionals and access to specialized care and how interaction and communication processes relate to adherence with medical advice, patient satisfaction, and issues of equity. Seemingly esoteric concerns of sociology have now become commonplace, such as the rights of patients in human experimentation, choices in pregnancy and childbirth, the right to be informed about the nature of one’s treatment, protection
against the uses of medicine for social control purposes, the excessive use of medical technology, the importance of primary care, the role of social behavior in disease and disability, and the potential of prevention.\textsuperscript{17}

**Disability as an example.** Because the scope of sociology is so broad, it is more useful to convey how sociologists think than to attempt to summarize the range of their concerns. The area of disability and rehabilitation offers one important example. From the early work of Talcott Parsons, it was clear that sickness and disability were, in part, social role definitions evolving from a system of expectations and social relationships.\textsuperscript{18} Expectations are seen as powerful influences in society, conditioning not only what is permitted but also the human possibilities of adaptation. Social norms and social arrangements commonly result in the unnecessary exclusion of persons with disabilities from many social settings and often indirectly undermine their subsequent motivations and efforts.

Sociologists have often noted that the social definition of a chronic disease or impairment and the processes of adaptation that relate to it shape future opportunities and constraints. In such instances as myocardial infarction, spinal injury, loss of hearing or sight, and other chronic disease and impairment, persons with comparable conditions adapt in varying ways to varying degrees. Whether the condition becomes the core of the person’s identity and totally incapacitates function or whether it is more peripheral depends not only on personality and motivation but also on social arrangements and public attitudes. Whether a person with an impairment becomes disabled thus depends in large part on how rehabilitation efforts are organized and the extent to which physical access, attitudes, and social reactions make jobs, recreation, and other forms of social participation feasible. Such thinking is the basis of the Americans with Disabilities Act, supported by a strong bipartisan coalition and pending action in Congress. These views are only now becoming commonplace. Yet their foundation and philosophy have been developing for decades by studies that established the deleterious ways in which people with disabilities were socially defined and dealt with.\textsuperscript{20}

**The Retrenchment Of The 1980s**

By the 1980s, the social sciences had become a fundamental part of how we think about societal affairs; their influences are seen pervasively in the mass media, education, government, business, and health affairs. Having a social science perspective is in some degree synonymous with being an educated and informed person. No educated person can be wholly ignorant of the role in American life of polling and surveys, of the
influences of incentives on motivation and behavior, and of the importance of organization in accomplishing our objectives. Much of social science appears obvious once we assimilate the ideas into our views of the world.

Ironically, social science came under sustained attack in the 1980s by conservatives who associated these disciplines with social policies and economic theories that were critical of capitalism and extolled the welfare state. Although social scientists could be found on all sides of the intellectual debate on the role of capitalism and the impact of welfare policies, conservatives perceived social scientists and their tendency to prefer government intervention in the marketplace and in many institutional spheres as “liberal.” While most of social science research was peripheral to these philosophical issues, and much investigation was apolitical in its focus and concerns, sustained efforts were made to reduce research support for these disciplines. In the early Reagan years, social research at the National Science Foundation was almost eliminated, and funding for broad social inquiry at NIMH and other federal agencies was substantially constrained.

The attack on social science was coincident with efforts to reduce government programs and with an ideology that attributed the problems of welfare to the social programs of the 1960s. The evidence is that government policies in the 1980s were unkind to the poor and disabled, and especially to children. In the period 1976 to 1987, real value of Aid to Families with Dependent Children (AFDC) benefits per family decreased by 30 to 50 percent. Between 1976 and 1984, the number of Americans in poverty increased from twenty-five to thirty-four million. By 1985, one in four children in America lived in female-headed families; more than half of children in such families are poor. Twenty percent of all children in our nation live in poverty. Access to health care also has decreased. As many as thirty-seven million people are uninsured, and many more are underinsured. Persons with serious chronic problems, such as the seriously mentally ill and those with chemical addictions, are greatly neglected, and the number of homeless persons has increased with the loss of low-income housing stock. Aware of a lack of sympathy with Reagan’s social welfare policies, conservative officials—particularly in the first Reagan term—substantially cut funding for basic inquiry and training in the social sciences, and careers in these areas became less attractive not only economically but also in relation to the new social environment.

In the 1950s and 1960s, the social sciences were linked with optimistic conceptions of the malleability of human nature and strong orientations to social reform. Supported by an ethos of social activism, university
enrollments in sociology and other social sciences accelerated. Social scientists became involved in public affairs and had important roles in the evolution of thinking underlying many of the social programs of the 1960s. By the 1970s, the country’s mood had changed, and social interventions were seen increasingly in the context of failure and the costs of good intentions. With few available positions in universities and little research funding, graduates could anticipate a constrained job market and difficult careers. Also, with growing emphasis on personal economic success, students refocused on business and the professions. A variety of conditions contributed to the retrenchment of sociology, including the economy and the fragmentation of the discipline itself, but the shift of emphasis to marketplace solutions in public policy and the hostility to social science added to pessimism and discouragement.

Medical Sociology And Medical Economics

Both sociology and economics were affected by the conservative attack in the 1980s, but economics responded more resiliently. Sociologists are much more actively engaged in collecting primary data, but the high cost and cutbacks in funding made this difficult. Social scientists using secondary data sources had a distinct advantage, a fact favoring economists and quantitatively oriented sociologists. Also, unlike sociology, economics had a broader base of support through employment in the private sector. Most sociologists outside of academia were in government agencies, and this was not an exciting time to be a bureaucrat. Economics was alone in retaining a core paradigm that was widely held whatever the individual differences among economists, while the other social sciences became increasingly specialized and fragmented. Unlike earlier periods, there was no longer any single theoretical paradigm that was commonly shared, and it became more difficult to identify common perspectives and assumptions that defined the work of the disciplines. In sociology, for example, traditional differences by theoretical perspectives, by adherence to quantitative and qualitative methods, by theoretical versus applied concerns, and by specific areas of interest became accentuated. It has become increasingly difficult to identify the common core that defines a sociologist, and definition occurs more typically by methodological approach than by common theory. Research as it applies to health and health policy shares these characteristics.

In the area of scholarship on health and health affairs, attention in the 1980s focused substantially on issues of financing, reimbursement, and cost containment mechanisms. While in the 1960s and 1970s, access and quality were equal partners in the access/cost/quality triad, in the decade
of the 1980s they became secondary to cost. Consistent with national and state policy concerns with mounting health care costs, pressures on public financing, and the pragmatic politics that accompanied these concerns, research questions about social justice and humanistic concerns were not high on the national agenda; nor were such previous common concerns as patient and provider satisfaction, the quality of provider/patient relationships, collaborative relationships among the health professions, and many more.

The political and social trends of the 1980s, and the growing dependence on secondary data, reinforced an already clear preference for addressing narrow research questions amenable to sophisticated quantitative methods and modeling techniques. Funded research in health emphasized cost issues, and the health research agenda became more restricted than it had been in previous decades. Strong interest in information on social problems did persist, but even our data systems suffered erosion due to budget constraints and a lack of receptivity to what was going to be bad news. The political environment was particularly inhospitable to analyses and interpretations that viewed problems of the poor, the homeless, the disabled, and the uninsured more as products of our social arrangements and politics than as the vulnerabilities, qualities, and choices of those affected. Moreover, in certain areas of American life, even factual investigation remains taboo. The current stalemate in gaining approval of a scientific survey of sexual behavior—a survey of vital importance for tracking the acquired immunodeficiency syndrome (AIDS) epidemic and planning AIDS prevention programs—suggests the complex ways in which values shape even attitudes about collection of information.

Shift from sociology to economics. It is not difficult to appreciate, thus, why the center of gravity in research on health research has shifted to the economic sciences. Economists bring to the area a widely shared and powerful conception of rational choice based on the dynamics of supply and demand. To many economists, purchasing health care is fundamentally no different than purchasing carrots or cameras, and many of the uncertainties or imperfections of medical care markets can be accounted for by “information costs,” the residual category of economic analysis that seemingly explains away many of the core concerns of the other social sciences.

Even when supply and demand analysis proves deficient, as in efforts to explain surgical fees or the consequences of the increasing supply of professionals, the presence of an agreed-upon paradigm, when the other social sciences are each floundering to identify what their practitioners share in common, gives economics a strong advantage. Economists also
bring sophisticated econometric techniques and models to their work, tools highly adaptable to the questions on which governments and policy focus. While economists come in all political persuasions, the paradigmatic orientation of most American economists is inherently conservative, and most are unlikely to challenge the deeper assumptions of public policy orientations. Health economics still remains a relatively new player, not yet fully established in its own basic discipline that values theory and method far more than the applied concerns to which health economists apply themselves. But the compatibility between economic theory and method and the issues that most concern health policymakers has put health economics in the ascendancy. These factors increasingly dominate the way in which health questions are being framed.

Unlike economics, which is highly focused, medical sociology covers an extraordinarily broad range of issues in social epidemiology, health care organization, patient/practitioner interactions, illness behavior, patient expectations and responses, the course of chronic disease, the organization of the health professions, and many more. The medical sociology section of the American Sociological Association had more than 1,100 members in 1987—almost 10 percent of its total membership. Because of the dispersion of efforts and the diversity of quantitative and qualitative methods medical sociologists use, they are often not easily distinguished from social epidemiologists, survey and evaluation researchers, and other researchers in public health and health services. While many medical sociologists are directly concerned with health policy issues, much of everyday activity involves gathering basic health status information, studying the social causes of illness and disability and their course, and examining factors associated with positive health status and behavior.

The Future Of Medical Sociology

Early publications from the RAND Health Insurance Experiment on the effects of copayment on ambulatory care reinforced interest in a market approach to health care. Later analyses that have received considerably less attention show that copayment had a diffuse effect on the use of services, affecting appropriate and efficacious care and less efficacious care equally. In short, contrary to much opinion and rhetoric, copayment was not selective in what services it reduced. Other analyses showed larger effects of copayment on the sick poor than on the affluent and showed that medical care had little impact on a broad array of outcome measures. In short, the Health Insurance Experiment and many of the studies that followed point to the extent to which the course
of disease and the behavior of patients and health professionals are governed by noneconomic factors.

The uncontrollable costs of medical care will continue to occupy a central place on the health policy agenda because of their implications for government budgets and tax demands and their potential influence on the competitiveness of American business. But as we look ahead, it is clear that our health care system is in considerable trouble. Inequities have increased in access to care and in quality of service, and significant proportions of our population are under- or uninsured. Encouragement of competitiveness has basically demolished our system of community rating, making it difficult for those who most need health insurance to obtain it. Tax subsidies for insurance give substantial entitlements to the most affluent, encouraging overinsurance and overuse among those who need care the least. We lack a viable strategy for organizing or paying for long-term care, despite the growing size of the elderly population and the old-old subgroup. Care for chronic illness—particularly for the stigmatized chronically mentally ill, alcohol and chemical abusers, and people with AIDS—is fragmented and in disarray. In the face of galloping medical technology, we lack standards of care and waste enormous resources through unnecessary and inappropriate procedures. Administrative costs are extraordinarily high. And, we have yet to effectively engage the tough ethical issues that biomedical advances make inevitable.

Examination of the future health care agenda makes it abundantly clear that if we didn't have a sociology of health we would now have to invent one. The influences affecting health and the provision of services are largely social, and the way we address problems of illness and care reflects our values and the arrangement of powerful interests within our social system. In a recent volume issued by The Henry J. Kaiser Family Foundation, *Pathways to Health: The Role of Social Factors*, substantial documentation is again presented, illustrating the pervasive influence of socioeconomic factors on disease processes, health status, longevity, and access to medical care. The integrity of our health care system requires that we address questions relating to such broad influences as well as to the more technical immediate ones and that we critically examine our goals and initiatives in the light of the best scientific knowledge of the determinants of health and welfare. There is little doubt that the powerful interests in our health care system, and our political processes of decision making, create serious obstacles to fundamental change. Nevertheless, a clear view of our goals, and the structures necessary to implement them, is an essential basis for constructive advancement.
NOTES


5. See, for example, National Center for Health Statistics, Health United States (Washington, D.C.: U.S. GPO, various years).


7. The term “socialization” is used by sociologists to describe the processes of social development and the acquisition of attitudes, values, and behavioral orientations. The appearance of some connection with political concepts is sometimes a source of confusion and misunderstanding. A major medical journal insisted that I eliminate the term from the title of a paper on the acquisition of health behavior because of its perceived link to socialism. The term “sociology” also sometimes confronts the same difficulty.


11. Merton et al., eds., The Student Physician; and Becker et al., Boys in White.


15. See studies cited in Note 8. Also, see E. Freidson, Professional Dominance: The Social Structure of Medical Care (New York: Atherton, 1970); and P. Starr, The Social Transfor-


17. For a general review of topics of general concern to medical sociologists, see Mechanic, Medical Sociology, 2d ed.; and Freeman and Levine, Handbook of Medical Sociology, 4th ed.


26. R.N. Lohr et al., Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial, R-3469-HHS (Santa Monica, Calif.: The RAND Corporation, 1986).

