An investigation of the cultural traits and processes of cultural change of the American health care system responsible for the lack of universal health insurance in the United States

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ABSTRACT

This investigation aims to determine what cultural traits and processes of cultural change in the American health care system are accountable for the present lack of universal health insurance in the United States. The research question is approached through Franz Boas' theory of *historical particularism* with the methodology of *problem-oriented ethnography*. The designated society is the American health care system, and its culture is the focus. Care is taken to avoid proposing solutions for the current condition of U.S. health care, as well as berating or rating the system. Instead, attention is placed on analyzing the conflicting values within health care that are embodied by private and public sectors of the system; the degree to which each value is represented in the system as well as their roles in shaping the system are then deemed to be the cultural traits and processes of change. In this way, and given the current dominance of private insurance, important traits of the health care system as a whole can be ascertained. American health care is a society whose culture dislikes inefficiency above all. In public health insurance (of which universal health insurance is a variant), its inefficiency has made others overlook its compassionate goal in providing indiscriminating health care. In exchange, the health care culture has—at the very least—permitted values geared on personal gain and on the lack of compassion and responsibility in the form of private insurance. Meanwhile, processes of cultural change have entrenched these cultural traits. Values of personal gain and antistatism have driven physicians to nurture the private insurance sector and discouraged grassroots advocacy for universal insurance respectively. Private insurance was therefore allowed the greater foothold in health care. Such are the factors that account for the present lack of universal health insurance in the United States.

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INTRODUCTION

The right to health care has been a long contested issue in the United States. A right recognized by international law,[1] health care nonetheless remains inaccessible to many Americans without insurance, and for those with coverage, many are left to waddle in hefty premiums and medical charges. Elsewhere, systems of universal health insurance have been established in industrialized nations such as Japan, Great Britain, and Sweden[2]—but not in the U.S. Attempts at health care reform have and still persist, but health care in the U.S. remains largely a for-profit, selective, and political enterprise. To understand the factors and developments of American health care that prevented the establishment of universal health insurance in the United States is the aim of this anthropological investigation.

Research Question

The investigation centers on the following research question:

What cultural traits and processes of cultural change in American health care are accountable for the present lack of universal health insurance in the United States?

Employed Anthropological Theory: Historical Particularism

This investigation follows the premises of Franz Boas' theory of *historical particularism*. It serves well to qualify this theory for the purposes of this investigation.

The definition of historical particularism is referenced from the work of C. Thomas Lewis, III and Jonathan Berry, students of the University of Alabama under the direction of Dr. M.D. Murphy:

> "Historical particularism is an approach that was developed by Franz Boas as an alternative to the worldwide theories of socio-cultural development as espoused by both evolutionists and extreme diffusionists, which he believed were simply unprovable. Boas believed that to overcome this, one had to carry out detailed regional studies of individual cultures to discover the distribution of

[1] "Article 25," Universal Declaration of Human Rights, 22 Jan. 2006 <http://www.unhchr.ch/udhr/lang/eng.htm>.
[2] John J. Macionis, Sociology: Student Media Version, (New Jersey: Prentice-Hall Inc., 1999) 545.

> culture traits and to understand the individual processes of culture change at work."[3]

The question of universal healthcare does not seek to develop "worldwide theories of socio-cultural development," as is often the goal of anthropological studies. Instead, the question aims to find a "regional" theory of the "culture traits" and "individual processes of culture change at work," specifically within the United States, which have allowed the American health care system to become what it is now. Keep in mind, as well, that although such components of historical particularism entail a brief review of historical events, this investigation is in no way a mere recount of the past events of health care reform. Rather, it is by analyzing the nature of these historical events (along with other data) that the investigation may capture the cultural traits and processes of change—the underlying causes—at the heart of the issue. In this way, historical particularism is a fitting approach to the research question.

Employed Anthropological Method: Problem-Oriented Ethnography

For sake of clarity, it is likewise important to outline the method of evidence collection for this investigation forthwith.

Again, in the words of Lewis and Berry:

> "Historical particularism is an approach to understanding the nature of culture and cultural changes of particular people [...] Boas and his students stressed the importance of gathering as much data as possible about individual cultures before any assumptions or interpretations are made regarding a culture or culture change within a culture. He and his students took great pains to record any and all manner of information."[4]

To collect copious amounts of data for the research of an issue, in turn, is the principle of *problem-oriented ethnography*,[5] the methodology employed in this investigation. However, being that the investigation is of a

[3] Thomas Lewis, III and Jonathan Berry, "Historicism," Anthropological Theories: A Guide Prepared by Students for Students, 22 Oct. 2001, 22 Jan. 2006 <http://www.as.ua.edu/ant/Faculty/murphy/histor.htm>.
[4] Ibid.
[5] Conrad Phillip Kottak, Mirror for Humanity (New York: McGraw-Hill, Inc., 2005) 33.

theoretical nature (rather than one based on fieldwork), certain types of data are not applicable. Participant observations, for instance, are not included; instead, findings of studies conducted by government institutions are utilized as ethnographic evidence—a common tactic of the problem-oriented approach.[6] Also, a large part of the included data is in the form of statistics. Admittedly, anthropologists typically do not use statistical techniques, but such a trend is changing as anthropologists increasingly work in modern nations,[7] nations such as the United States.

It must be made clear, too, that any source serving to evaluate or rate American health care is not referenced. Rankings are judgments of the American system as a whole and as compared to health systems of other nations, both of which extend beyond the intended scope of the investigation. The investigation remains largely a self-contained examination solely of American health care.

With all said, the compilation of selective data is used to analyze the current lack of universal health insurance, and in doing so, reveal the cultural traits and processes of cultural change of American health care that is to be held accountable. This is the investigation's cumulative plan of attack.

Important Premises and Limitations

As in any anthropological study, the culture and society on which this investigation rests need to be designated. Foremost, though, *culture*—a difficult term to define in anthropology—is defined in this investigation according to the words of Franz Boas himself:

> "Culture embraces all the manifestations of social behavior of a community, the reactions of the individuals as affected by the habits of the group in which he lives, and the product of human activities as determined by these habits."[8]

The "community," or society, is limited in this investigation to those who are associated with American health care—physicians, patients, insurers, employers, and even lobbyists—and the culture, hence, pertains to the attributes

[6] Ibid.
[7] Ibid. 24.
[8] As quoted by John Monaghan and Peter Just, Social and Cultural Anthropology (New York: Oxford University Press, Inc., 2000) 37.

of these people within the United States. Given the research question though, it is implied that American health care bifurcates into two *subcultures*: those in favor of universal health insurance, and those in favor of private health insurance. This concept of subcultures is in keeping with Conrad Phillip Kottak's acknowledgment that societies "may contain many different culturally defined groups [who] may strive to promote the correctness and value of their own practices, values, and beliefs in comparison with those of other groups."[9] Recognition of these two subcultures serves to streamline the investigation by delineating the two main parties whose clashes may elucidate cultural traits and processes of change.

Though historical particularism inherently aims to avoid making world-wide theories of socio-cultural development, this trait may nonetheless be deemed a limitation of this investigation. Some may find the conclusion reached here to be too limited in scope or set outside the context of health care systems of other nations to provide much information of human culture as a whole. Lewis and Berry pose a criticism as well:

> "If the investigator was reluctant to generate broad theories on cultural development and culture change, what was the point of gathering so much and such detailed work?"[10]

The point, indeed, is to provide a detailed study of a specific region. Readers must therefore be advised that any conclusion reached in this argument should not be judged—in degree or extent—alongside health care systems in nations other than that of the United States.

On one last note, *health care* is guaranteed by *health insurance*. They are synonymous in that a universal health insurance policy entails a universal health care system.

Collected Evidence

The collected evidence is grouped and laid out in categories depending on the subject of the data.

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[9] John Monaghan and Peter Just, Social and Cultural Anthropology (New York: Oxford University Press, Inc., 2000) 49.

[10] Thomas Lewis, III and Jonathan Berry, "Historicism," Anthropological Theories: A Guide Prepared by Students for Students, 22 Oct. 2001, 22 Jan. 2006 <http://www.as.ua.edu/ant/Faculty/murphy/histor.htm>.

Designated Subcultures

The subculture in favor of private health insurance consists primarily of the insurers themselves. In the other subculture stand the government and lobbyists who advocate for programs of public health (such as universal health insurance). Between the two, however, remain numerous special-interest groups, ranging from doctors to pharmaceutical companies to employers. These latter parties seek to fulfill their financial needs, and since private insurance succeeds in doing so, they typically side with that subculture. However, because they are not the principle players of either subculture, their influence on the health care question are only included as necessary.

Private Health Insurance

Current American health care is primarily privately insured and organized as a *direct-fee system*, a "medical-care system in which patients pay directly for the services of physicians and hospitals."[11] Insurance providers are the gate keepers to health care,[12] offering to cover the costs of selected services for patients in return for regular payments. However, health insurance has become a system run like a business, where decisions are effected by the profit motive and market forces.[13] Add this to the fact that no requirement exists at the state or federal level for insurance to be provided for workers,[14] such a system has led to several significant trends.

The free market and for-profit nature of American health insurance was promoted by the federal government as the method to "bring high-quality care to all."[15] Instead, such a system has engendered health insurance that is largely unequal and which focuses on generating revenue. People with mild health problems such as arthritis are commonly charged higher premiums than healthy people, and people with serious diseases such as leukemia are likely to be denied coverage completely due to treatment costs.[16] Many insurers avoid entire industries which they consider to

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[11] John J. Macionis, Sociology: Student Media Version (New Jersey: Prentice-Hall Inc., 1999) 545.
[12] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 5.
[13] Donald L. Barlett and James B. Steele, Critical Condition: How Health Care in America Became Big Business and Bad Medicine (New York: Doubleday, 2004) 4.
[14] Susan Starr Sered and Rushika Fernandopulle, Uninsured in America: Life and Death in the Land of Opportunity (California: University of California Press, 2005) 196.
[15] Donald L. Barlett and James B. Steele, Critical Condition: How Health Care in America Became Big Business and Bad Medicine (New York: Doubleday, 2004) 4.
[16] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 3.

be high risks,[17] and for those that choose to provide insurance, they do so at higher rates. It is a system where "health care providers can—and do—charge one customer five times, in some cases even ten times, as much as another,"[18] the most overcharged of which are often those who are most ill.

Not unexpectedly, not everyone has access to health care; in 2003 the ranks of uninsured Americans stood at 45 million.[19] Of these people, nearly 80 percent are working, with another 6 percent looking for work.[20] Only the remaining is not in the labor force, usually because they are in fact too ill to work.[21] To add to these numbers, there are tens of millions of people who are underinsured. These are people who have insurance, but coverage which would not meet the costs they may incur should they fall ill.[22] Without an unforeseen upsurge in job creation, the numbers of the underinsured and uninsured will continue to increase.[23]

Public Health Insurance

In capitalistic societies, the high costs of medical care often encourage the government to "[underwrite] a considerable share of [health care] expenses"[24] in the form of public health programs. Universal health insurance stands as the epitome of public health care, a system under which all citizens is guaranteed some sort of coverage. This form of health care does not currently exist in the United States. Nonetheless, the U.S. does have several programs of public health insurance catered to select groups of the population. These programs are Medicare and Medicaid, created in 1965.

The larger of the two, Medicare, is a federally funded program that provides the much needed cost coverage for all citizens over 65 years of age. Under the program, a patient would visit the doctor and the doctor would bill Medicare; the patient would then pay out of pocket any difference between the doctor's charges and Medicare's

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[17] Ibid.
[18] Donald L. Barlett and James B. Steele, Critical Condition: How Health Care in America Became Big Business and Bad Medicine (New York: Doubleday, 2004) 2.
[19] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 3.
[20] Ibid.
[21] Ibid.
[22] Donald L. Barlett and James B. Steele, Critical Condition: How Health Care in America Became Big Business and Bad Medicine (New York: Doubleday, 2004) 26.
[23] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 33.
[24] John J. Macionis, Sociology: Student Media Version (New Jersey: Prentice-Hall Inc., 1999) 545.

reimbursement.[25] However, since its creation in the 1960s, the average age of death has increased, and coupled with the increasingly expensive medical technology, the cost of Medicare and access to services has become critical issues.[26] As seniors live longer and use more services, American tax dollars and senior out of pocket expenses increase. Health care costs, already high due to profit-driven private insurance, have been made to further skyrocket by Medicare.[27]

Medicaid, too, faces similar problems. A joint federal-state program aimed at supplying health services to "federally designated categories of the poor,"[28] Medicaid follows a spending trend that rose 13 to 14 percent in the years 2001 and 2002.[29] Under the program, each state receives federally predetermined funds to spend on the program, but with Medicaid taking up 20 percent of most state budgets, many states are eliminating people from coverage or limiting benefits.[30] In turn, this means even less federal money for the program, perpetuating the crisis of the program.

Services to be included under both Medicare and Medicaid require an act of Congress.[31] Any new technology or procedure that is to be added must be approved individually, "without a view for the health of the body as a whole, much less the health of a nation as a whole."[32] Likewise, Congress sets the rates of payment for hospitals and doctors, which change according to the latest lobbying effort rather than being established along reasonable standards.[33] As a result of such regulations, many doctors refuse to participate in public programs or treat Medicare and Medicaid patients because not enough money is received to cover their costs.[34] Consequently, many who ostensibly have insurance really do not, as hospitals or doctors may deny them service.[35]

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[25] Kathleen O'Conner, The Buck Stops Nowhere: Why America's Health Care is All Dollars and No Sense (Washington: Hara Publishing Group, 2003) 70.
[26] Ibid. 71.
[27] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 9.
[28] Susan Starr Sered and Rushika Fernandopulle, Uninsured in America: Life and Death in the Land of Opportunity (California: University of California Press, 2005) 199.
[29] Kathleen O'Conner, The Buck Stops Nowhere: Why America's Health Care is All Dollars and No Sense (Washington: Hara Publishing Group, 2003) 20.
[30] Ibid. 21.
[31] Ibid. 70.
[32] Ibid. 71.
[33] Ibid. 72.
[34] Kathleen O'Conner, The Buck Stops Nowhere: Why America's Health Care is All Dollars and No Sense (Washington: Hara Publishing Group, 2003) 72.
[35] Ibid.

A History of Health Insurance Reforms

Physicians were the most vocal opponents of government-sponsored health care from the Progressive Era to the 1960s, determined to keep out any third-party that might regulate their fees.[36] To pursue these aims politically, physicians formed the American Medical Association (AMA), an organization honed for political action. It was this organization which worked to defeat a plan for compulsory health insurance proposed by the American Association for Labor Legislation in 1910.[37] In 1935, the AMA again waged a campaign to prevent the inclusion of national health insurance in the Social Security Act of 1935.[38] When President Harry Truman made national health insurance the key domestic issue of his Fair Deal, fierce protest from physicians ultimately forced Truman to concede defeat.[39]

By the 1980's, however, quelled by guaranteed payment and tempered by conflict among specialty groups, physicians' antipathy to national health insurance subsided. Insurers moved to take their place. When President Bill Clinton put up a plan to ensure universal health care coverage in 1992, a coalition led by insurers funded a public relations campaign against, utilized lobbying firms, and increased campaign contributions to members of committees that presided over health reform.[40] The Clinton plan, too, crumbled.

These failed attempts at health care reform have often been explained by the antistatist political nature of the United States.[41] Because "Americans honor private property, hold individual rights sacred, and distrust state authority,"[42] it has been difficult to construct a convincing case for government financed health care. This mindset has been instilled early in the health care wars. Following World War I, "any hint at national health insurance was seen as a move toward socialism and government control of physician salaries and hospital rates."[43] Americans' subsequent

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[36] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 6.
[37] Ibid. 7.
[38] Ibid.
[39] Ibid.
[40] Ibid. 11.
[41] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 12.
[42] Ibid.
[43] Kathleen O'Conner, The Buck Stops Nowhere: Why America's Health Care is All Dollars and No Sense (Washington: Hara Publishing Group, 2003) 52.

distrust of the government and their predilection for private solutions to public problems thereby stands in the way of public health insurance. [44]

Effects of Uninsurance

Below are two findings concluded by the Institute of Medicine of the National Academies to be the effects of uninsurance:

> "*Hospital-Based Care*
>
> Community uninsurance can put financial stress on hospital outpatient and inpatient departments, sometimes resulting in lessened availability of services or the closing of a hospital. When public jurisdictions respond to this and other financial pressures by converting their hospitals to private ownership status, the availability of services may be adversely affected, especially for members of medically underserved groups."[45]

> "*Budget Implications for States and Localities*
>
> Public subsidy of uncompensated care delivered to uninsured persons requires that additional public revenues be raised, resulting in a higher tax burden at the local level, the receipt of monies from federal coffers, or the diversion of resources from other public purposes. If additional revenues are not generated, budget cuts may be imposed, either for health care or across the board, that can adversely affect all members of the community and even increase the number of uninsured persons locally.
>
> State and local governments' capacity to finance health care for uninsured persons tends to be weakest at times when the demand for such care is likely to be highest (i.e., during periods of economic recession)."[46]

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[44] Jill S. Quadagno, One Nation Uninsured: Why the U.S. has No National Health Insurance (New York: Oxford University Press, 2005) 12.
[45] Institute of Medicine of the National Academies, A Shared Destiny: Community Effects of Uninsurance (Washington, D.C.: National Academies Press, 2003) 101.
[46] Institute of Medicine of the National Academies, A Shared Destiny: Community Effects of Uninsurance (Washington, D.C.: National Academies Press, 2003) 123.

ANALYSIS

Central to the issue of health care is the perpetual question of whether health care is—as stated by international law—an actual inherent right. To this issue the American medical community has become a hotbed of conflicting values: values of efficacy, antistatism, compassion, and of personal gain. In turn, such values have come to be embodied by two subcultures: those who support and those who oppose universal health insurance. An analysis of each respective group and of their interactions will thereby reveal how American health care weighs the values above, and in doing so, come to define the cultural traits and processes of change which has led to the denial of universal health insurance.

It seems perplexing, at first, to fathom how private insurance would become the dominant form of health care in the United States. For one, it is a policy based on personal gain, a value which has made the private insurers highly selective. Over 45 million Americans have been left uninsured due to premises of existing illnesses or costly treatments. Often, those most ill are denied access to health care or subjected to elevated premiums that cannot be fulfilled. And this mistreatment occurs on a large scale; indeed, private insurers may well avoid whole industries deemed too unprofitable to cover. Yet, at the same time the majority of the uninsured are working Americans, with the problem being that their employers are not financially capable to provide coverage. Juxtaposing the consequences with the circumstances, it seems evident that the plight of many uninsured Americans is underserved, especially in a system where employment has traditionally granted access to health care. In addition, even of those with insurance, millions are underinsured by a coverage plan that is actually inadequate in covering potential costs. Such disparities thereby critically reveal private insurance to be bereft of compassion, a nature which thus denies the very notion of health care as an inherent right. It is also a nature which has engendered serious consequences. With the vast numbers of uninsured ignored by private insurance, any health care provided to the uninsured has placed a tax burden on states and localities that must be shouldered by the population. In more drastic cases, cuts must be made across the board that adversely affects even those with health insurance; losses even threatens to trigger the privatization of hospitals (and thus the further restriction to health care) to preserve fiscal viability. Indeed and in sum, all the evidence seems to point at private insurance as being a detriment; it is an industry that is uncompassionate, driven by personal gain, and irresponsible to the welfare of the nation as a whole.

With a present system that appears to be undeserving of its role as the main provider of American health care, the answer to the lack of universal health insurance, hence, must lie in public insurance itself. Unlike private insurance, public health insurance is built upon the premise that health care is indeed an inherent right. Medicare and Medicaid, the two largest existing forms of public health insurance, demonstrates this value by providing health care coverage to all seniors above 65 and all those beneath the poverty level respectively. From this perspective, it seems entirely logical to supplant the private sector with the more compassionate public alternative, but the fact is that current programs of Medicaid and Medicare are fraught with serious problems themselves. The main concern is their efficacy, which is unacceptable. Lacking a clear view of what health care should be, each technology or procedure that is to be covered must be approved individually by Congress. Furthermore, such public programs stringently delineate the rates of payments for hospitals and doctors, rates which are spuriously decided rather than to reflect actual costs. Many hospitals and doctors, in response, refuse to participate in Medicaid or Medicare. Just as worrisome, however, is the tendency for these public programs to skyrocket health care costs already made high by profit-driven private insurance. For Medicare, increased longevity of seniors has led to an increase use of costly services, while the maintenance of the Medicaid program itself has experienced double-digit inflation. Being government funded, much of these costs translate into increased taxes for all, an effect similar to that of the uninsured left behind by private insurers. In this way, the only real virtue that public health insurance can tout over private insurance is that of compassion; after all, both are irresponsible to the wellbeing of the population in the form of unanticipated costs, and while public health insurance may not be driven by personal gain, it is certainly not made appealing due to its blaring inefficiency.

Between the battles waged by these conflicting subcultures, however, stand many freelancers ready to be recruited by those who fulfill their needs. Considered here are the physicians and workers, whose respective alliances to private or public health insurance has just as significantly led to the present state of American health care. Indeed, it was the physicians, through the American Medical Association (AMA), who helped protect the private insurance industry when it was but a defenseless fledgling. Their motive, like private insurers, was to prevent the tampering or limitation of their profits—again exhibiting the value of personal gain. From 1910 to the 1980's, the AMA had successfully defeated many plans for compulsory health insurance, especially a plan for its inclusion in the Social Security Act of 1935. President Truman too, despite having made national health insurance the key issue for his

Fair Deal agenda, ultimately admitted defeat after fierce protest. Admittedly, a grassroots movement could have arisen to counter the physicians' lobbyists (since it is a natural interest for all workers to desire health coverage) but no such movement ever found strength. The explanation for this can be found in yet another important value, that of antistatism. Distrustful of state authority and big government, such a mindset has been instilled early as well. Following World War I, any step towards national health insurance was interpreted to be a move towards socialism and the control of physician profits. In this way, a workers' movement was discouraged at the onset, and thus, physicians in their advocacy of private health insurance were hardly challenged at a time when the industry was most vulnerable. The end result of this is the entrenchment of private health insurance, so much so that it has become a self-sustaining, self-advocating group even without an affiliation with physicians. This is most strikingly evident in the insurers' resounding rout of the Clinton plan in 1992. Altogether, the present lack of universal health insurance, therefore, is due in no small part to the relative strengths of the physicians and workers, with the former driven by personal gain, and the latter made benign by antistatism.

CONCLUSION

Given that the private insurance industry currently has the upper hand in health care, the analysis in the preceding section thereby reveals significant cultural traits and processes of cultural change in American health care as a whole. The American health care system is a society whose culture does not necessarily advocate values geared on personal gain or the lack of compassion and responsibility, but it is one which refuses to deal with inefficiency above all. In public health insurance, its inefficiency has caused others to overlook its compassion in providing health care for all. Universal health insurance, a variant of public health insurance, is thereby unfeasible. With this aversion, personal gain, irresponsibility, and the dismissal of said compassion have been allowed—if not encouraged—in the form of private insurance. For processes of cultural change, values again of personal gain as well as antistatist beliefs have driven physicians to nurture the private insurance industry from the start and discouraged grassroots advocacy for public insurance respectively. Private insurance and the values it embodied were therefore given dominance in defining the aforementioned cultural traits of the system as a whole. With all said, these are the underlying attributes of American health care that account for the present lack of universal health insurance in the United States.

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