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RESEARCH IN THE SOCIOLOGY OF HEALTH CARE

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CONTENTS

LIST OF CONTRIBUTORS ix

ABOUT THE AUTHORS xiii

PART I
INTRODUCTION TO VOLUME

HEALTH, HEALTH CARE, AND WOMEN AND RACIAL AND ETHNIC MINORITIES
Jennie Jacobs Kronenfeld 3

PART II
WOMEN AND REPRODUCTIVE RELATED HEALTH AND HEALTH CARE CONCERNS

THE RELATIONSHIP OF PREGNANCY INTENTIONS TO BREASTFEEDING DURATION: A NEW EVALUATION
Michael Seth Friedson, Mikaila Mariel Lemonik Arthur and Allison Pope Burger 13

TAKING INSURANCE IN ABORTION CARE: POLICY, PRACTICES, AND THE ROLE OF POVERTY
Katrina Kimport and Brenly Rowland 39

THE PATIENT–HEALTHCARE WORKER RELATIONSHIP: HOW DOES IT AFFECT PATIENT VIEWS TOWARDS VACCINATION DURING PREGNANCY?
Rose Jane Wilson, Tracey Chantler, Shelley Lees, Pauline Paterson and Heidi Larson 59

AN EXAMINATION OF STATE-LEVEL MANDATES FOR INSURANCE COVERAGE ON HEALTH-SEEKING BEHAVIORS FOR INFERTILITY
Nicole Maki Weller 79
PART III
HEALTH CARE PRACTITIONERS AND HEALTH AND HEALTH CARE

BEARING THE BURDEN OF CARE: EMOTIONAL BURNOUT AMONG MATERNITY SUPPORT WORKERS
Miriam Naiman-Sessions, Megan M. Henley and Louise Marie Roth 99

“LOST IN TRANSLATION”: HOW CLINICIANS MAKE SENSE OF STRUCTURAL BARRIERS TO DIABETES CARE AMONG US LATINOS WITH LIMITED ENGLISH PROFICIENCY
Claudia Chaufan, Mi-Kyung “Miki” Hong and Alicia Fernandez 127

RACIAL RESIDENTIAL SEGREGATION AND THE DISTRIBUTION OF AUXILIARY HEALTH CARE PRACTITIONERS ACROSS URBAN SPACE
Kathryn Freeman Anderson 145

PART IV
RACIAL AND ETHNIC MINORITIES AND HEALTH AND HEALTH CARE

NATIVITY, RACE–ETHNICITY, AND DUAL DIAGNOSIS AMONG US ADULTS
Magdalena Szaflarski, Shawn Bauldry, Lisa A. Cubbins and Karthikeyan Meganathan 171

HYPERTENSION EXPERIENCES OF BLACK MEN: A CRITICAL NARRATIVE STUDY
Rob Haile, Lilian Magalhães and Debbie Laliberte Rudman 193

INFLUENCE OF HEALTHCARE UTILIZATION AND SOCIAL CHARACTERISTICS ON HEALTH OUTCOMES AMONG ELDERLY ASIAN AMERICANS: A STRUCTURAL EQUATION ANALYSIS
Jacob Chao-Lun Huang 211
BEHAVIORAL FUNCTIONING AMONG MEXICAN-ORIGIN CHILDREN: THE ROLES OF PARENTAL LEGAL STATUS AND THE NEIGHBORHOOD CONTEXT
   Aggie J. Noah and Nancy S. Landale 231

DO YOU WANT TO SEE A DOCTOR FOR THAT? CONTEXTUALIZING RACIAL AND ETHNIC DIFFERENCES IN CARE-SEEKING
   Emily Walton and Denise L. Anthony 249

CHANGING PATTERNS OF FEMALE SMOKING: A COMPARISON OF WORKERS AND FULL-TIME HOMEMAKERS BY CLASS, RACE, AND COMMUNITY TYPE
   William C. Cockerham, Bryant W. Hamby,
   Shawn Bauldry and Patricia Drentea 279

ABOUT THE EDITOR 299

INDEX 301
LIST OF CONTRIBUTORS

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Tracey Chantler has been involved in research relating to vaccines and immunization for 15 years. She also has significant experience of coordinating community health and immunization programs in Haiti, which included supervising and training health workers in vaccination. Dr. Chantler’s research in this field spans pediatric clinical vaccine trials, organizational, qualitative, and mixed methods research in the United Kingdom related to the delivery of vaccine programs, vaccine trial participation, public engagement, acceptance of new vaccines, as well as longer term ethnographic fieldwork related to community engagement, vaccine trials, and ethics in western Kenya. In post-doctoral work, Dr. Chantler studied the role and value of reciprocal monitoring in clinical trials, and has been part of a multi-disciplinary research team developing a mobile health self-monitoring system for patients with heart failure. As part of this research, Dr. Chantler conducted home visits, to observe how patients were integrating use of this system into their daily lives, and do talk to them about their experiences of adopting technology for self-monitoring.

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PART I
INTRODUCTION TO VOLUME
Health, Health Care, and Women and Racial and Ethnic Minorities

Jennie Jacobs Kronenfeld

Abstract

This chapter provides both an introduction to the volume and a brief review of literature on women, gender, and health and health-care services as well as racial/ethnic minorities in the same areas.

The chapter argues for the importance of greater examination of women, issues of gender, and racial and ethnic minorities in health and health-care services.

The chapter reviews the issues of women and racial and ethnic minorities and previews this book.

Keywords: Women; gender and health care; ethnic minorities; racial minorities

This chapter provides an introduction to Volume 35 in the Research in the Sociology of Health Care series, Health and Health Care Concerns Among Women and Racial and Ethnic Minorities. The beginning of this chapter will

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review some of the more important material about women, gender, and health and health care and racial and ethnic minorities. The second part of this chapter will review the overall contents of the volume and the structure of the volume.

WOMEN, GENDER, AND HEALTH AND HEALTH CARE

Throughout the 20th century and into the new century, an important feature of mortality trends has been that women live longer than men (Rieker, Bird, & Lang, 2010). This was not always true in the more distant past. At one point in time, binary approaches to differences in health between men and women often tried to determine which was the weaker sex or which gender was more advantaged. Part of the complexity is that although women have better mortality experiences, they have higher morbidity rates and in later years of life report a diminished quality of life (National Center for Health Statistics, 2009).

Understanding these differences is complex, as there are some variations across countries and other social factors. One of the most important of these is socio-economic status and another is racial and ethnic differences. Altogether, these also impact differences between men and women both in the United States and in many other countries in the world.

One approach to understanding of differences between men and women in health and health outcomes is the constrained choice model developed by Bird and Rieker (2008) in their book, entitled Gender and Health. In this multilevel model, they conclude health is not only an individual responsibility but is also one shared by decision makers at multiple levels. The model argues that individuals make everyday choices that create health outcomes. These choices are made within the context of family, employment settings, and community. There is also a relationship with biological processes, such as stress responses, and all these go together to create health outcomes, both morbidity and mortality.

A different review article has examined gender and health care (Anspach, 2010). This review points out that the health-care system is a deeply gendered institution, and because of that, it often impacts men and women differently. They also note, as have many other authors, that women are more likely to seek medical treatment than men, and because of this, they become the principal consumers of health care. Often the care women receive is somewhat different from what men receive, and documenting these types of differences was an important topic of research as part of the resurgence of the feminist movement in the 1960s and 1970s in the United States, with many researchers pointing out that definitions of health and illness are impacted by social context including in the past differences in providers with nurses generally being women and physicians more often being men. This has changed greatly in the United States in the past 30 years, so that there are now many more women physicians, although nursing is still very heavily a female dominated field.
In addition to differences by gender in providers of care, differences have been noted in communication styles between men and women providers and linked also to the sex of patients. For some health problems, especially cardiovascular problems, women have been treated less aggressively than men (Lutfey & McKinlay, 2009). Some of this stems from an older, now discredited idea that heart disease is more important for men than for women. Other factors are that some procedures have been viewed as more risky for women, women often present with different symptoms and other cultural assumptions about gender and disease (Anspach, 2010). Importantly, in the past few decades, research on gender and health care has been modifying away from an exclusive focus on gender to broadening the approach to include the intersection of gender with race, class, and other forms of inequality. The constrained choice model already discussed is one example of this type of work. The chapters in this volume in many cases help to contribute to these more complex understandings of issues of gender, often linked in with other social factors such as social class and race/ethnicity.

RACE AND ETHNICITY

In the early years of sociology within the United States, there was a major focus both on social class differences, to the extent that data were available and to an early consideration of both racial and ethnic issues within the United States. From a health care and medical sociology perspective, these types of differences in recent years have become redefined as disparities with the growth of federal government efforts in health, and there has been more focus on race/ethnicity. I have already discussed some of this material in greater depth in an earlier volume within this series (Kronenfeld, 2012). If studies focus on race/ethnicity and ignore social class issues, it is too easy to conclude that differences are linked either specifically to race/ethnicity or even to biological differences that may be linked to race and ethnicity (Issacs & Schroeder, 2004).

In a review article, Takeuchi, Walton, and Leung (2010) argue that there is an important role played by segregation as a social process. It contributes to differential exposure to many particular environments and contexts and these different opportunity structures and community structures may influence health by shaping social processes. Similarly, a recent review article about the Hispanic paradox by Dubowitz, Bates, and Acevado-Garcia (2010) points out how the sociopolitical context and patterns of migration contribute to health and to the paradox that Hispanics/Latinas have higher life expectancies than would be expected based on their higher representation among the poor. The more factors researchers consider in trying to understand the complexity between health differences, immigration, race/ethnicity, and socioeconomic status, the more confusing and conflicting results researchers sometimes find.
Perhaps some of the studies in this volume will add to better understanding as well as the growing complexity of this confusing literature along with the literature on sex and gender within health and health care.

**REVIEW OF CONTENTS OF THE VOLUME**

This volume is divided into four sections. The first section is the introduction to this volume and contains only this chapter. The second section is on women and reproductive related health and health care concerns and includes four chapters related to this topic. In the first chapter, Freidson and coauthors Arthur and Burger examine the relationship of pregnancy intentions to breastfeeding duration. They point out that previous research has found that whether pregnancies are wanted, unwanted, or mistimed influence breastfeeding behavior. Using national survey data from the United States, they find that pregnancy timing matters most for sustaining breastfeeding for durations past 6 months and that differences in rates of breastfeeding discontinuation between mothers with wanted, unwanted, and mistimed pregnancies are most pronounced in the 3–7 months post-partum period. In addition, they find that Medicaid recipients (but not non-recipients) are less likely to exclusively breastfeed for 6 months when their pregnancies are mistimed. In the next chapter in this section, Kimport and Rowland discuss insurance in abortion care and the role of poverty. They point out that, partly due to legal restriction on insurance coverage, most women seeking abortions pay out-of-pocket for care. Because most abortion patients are low income, these costs can constitute a hardship. They interviewed 22 abortion facility administrators, representing 64 clinical sites in 21 states that varied in their legal allowance of public and private insurance coverage for abortion, about their facility’s insurance practices and experiences. Accepting private insurance carried risks, including non-payment because costs fell within patients’ deductibles. Different facilities used work-arounds to protect their facility from non-payment and enable patients to use their private insurance. The third chapter in this section looks at the patient–health-care worker relationship and how it affects patient views toward vaccination during pregnancy. Wilson and her coauthors use the theory of relational autonomy with its emphasis that persons are socially embedded, with decisions being made within social relationships, to explore how the health-care professional–patient relationship can affect pregnant women’s decisions to accept pertussis and influenza vaccines. They conducted in-depth interviews with 40 pregnant and recently pregnant women, as well as 10 health-care professional within the National Health Service (NHS) in Great Britain. Their findings indicate that advice from friends and family can greatly influence a pregnant woman’s vaccination decisions. If close relationships with patients are formed, health-care professional advice is more likely to be trusted.
With support from health-care professionals, patients feel competent, empowered to make the right decision, and are more likely to vaccinate. The last chapter in this section examines a different reproductive health concern, health-seeking behaviors for infertility. This chapter by Weller also looks at insurance coverage for infertility and examines state-level mandates for this within the United States. The behavioral model of health services utilization is used in this chapter to examine the relationship between state-level mandates that insurance providers cover infertility service on the rates of health seeking behaviors (HSB) for infertility among a nationally representative sample of women. Fifteen US states have such mandates. The rates of health-seeking behaviors for infertility were higher among women residing in states with state-level mandates.

The third section in this volume includes three chapters related to health care practitioners and health and health care. In the first chapter, Naiman-Sessions and her colleagues examine emotional burnout among maternity support workers. They use data from a study of about 800 labor and delivery nurses in the United States and Canada, along with around 1200 doulas in the same locations. Multivariate ordinary least squares (OLS) regression models examine the effects of work—family conflict, overwork, emotional intelligence, witnessing unethical mistreatment of women in labor, and practice characteristics on emotional burnout. Work—family conflict, feelings of overwork, witnessing a higher frequency of unethical mistreatment, and working in a hospital with a larger percentage of cesarean deliveries are associated with higher levels of burnout among master’s of social works (MSWs). Higher emotional intelligence is associated with lower levels of burnout, and the availability of hospital wellness programs is associated with less burnout among L&D nurses. In the second chapter, Chaufan, Hong, and Fernandez examine how clinicians make sense of structural barriers to diabetes care among US Latinos with limited English proficiency (LEP). The chapter focuses on how clinicians assisting low-income US Latino patients with diabetes and LEP made sense of language-discordant care in the context of the social determination of health. They interviewed 14 physicians in an urban teaching hospital. Participants believed that language barriers undermine the quality of the clinical encounter and diabetes outcomes, were eager to serve disadvantaged patients, and were well-schooled in the social determination of health and its role in diabetes inequalities. The last chapter in this section by Anderson looks at racial residential segregation and the distribution of auxiliary health-care practitioners across urban space. They point out that recent studies have shown inequities in the distribution of a wide variety of health-related organizations across urban neighborhoods, but relatively little attention has been given to the distribution of health-care facilities in particular. The chapter considers how segregation is related to the distribution of several auxiliary health-care practitioners in a series of spatial regression models of zip codes across the United States using data from the 2010 U.S. Census and County Business Patterns. She finds that both Black and Latino segregation are negatively
related to the density of a number of auxiliary health-care practitioners, including mental health providers, dentists, physical/occupational/speech therapists, chiropractors, optometrists, podiatrists, and miscellaneous health-care practitioners. However, this association is reduced (in certain instances to non-significance) with the inclusion of socioeconomic indicators, chiefly the percent of college educated individuals and the unemployment rate of the zip code. This association is reduced for both Black and Latino segregation, with a larger reduction in the size of the effects for Latino segregation.

The last section in this volume has six chapters, all related to racial and ethnic minorities and health and health care. One focuses on Black men, one on Asian Americans, and one on Mexican Americans, while the other chapters look across some racial and/or ethnic differences. The first chapter by Szafarski and her colleagues examines issues of nativity, race—ethnicity, and dual diagnosis among US adults. This chapter investigates disparities in dual diagnosis (comorbid substance-use and depressive/anxiety disorders) among US adults by nativity and racial—ethnic origin and socioeconomic, cultural, and psychosocial factors that may account for the observed disparities using two waves of the National Epidemiological Survey on Alcohol and Related Conditions. Racial—ethnic categories included African, Asian/Pacific Islander, European, Mexican, Puerto Rican, and other Hispanic/Latino. Substance-use and depressive/anxiety disorders were assessed per diagnostic and statistical manual-VI (DSM-VI). The prevalence of dual diagnosis was low but varied by nativity, with the highest rates among Europeans and Puerto-Ricans born in US states, and the lowest among Mexicans and Asians/Pacific Islanders. The nativity and racial—ethnic effects on likelihood of having dual diagnosis remained significant after all adjustments.

In the second chapter by Haile, Rudman, and Magalhaes, the hypertension experiences of Black men are examined. This chapter explores how Black men make sense of their hypertension and how they negotiate this condition within their everyday lives, illuminating how racism and power dynamics embedded within their environments affect their experiences living with hypertension. Critical race theory tenets were used along with a narrative design to obtain stories of hypertension experiences of a small sample of men in Ontario Canada. Participants’ experiences with discrimination, isolation, and migration raise awareness of how power relations embedded within social, political, and historical contexts can affect hypertension experiences. The next chapter by Huang discusses the influence of health-care utilization and social characteristics on health outcomes among elderly Asian Americans. Using the Andersen health behavioral model, the chapter examines if there is a reciprocal relationship between health-care utilization and health outcomes, and how social characteristics play their role in this relationship between US born and foreign born elderly Asian Americans with data from the US National Health Interview Survey (NHIS) 1998–2012. Results show a reciprocal relationship between health outcomes and health-care utilization. Also, predisposing characteristics
had a direct effect on health outcomes, and enabling resources had an indirect effect on health outcomes via health-care utilization. In addition, living in the West had both direct and indirect effects on health outcomes.

Noah and Landale examine behavioral functioning among Mexican-origin children, with a focus on parental legal status and neighborhood context. Their chapter investigates the influence of parental legal status and neighborhood characteristics on Mexican-origin children’s behavioral functioning using a multilevel approach with data from the Los Angeles Family and Neighborhood Study and 2,000 decennial census. The multilevel results show the importance of considering parental legal status. Mexican children of unauthorized mothers are more likely to exhibit internalizing and externalizing problems than all other groups of Mexican children. Furthermore, neighborhood-concentrated disadvantage is significantly associated with internalizing behavior problems, and neighborhood-concentrated affluence is significantly associated with externalizing behavior problems.

The next chapter in this section by Walton and Anthony contextualizes race and ethnic differences in care-seeking. The chapter deals with past data demonstrating that racial and ethnic minorities utilize less health care than their similarly situated White counterparts in the United States, and the speculation that these actions may stem in part from less desire for care. Using data from a 2005 national survey of community-dwelling Medicare beneficiaries ($N = 2,138$), they examine racial and ethnic variation in intentions to seek care, grounding analyses in the behavioral model of health-care utilization. They find that Latino, Black, and Native American older adults express greater preferences for seeking health care compared to Whites. Worrying about one’s health, having skepticism toward doctors in general, and living in a small city rather than a metropolitan area, but not health need, socioeconomic status, or health-care system characteristics, explain some of the racial and ethnic variation in care-seeking preferences. They show that even after comprehensively accounting for factors known to influence disparities in utilization, elderly racial and ethnic minorities express greater desire to seek care than Whites.

The last chapter in the volume is by Cockerham and colleagues and examines changing patterns of female smoking by comparing workers and full-time homemakers by class, race, and community type in the United States at two points in time, 1979 and 2014. Results show that smoking is most prevalent among homemakers in small communities. This outcome supports earlier studies citing smoking as a major causal factor for the decline in female life expectancy among less-educated White women in certain low-income and rural counties in the United States. The premise that female smoking is strongly associated with the workplace appears to be no longer true. Similarly, Black women in 1979 had 67% higher odds of smoking, but by 2014 they had 49% lower odds of smoking showing a significant racial reversal in cigarette use. This suggests Black women have been more receptive than White women to smoking avoidance and cessation over time.
REFERENCES


