

FROM CULTIVATION TO NEGLECT: WOMEN'S BODIES IN THE SOCIAL
REPRODUCTION OF HEALTH

BY

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Submitted to the graduate degree program in Anthropology and the Graduate Faculty of the
University of Kansas in partial fulfillment of the requirements for the degree of Doctor of
Philosophy

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From Cultivation to Neglect:
Women's Bodies in the Social Reproduction of Health.

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Date approved: March 29, 2011

Abstract

In *Unbearable Weight: Feminism, Western Culture, and the Body*, Susan Bordo (1993) integrated Mary Douglas's theoretical ideas about the body with Michele Foucault's ideas about power to explore how the female form is constructed within United States (US) society. She analyzed media representations and extreme attempts at body modification to understand US cultural fantasies and anxieties about women's bodies. Building on this work and using John Janzen's (1992) theory of the social reproduction of health, a theory that looks at how classes attempt to maintain the social structures and patterns that give them advantage across generations, this dissertation considers beliefs about body construction among fifty-five women of varying social position in Kansas City from February 2008 to February 2009. Among these fifty-five women, those with the greatest access to resources engaged in strategies attempting to obtain the ideal body, while women with the least access had bodies that deteriorated to a point where they had several chronic, often disabling health conditions. Based on these fifty-five women, four composite categories or ideal types were identified. Women's attempts to obtain the ideal body related to a desire to control and regulate their lives. Once women lost the ability to actively improve their bodies, they sometimes purposefully engaged in unhealthy behaviors in an attempt to exert agency.

Acknowledgments

Writing a dissertation is a difficult task that no one can do alone. Many people deserve special recognition for this project. First, I must thank the Sisters at Keeler Women's Center. They are very special women. I am blessed to know them. I must also thank Dr. John Janzen. Dr. Janzen is a unique advisor in that he not only allowed me to explore my own ideas but offered me the encouragement and support I needed to delve into new intellectual waters and come away feeling I had truly contributed to the creation of knowledge in my own way. Dr. Don Stull deserves special recognition for always being forthright about the flaws of my work, never afraid to tell me the truth about what needed to be fixed in order to make it better. I am also especially grateful to Dr. Jean Hall for her support and encouragement throughout the dissertation process. By allowing me to assist her with her research, she not only provided the financial support I needed to finish this project but showed me how to apply research in a policy setting and make real changes that benefit people. I would like to thank Doctors Ben Chappell, Christine Makosky Daley, and Brent Metz for their diligence in serving on my committee, reading my dissertation, and providing appropriate suggestions for it and future research.

A dissertation is an academic work but also a labor of love and as such requires a great deal of sacrifice. This sacrifice comes not just from a student but also from her friends and family. In that vein, I would like to thank my parents for understanding the limitations on my time these past several years, most particularly my mother who often functioned as both sounding board and proofreader. I would also like to thank my friends who let me disappear for six months at a time and then reappear as if nothing strange had happened. Of course, of all the people I should acknowledge the most important to my success are my husband and my daughter. My husband is the love of my life. Without him, this project would not have happened. My daughter came to be half way through this process and showed me what real motivation was all about. It is to these two, Major Travis Chapman and Lucille Rose Chapman, that this dissertation is lovingly dedicated.

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Chapter 1 – Women’s Health and Wellness in Kansas City

Introduction

In *Unbearable Weight: Feminism, Western Culture, and the Body*, Susan Bordo (1993) integrated Mary Douglas’s theoretical ideas about the body with Michele Foucault’s ideas about power to explore how the female form is constructed within United States (US) society. She analyzed media representations and extreme attempts at body modification to understand US cultural fantasies and anxieties about women’s bodies (ibid: 15). Building on this work and using John Janzen’s (1992) theory of the social reproduction of health, a theory that looks at how classes attempt to maintain the social structures and patterns that advantage them across generations, this dissertation considers beliefs about body construction among fifty-five women of varying social position in Kansas City from February 2008 to February 2009. Among these fifty-five women, those with the greatest access to resources engaged in multiple strategies attempting to obtain the ideal body, while women with the least access had bodies that deteriorated to a point where they had several chronic, often disabling health conditions. Based on these fifty-five women, four composite categories or ideal types were identified. Women’s attempts to obtain the ideal body related to a desire to control and regulate their lives. Once women lost the ability to actively improve their bodies, they sometimes purposefully engaged in unhealthy behaviors in an attempt to exert agency.

Research Problem

When research began in February 2008, the primary question was whether women’s cultural construction of cardiovascular disease (CVD) risk varied based on their access to health care as that care was mediated by health insurance. The research was not meant to address CVD risk from a public health perspective. It was meant to be an anthropological study of how public health and health-related industries influenced cultural knowledge. The primary hypothesis was that a woman’s relationship

with her health care provider would be the most influential factor in determining her health-related behaviors, and women with good insurance would have access to good doctors who spent long periods of time with them telling them what to eat, how often to exercise, and supporting them in these efforts. The research had three elements: (1) to assess the CVD information that was circulating in the area and how that information was influenced by public health and health-related industries; (2) to explore how women's knowledge of CVD and CVD risks were influenced by circulating information and from women's own experiences; and (3) to record how the knowledge that women expressed affected their actions and interactions. As elements of the research progressed, it became clear that the hypothesis was both wrong and inadequate to understand the cardiovascular-related health behaviors of these fifty-five women. Instead, their perceptions of cardiovascular health were tied into ideas about body image, social class, and individual morality.

Data Collection and Analysis

Data were collected through a combination of (1) participant observation, (2) informal discussion, and (3) formal interviews with women found at locations such as laundromats (coin laundries), clinics, community centers, workout facilities, cafes, coffee shops, and libraries. Locations were selected based on what women reported in terms of where they spent their time and accessed needed services. Based on the information women provided, research settled on locations and events along the state line in Wyandotte and Johnson counties in Kansas and Jackson County in Missouri. Some places were visited repeatedly, others only one or two times. When possible, through an attendant or governing body, permission was sought and granted prior to observation and recruitment. Because many of the beliefs that are part of modern socialization come from what people see on television, a sample of the evening news and commercials shown during it were also reviewed

I asked the fifty-five women who participated in formal interviews if they could be recorded and to fill out a demographic questionnaire. Only two refused the questionnaire; three refused to be recorded. Because of the nature of the research, I met with some women many times over the course of the year. Others I met with only once or twice. Because the women came from all over Kansas City, interviews

took place throughout the metropolitan area with the exception of locations to the north of the Missouri River (Northtown). None of the women who agreed to be interviewed lived in that area.

The Women

Of the fifty-five women who were formally interviewed, ten had medical training; forty-five did not. Of the fifty-three who filled out a demographic form, participant ages ranged from twenty to seventy-four years with six participants in their twenties, eleven participants in their thirties, twelve in their forties, fourteen in their fifties, seven in their sixties, and three in their seventies. Annual household incomes began at under \$5,000 and ended at more than \$300,000. Education levels started with the tenth grade and ended with ten women who completed graduate school. In addition, two of the women who completed graduate school had two master's degrees. A third was in a Ph.D. program, but she had only completed one course.

As data were coded, patterns in how women responded to questions began to emerge based on women's descriptions of their health insurance and access to care. Four groups were identified and labeled as (1) cultivated bodies, (2) managed bodies, (3) neglected bodies, and (4) forgotten bodies. Women were placed in a group based on whether they had insurance and, if they did, what they said they paid for their premiums, copayments and coinsurance, and deductible as well as their experiences using their insurance to access care and whether they had unmet health needs. Criteria for categories were based on women's responses the following questions:

- Tell me about your health insurance. For example, what is good or bad about it? What does it cover or not cover?
- Can you tell me about an experience you had with your insurance company that stands out to you?
- Was there ever a time you needed to go to the doctor but didn't go because of the cost? Was there a time a loved one could not go? Was there another reason that prevented you from going to the doctor?

Responses were broken into eight insurance categories from one (none) to eight (great) defined not only by insurance but also unmet health care needs. Women were designated as none if they lacked health insurance and had a great deal of unmet need. Women with great insurance paid very little for their

policies and were not only able to go to the doctor whenever they wanted but treated their health care as a commodity. I was then able to code data for concepts and consider codes in correspondence to insurance types. Concept clusters were identified. The different body groups--cultivated, managed, neglected, and forgotten--came from review of these patterns as they revealed differences in how women talked about medical care, diet, exercise, and the body.

The information used to create each group was subjective, derived from women's explanations and interpretations of their insurance and care. One woman showed me statements she received from her health insurance company denying her claims. Another showed me premium bills and a third lab results. These were the only formal documentation seen. It was possible that some women lied about this information or, more likely, that they provided the wrong information because they did not know it was wrong. For example, there were women with neglected bodies who said they did not have coinsurance when, based on my knowledge of their policy holder, they did. Since they were never able to meet their deductible and paid for all of their health expenses without reimbursement, they did not realize they had coinsurance. Because of the way categories were constructed, using not only insurance information but also unmet health care need, such discrepancies in premium or cost sharing amounts should not invalidate categories.

Women with cultivated bodies had health insurance that allowed them to see any kind of doctor (e.g., primary care physician, dermatologist, cardiologist) at any type of location (e.g., hospital, clinic, private practice) whenever they wanted for little or no out-of-pocket cost. Women with managed bodies had insurance that allowed them to make an appointment to see a basic provider (e.g., primary care physician, gynecologist) when they wanted, but they had to wait for several days or weeks for their appointments depending on their problem; three had Medicare. They were usually required to obtain a referral to see a specialist and had higher copayments and deductibles than women with cultivated bodies. They had incomes high enough to pay these out-of-pocket costs. Women with neglected bodies had insurance that allowed them to schedule appointments with providers but, because of copayments and deductibles, had a difficult time paying for them; three had Medicaid. These women received limited care

except for extreme problems because they could not afford it. Women with forgotten bodies did not have health insurance at the time of their interviews. They could not afford to pay for health care out-of-pocket and were dependent on charity services for assistance.

Among the fifty-five women interviewed, health insurance was a good indicator of their social position. Income levels corresponded to insurance as women with higher incomes had better insurance and women with lower incomes either had worse plans or did not have insurance at all. However, the relationship between income and insurance was not perfect. The best health insurance came from employment with the federal government, and while women who had or whose husbands had such employment had high incomes, women who worked as corporate executives made more. Women with group health insurance plans had better overall coverage and paid less out-of-pocket for premiums than those with individual-based insurance plans. Only two women out of the fifty-five said they passed on an employer-based group plan because the price of the premium was unaffordable. At that time, both were at the bottom of their employer's pay scale.

Among the ten women with a graduate degree, only one had no health insurance and was identified as having a forgotten body. Similarly, only one woman with a graduate degree had bad insurance and was identified as having a neglected body. There were an additional four women with four-year degrees who had neglected bodies. All of them worked in service-related industries, two in advocacy or assistive positions for people with disabilities and people who were indigent. Two of the women with managed bodies had no more than a high school diploma and one had only some college. All but one of the women with in the cultivated body group had at least a four-year degree. The one without a degree had some college and was married to a college graduate. She also worked as a corporate executive at a firm that allowed her to start as an office girl and work her way up the ranks to vice president.

The Ideal Body

Health and health care are commodities in the US (Horton and Lamphere 2006: 33). In Kansas City, multiple entities offer health-related products from colonoscopies to step-aerobic classes for money.

Ads for products also run in many media outlets. They encourage people to use products to make their bodies look young and thin. People see ads several times a day, which may influence how they think about themselves and others. Based on the things women said about their bodies, women in Kansas City want to look like the women in ads. They think that other women should look like the women in these ads as well. Public health messages that associate disease risk with age and body weight legitimate the images that are presented. Both public health messages and ads reinforce social ideas that there is a normal, preferred body type. Ads also project the idea that with the right products and amount of effort everyone can have that body type. In reality, what society identifies as the perfect body is impossible to obtain without the use of extreme forms of body modification such as plastic surgery (Bordo 1993).

While the socially defined version of the perfect body is out of reach for most people, even everyday products with real, related benefits like fresh fruits and vegetables are easier for women with high incomes and suburban addresses to obtain. This situation leads to observable differences in the bodies of high and low status individuals (Schroeder 2007). Among the women interviewed in Kansas City, those with the highest incomes and best access to health care were generally the most like women in ads and were thin. Women with the lowest incomes and worst access to care were generally overweight or obese. The association between the ideal body type and social status increases the desirability of this body type as a marker of social class. Interviewed women wanted the perfect body. Those with the most income worked hard and used medical help to approximate it. Women with less income were frustrated and believed they could not obtain such a body without products they could not afford.

Beliefs about individual body form simultaneously integrate into existing ideas of why society is hierarchical and why people at the top deserve greater access to resources. Prestige is based on individual wealth as well as the perceived ability of an individual to improve her social position or to “raise herself up by her bootstraps” (Bordo 1993: 193-195). An overweight person is perceived to lack the necessary discipline for self-improvement. Women in Kansas City repeatedly said that overweight people were out of control even when the person speaking was overweight. This social pressure drives women at the top to use every resource available to look as good as possible. Women in the middle tried to mimic the

women at the top. Without access to the same resources, they ended up purchasing convenience products that misled them about their actual health benefits. Women at the bottom were frustrated and felt left out. Improvement occurred among a very few women at the bottom who found a combination of education and social support. They were assisted by people who cared about them individually and helped them learn about good nutrition, physical activity, and ways to incorporate these into their lives with their limited time and budgets. This support was part of a process whereby women developed a sense of self-worth. Simultaneously, women who slipped down the class ladder and lacked support complained they had no control over their lives and they were socially abandoned. They engaged in self-described self-destructive behaviors that destroyed their bodies from within.

Women with the greatest access to resources strove for bodily perfection because of social pressure. They tried to make their bodies look good, but their efforts did not always improve their health and sometimes were harmful. They treated doctors like expert salesmen and shopped from specialist to specialist to find the treatments they believed would help them the most. Women below them in social position either mimicked them or were jealous of them, believing these women had the best this system could offer. Although women expected the system to work this way, they also wished they had a more intimate relationship with their health care providers. All of the interviewed women wanted a healer who knew them. They wanted a person they could trust to take care of them. As one woman said, they wanted a person with whom they were comfortable interacting with “when naked.”

Regardless of social position, all of the interviewed women made statements that cast health and health care as commodities. But they wanted more. Women indicated that health was not just an individual state. Ideally, it was also a social one. As health related to society, women indicated that good health was a group effort made not only for individual improvement but for the improvement of society as a whole. When women believed that someone was not doing her part, they were angry about it. Women were divided on how to best achieve such a system with ideas being associated with the amount of trust they were willing to place in government institutions.

Dissertation Chapters

The themes above are discussed in the following ten chapters. Chapter 2 begins with a discussion of inequality in the US and the decline of the American worker since the 1970s. It explores social class in this country and how class relates to social reproduction or the use of social institutions to maintain classes from one generation to the next. It specifically addresses the social reproduction of health or how access to health resources plays into social reproduction. Because access to health care is largely controlled by access to health insurance, the chapter explains how health insurance worked in the US at the time of the fieldwork, how it helped shift resources from the poor to the rich, and how a health care system based on the accumulation of wealth has led to profit becoming more important than caring for the people within this system. The unequal distribution of resources leaves visible marks on bodies through poor health. These marks show social position, while the individualized nature of risk causes people to internalize their poor health and blame themselves for behaviors that they are often unable to control because they lack the necessary resources. This chapter concludes with a discussion of body theory as used by medical anthropology. This theoretical tool is used to conceptualize how individual, social, and political worlds intersect and influence one another and leads into a final discussion of the literature on lay epidemiology.

Chapter 3 introduces Kansas City. It offers a demographic snapshot of the city with particular emphasis on how social division was geographically spaced. It provides a detailed discussion of the methods, beginning with how data were collected and finishing with a description of how the four body types were derived. It also provides an overview of the fifty-five interviewed women. Finally, it shows how economic decline affected Kansas City at the time of the research.

Chapter 4 begins with a discussion of the information circulating about CVD in Kansas City. It explores how information varied based on its intended audience. It then talks about themes in news stories and commercials that were presented to the general public. It finishes with a review of women's shared perceptions of CVD and CVD risk.

Chapter 5 is about women with cultivated bodies or women who used an excess of health resources to try and maintain or create the American idea of the ideal body. Chapter 6 introduces women with managed bodies, or women who attempted to cultivate their bodies without the same resources as the women in Chapter 5. Women with managed bodies relied on products that promised to help them cultivate their bodies but were often disappointed. Chapter 7 is about women with neglected bodies, or women who once cultivated or managed their bodies but who had slipped down the social ladder and were no longer able to invest the same level of resources into their physical forms. These women attempted to exert control over their lives and bodies using strategies that were diametrically opposed to the strategies of women with cultivated bodies. The breakdown of their bodies and their poor health behaviors helped legitimate the individual, for-profit nature of the US health care system. The women in Chapter 8 had forgotten bodies and had difficulty accessing quality health resources, which led to the deterioration of their bodies as they slipped down what was known as the disability trajectory. These women longed for a cultivated body, but they rarely attempted cultivation because they simply did not have the resources required.

Chapter 9 relates four case studies that show how attempts to cultivate or not cultivate the body related to feelings of control. Chapter 10 finishes the dissertation with a discussion of the social reproduction of health in relation to the four body types and how the distribution of health resources could be used to maintain class structures within the US. It also looks at how the distribution of resources combined with for-profit motivations could destroy the social reproduction of health in the sense that this combination can cause people to lose sight of their responsibility to one another.

One Limitation of the Research

Limitations of the research are addressed in more detail in Chapter 3, but it is especially noteworthy that the form of the human body is always limited by biology. No matter how they are treated, all bodies eventually deteriorate (Schilling 2003: 124; Bourdieu 1986: 245). Because of this, individuals in higher classes may choose to take the resources others would use for cultivation and invest them somewhere else (Schilling 2003: 125; Bourdieu 1986: 254). In the US, women are much more

likely to invest in their bodies than men because of the importance placed on the feminine body ideal. This is especially true of professional women because youth is an important part of this ideal and professional success often comes at a later age (Wolf 1991). A limitation of this research is that the majority of participants from higher social strata are professionals. Those who are not once were and remained friends with women who continued to work in high-level positions. Thus, the women discussed may have been more likely to feel a need to cultivate their bodies than other women. Women in the lower social strata also worked and may have been more inclined to desire cultivation than their unemployed counterparts as well. Similar studies of nonworking women are needed to address their attitudes toward the body.

Summary

The research initially proposed that women's health behaviors were a product of their health care access. This was too simplistic. Instead, women's health behaviors related to their social class, beliefs about body image, and about morality. Participant observation and interviews, including formal interviews with fifty-five women, led to the creation of four groups identified as women with cultivated, managed, neglected and forgotten bodies. These groups are explored throughout the body of this text. While the applicability of the dissertation to a larger population is not possible because of the small sample size, the fact that these groups were found among these fifty-five women speaks to problems with the US health care system at the time of the research.

Chapter 2 –Social Class, Health, and the Social Reproduction of Health

Introduction

Information provided by interviewed women showed that for them, beliefs about cardiovascular disease (CVD) were deeply tied into their beliefs about body image, social class, and morality. Women said CVD was a result of bad or immoral behavior such as overeating and being lazy, reflected through what bodies looked like. The interviewed women then related their ideas about body image to social class. The research happened at a time of growing wealth inequality in the United States (US). Because people's social position affects their ability to access health-related resources, poor people in the US bear the marks of poverty in the form of increased rates of disease and disease risks, such as obesity (Nguyen and Pescahard 2003: 458). Although the limits placed on people's access to resources are largely structural, the dominant ideology in the US is that all people can control their social position through hard work and individual ability, making such physical manifestations of disease and disease risk indicators of personal failure. Increased wealth disparity is a result of changes in public policy that place the rights of corporations over the rights of individuals and allow corporations to obtain extreme profits at the expense of common people (Perrucci and Wysong 2008). While corporate changes have happened across all industries (Bodley 2005), the conglomeration and quest for profits in the insurance and food industries increased health-risk and made associations between a body at risk for CVD and personal failure more salient.

This chapter begins with a discussion of America's growing inequality at the time of the research, and relates it to social class, exploring beliefs that associated social position with individual ability. The chapter ties class to health using the theory of the social reproduction of health, a theory that looks at differential class access to resources, based on earlier theories of social reproduction. This leads to a discussion of health insurance because of the influence it has over the social reproduction of health. Because health insurance can either be used to redistribute resources collected from the able bodied to those in need or can be used to centralize resources, collecting them from people who fear the onset of

poor physical health with the promise of assistance and then failing to provide that assistance, a discussion of the health insurance industry at the time of the research finishes this section.

In the US, health insurance centralizes resources to the benefit of a few at the expense of the many, but this shift in resources and its associated effects on health go largely undocumented. Reasons for this are mentioned. Failure to look at class and health obfuscates class differences and the structural limits that are placed on achieving good health. Limits are then socially redefined as manifestations of bad behavior. Because behavioral risks associated with poor health become important in perpetuating American ideology, the anthropology of risk is reviewed and followed with a discussion of obesity as a class issue. This section ties obesity to the rise of cheaply-produced, processed foods and poor access to resources. The nature of the body makes it a site of assimilation and resistance (Scheper-Hughes and Locke 1987), which is theoretically considered in the section, *The Hegemonic Body*. Finally, because the original intent of the study was to consider the lay epidemiology, or lay perception of CVD risk, the literature on the lay epidemiology is reviewed with special attention to clinical CVD risks.

Although obesity is considered at length, smoking is only briefly mentioned. Smoking is relevant to the issues discussed in this chapter and dissertation. In many ways it appeared that the interviewed women's beliefs and behaviors associated with smoking paralleled their beliefs and behaviors associated with obesity. However, smoking was regarded as a sin to such an extent among these fifty-five women that it received only a cursory mention and little detailed discussion. Further consideration of smoking in this context and its relation to obesity is planned for future work.

American Inequality

In, *The Epic of America*, James Truslow Adams (1931) defined the American Dream as a dream of opportunity and of prosperity, where everyone could achieve the highest standard of living they were capable of, based on hard work and ability, not on the circumstances of birth or social position (Library of Congress 2010: on-line). The American Dream is a promise that everyone can succeed in the way they define success, although people may define it differently. The American Dream is the central ideology of American society (Hochschild 1995: xi), but it is hard to say whether it was ever real. Segments of the

population were always excluded based on characteristics of their birth. For others, something like it existed between 1946 and the early 1970s, a period called the age of shared prosperity. This was the time when the US was at its most equal in terms of wealth and income (Gilbert 2008: 236; Hardy 2009: 496). This level of equality was hard won and achieved only through social programs that came out of workers movements that culminated during the Great Depression. These programs were funded by a progressive tax code that required the rich to pay a more equal share in terms of their total wealth and helped many Americans climb the social ladder (Aronowitz 2003).

The climb ended in 1973 when the standard of living for the average American began to decline (Perrucci and Wysong 2008: 54). Wage disparities between top and bottom earners also began to increase and continued to do so for the next three decades (Hardy 2009: 496; Gilbert 2008: 236). In 1980 the ratio between the average annual incomes of a corporate executive officer (CEO) compared to a production worker was forty to one, or around \$1.4 million to \$33,758 in 2005 dollars. By 2005 the ratio was 411 to one. In 2005 the CEO made \$11.3 million while the production worker made \$33,509, or \$241 less than the worker did in 1980 (Perrucci and Wysong 2008: 58). In this period, income and wealth inequality increased in other Western nations as well but none as much as in the US. By 2008, earning's disparity in the US was the greatest of any Western country and the highest it had been since the Great Depression (Hardy 2009: 496; Piketty and Saez 2006: 201).

The decline was predicated by a number of political and social events. Many of the hard won programs and industry concessions that were instrumental in improving the lives of average Americans were eliminated. In the late 1970s, the US government began to deregulate industry, dismantling union rights and eliminating worker protections (Aronowitz 2003: 103-110). In the 1980s, changes in programs like Aid to Families with Dependent Children (AFDC) created more requirements to qualify. New requirements meant greater bureaucratic entanglements and reduced program effectiveness. By the mid-1990s, some programs spent more than half of their budgets on administration. Once bound in red tape, the same groups who demanded new requirements used program bureaucracy to cast doubt on the effectiveness of the government (Duffy 1997: 2). By the late 1990s, the social safety net, or programs

created to help those most in need survive, were limited (ibid: 3-4). For example, increased restrictions on food stamp and Medicaid eligibility meant that those most affected by poverty, single mothers with dependent children in southern states, sometimes remained more than 50 percent below the national poverty level as they collected benefits (ibid: 8). Cuts in programs were required because changes in tax policy reduced how much the highest earners paid. In the early 1960s, the marginal income tax rate for the highest earners was 91 percent. In 1988 it was 39.8 percent. By 2003 it was 35 percent. As it decreased for the richest Americans, it increased for the poorest from around 6 to 15 percent (Piketty and Saez 2007: 3, 23-24).

Americans allowed changes in policy to happen for several reasons. Because the generations born after World War II did not see the hardships of the late 19th and early 20th century, they were not as concerned about economic battles as their parents and grandparents (Aronowitz 2003: 58). Instead they turned toward moral issues like abortion. Those opposed to social programs also took advantage of the combination of American ideology and increased prosperity to blame people who lacked access to opportunity for their poverty. Blame was especially harsh against people who did not fit social ideals, such as single mothers. This turned remaining economic issues into moral ones (Davidson and Harris 2006: 53-54). Many Americans also failed to fully notice their quality of life was diminishing because they used Band-Aids like the wages from newly working women to cover losses in family income (Heathcote 2009; Hoynes, Page, and Stevens 2006). When women's wages were not enough, families turned to credit cards, introduced in the 1970s, to offset the difference (Manning 2000). Each year brought changes in policy that let things grow a little worse for the average American, but most families found ways to staunch the bleeding. However, Band-Aids made things worse in the long run because they turned reductions in quality of life into individual problems, which kept people from coming together to talk about the structural problems that hurt them.

Social Class

Class is one of the last great American taboos. This is not because Americans believe the US is a classless society (Perrucci and Wysong 2008: 48; Lareau 2008: 4). Americans are experts at reading class

cues and assigning social place (Suarez 2008: 361). They do not talk about class because it is not supposed to exist, at least not in a permanent way. Just as the American Dream implies, Americans believe that in the US anyone can "raise themselves up by their bootstraps." This idea is called the Horatio Alger myth after a 19th century author who wrote about working-class protagonists who succeeded based only on their own merits. However, multiple studies of social mobility have shown that it is very difficult to improve social position in the US. When these studies compare social mobility in the US to other Western countries, they find that it is no easier to improve social position here and, in fact, in many cases it is actually harder (Breen and Jonsson 2005: 233-234).

Because people believe in the Horatio Alger myth, they think the US is a meritocracy, a place where people's lives are a reflection of what they deserve. For the people at the top, this belief affirms their use of a disproportionate number of resources when compared to others in society. For people at the bottom, it is disheartening particularly if they internalize their social place and see it as a sign of personal failure. The myth that the US is a meritocracy keeps people from questioning the unfair system of resource distribution (Pratto et al. 1994: 741). It also stops them from talking about social class because in a meritocracy admitting someone has a low social place relative to others implies that the person has not worked hard enough to grasp the opportunities presented to them. Suggesting they will not raise their social position, even if it is because of structural factors, says they never will.

Past failure to discuss social class means class is hard to define. Previously people were more open about social class and used several categories to talk about it. Categories were based on things such as occupation, income, and education and included such distinctions as working class, middle class, and upper middle class. By 2008, these finer gradations had all but disappeared for most members of the public who represented the different classes using three broad categories. These included the rich, the middle, and the poor. People nearly always place themselves in the middle, which makes this category amorphous and useless (Gilbert 2008; Aronowitz 2003: 15; Wolff 2002, 2004). In fact, the term middle class often mutes class issues by obscuring real social differences (Perrucci and Wysong 2008: 49).

Academics who talk about class also seem somewhat at a loss for how to define it. Most look at a broad range of variables that affect not only a person's current social position but a person's potential future position as well (Perrucci and Wysong 2008: 4-7; Gilbert 2010). Karl Marx was the first to create a systematic way of looking at class. He based his definitions on people's relationship to the means of production. That is, he assigned people their class station based on whether they owned the factory or worked on its line (Gilbert 2010: 3). Max Weber expanded on Marx' definitions to include available opportunities and differentiated between class and status, so that, for example, a working class, white American might feel he was middle class because he did not identify with the minorities he saw as making up the working class (ibid: 4).

While class is most often associated with income and wealth, at its heart social class is about power and people's ability to access present and future resources (Aronowitz 2003: 26). Pierre Bourdieu understood this kind of power was capital and added cultural capital (i.e., any quality people have that gives them advantage and status in society such as the way they talk or their educational credentials), social capital (i.e., the resources available to people through social obligation and social networks), and symbolic capital (i.e., the resources available to people through their embodiment or ascription of things with cultural value such as a veteran teacher running for the school board (Bourdieu 1986: 47, 243-258)).

Social capital became a popular idea in the late 1990s, but it is not so much the development of this idea of social or cultural capital that set Bourdieu's work apart. Bourdieu provided an analytical toolkit to break apart complex social concepts that related to class. Anything people had that was socially valued so that it gave them differential access to or control over resources is a kind of capital. For example, the rise of globalization and emerging technologies like the Internet make the ability to find and discern whether information is credible a form of capital (Appadurai 2006).

This text relies heavily on physical capital, a form of symbolic capital that deals only with the body. Physical capital is a concept meant to relate the importance of the body as a symbol of one's class status and as such to the body's importance in providing access to current and future resources. The body works as capital because some forms are socially valued more than others and because of the physicality

of things such as work. Physical capital is usually converted into other kinds of capital (Schilling 2004: 474; Bourdieu 1984).

The kinds of capital that Bourdieu identified are learned, embodied, and then transmitted across generations (Schilling 2004; Bourdieu 1984). Physical capital comes from learned skills in physical education courses (e.g., pickle ball, fencing), private classes (e.g., gymnastics, tai-kwon-do), community activities (e.g., football, soccer), and by playing with family members. If a child's parents work several jobs and do not have time to play, it makes it more difficult for that child to learn to do things like throw a softball. This can affect their ability to play this popular team sport throughout their lives, affecting both the physical condition of their body, a form of symbolic capital, and their potential for social capital, as people often form friendships with their softball teammates. Physical capital is also affected by the foods people eat as they grow up because people tend to acquire a taste for the foods they are served as children (Bourdieu 1984: 175-177). The learned nature of physical capital combined with the rigid class structure of the US relate well to a prominent branch of social science theory known as social reproduction.

“Social Reproduction” was defined by Marx (1967) to represent the idea that social systems, including their class gradations, are reproduced through day-to-day activities across generations. Social reproduction includes survival basics such as provision of food, clothing, and shelter as well as more intangible things such as the transmission of knowledge, values, and beliefs. It is a way to think about how, “Various institutions (such as the state, the market, the family/household, and the third sector) interact and balance power so that the work involved in the daily and generational production and maintenance of people is complete” (Bezanson and Luxton 2006:3). Work can be completed by any institution. For example, the elderly can be taken care of by the state through a government pension, the market by private pensions, the family by children looking after aged parents, or through what Bezanson and Luxton (2006) call “the third sector,” charity programs such as Meals on Wheels.

Who is seen as responsible for and who does the work of social reproduction varies culturally but tends to fall most heavily on women (ibid: 3-4). The work that mothers do for their children lays the foundation for social reproduction (Fox 2006: 231). In addition, when the state, market, and third sector

fail to assist with reproductive tasks, these are left to families or what is considered the sphere of women in most societies (Luxton 2006: 11-44). In capitalist nations, family labor rarely counts in terms of payment or profit, so when other institutions do not help, women's work is used to make up the difference (Caffentzis 1999: 175-176).

Class and the Social Reproduction of Health

Social reproduction considers how societies reproduce and how groups within them, usually social classes, work to continue the social structures and patterns that give them advantage from one generation to the next (Bourdieu 1977; Bourdieu and Passeron 1977; Meillassoux 1981; Foster 1995; Katz 2001). The social reproduction of health combines this with analysis of how structures perpetuate conditions of health and ill-health among different members of society. It looks at how health-related resources are made available through relationships, institutions, and support organizations and how this affects health directly and indirectly (Janzen 1992: 173, 154; Feierman & Janzen 1992; Janzen 2001). The social reproduction of health begins with the premise that health and ill health do not just happen but are produced socially because good health requires that people have access to adequate food, clean water, and appropriate housing. At any given time there are individuals within a society, such as infants, who require care from others for their and for society's survival. Productive members of society must make enough for themselves and for those who need assistance. In addition, there have to be structures of customs and relationships in place to distribute excess resources (Janzen 1992).

Quality of life for the average person has not declined just in the US over the past 30 years. It has also diminished in other countries. Many academics trace this reduction in standard of living to globalization and the rise of a certain kind of capitalism that favors the rights of corporations over the rights of individuals and societies (see: Bezanson and Luxton 2006; Aronowitz 2003; Gilbert 2008 and 2010; Bodley 2005; and Perrucci and Wysong 2008; Katz 2001). As quality of life deteriorates, class issues become more salient and things once taken for granted, such as access to clean drinking water, are lost. Market-driven forces attempt to redefine the relationship between the state and society to increase corporate profits. As they do this, they un stitch the very social fabric that makes up this social system.

Nowhere is this destruction more evident than in the US health care system (Rylko-Bauer and Farmer 2002).

Health insurance originated when groups of working people began to create small pools of resources so that if one among them became ill or was hurt their expenses would be covered (Stone 1993, 2008). This idea offers a perfect example of the economic side of the social reproduction of health when it works well because the underlying premise behind health insurance is that there is a need for mutual aid and that resources should be taken from the healthy and redistributed to the ill to increase the likelihood of recovery. Health insurance can mitigate misfortune for the individual by sharing it with other members of a community and is thus a solidifying force. Because who is allowed to participate in it defines community boundaries, it is also inherently political (Stone 1993: 289).

Save the US, all developed nations as well as many developing ones use funds from taxes to provide health insurance for all of their citizens. While health care systems in these countries vary, all share the same basic set of unifying goals that include (1) adequacy and equity in access to care for all citizens; (2) protection of all citizens income during times of health crisis; (3) citizens ability to have some choice in care; (4) provider ability to determine treatment without government interference; and (5) payment of all or most inpatient cost (Freeman 2000; Saltman 2004). Countries have differing levels of success for each ideal and variations in health indicators shows that there is no perfect system. Instead, each system reflects the core values that its society uses to define itself and is integrated into, as well as a reflection of, its culture (Saltman 1997, 2004; Stone 2008: 653). Becker (2007) made the point that in many of these countries non-citizens, which are immigrants and others seen as socially unacceptable, are excluded from care. The US excludes not only non-citizens but many of its citizens as well.

Although the administration of health insurance generally reflects society's core values and culture, America's system is a free market one that developed haphazardly over many years. During World War II, companies unable to raise worker pay offered health benefits as an incentive to retain or attract employees. After the war, programs continued administered by the then not-for-profit Blue Cross and Blue Shield. Through the 1970s, each employer that offered benefits received a single community

rating, and everyone in that employer group paid the same monthly premium to buy into their company's plan (Stone 2008: 653-654). In the late 1970s, rising health care costs combined with political change to create for-profit insurance and an actuarial system that determines policy cost based on health risk (ibid.).

With the exception of Medicare and Medicaid, the US health care system is not rooted in social solidarity but in profit motivation with the idea that each person deserves only what care they can afford. For most, the cost of care means that affordability is based on the cost of health insurance. Employer plans often provide more benefits for less cost than individual ones but, for both types of coverage, a person is supposed to choose what services to pay for, usually combined into packages, and these services are the only things the plan covers (Stone 2008: 653). This makes health insurance in the US a gamble for customers and providers, but insurance companies make sure the odds are in their favor.

Insurance companies use complex actuarial algorithms to determine what they are likely to have to pay for each customer's future care and then charge that customer accordingly. For individual plans, companies look at the probability that a person will have an accident or develop a disease based on factors such as age, sex, and previous health history. Companies then base the cost of the packages offered to each individual on that person's risk of needing care. Those who are already sick or who have what a company identifies as the precursor of a disease are either charged high amounts, told their policies will not cover particular kinds of care, or are deemed uninsurable entirely and refused access (Stone 2008: 654). Insurers use similar methods for employer-based group plans but attempt to assess the potential cost of the group as a whole. Businesses with many employees can negotiate lower rates because they have a bigger pool of people to offset the cost of those who will need care. Smaller groups have a more difficult time and, in some cases, one person with a poor health history can make insurance unaffordable for an entire group (Stone 1993).

Perverse incentives are free market incentives with unintended and undesirable consequences. Perverse incentives riddle US health insurance. Companies are known to emphasize cost containment over service because they are best able to increase their profit when they: (1) shift health care costs onto patients; (2) limit the health care services that are provided; (3) limit payments to health care providers;

(4) only allow people with limited health care needs to participate (Kuttner 2008: 549). Insurance companies charge customers a premium or monthly fee to provide services, which is how they make a profit, but they use additional charges to either keep people from using the services or so that the customer and not the insurance provider have to pay for them. Additional charges are known as cost-sharing and include: (1) Deductibles or the initial amount insurers are exempt from when people seek care; (2) copayments or the standard fee that is paid for a provider visit; and (3) coinsurance or the percent of the total bill an insured person pays regardless of other fees.

The insurance industry defends cost sharing as a way to stop the overuse of health care services, which the industry says is supported with results from the RAND Health Insurance Experiment (HIE), a study conducted from 1971 to 1982. The HIE was instrumental in the formation of the current health insurance system. For it, RAND studied more than 7,700 people under sixty-five years of age in six US cities. Those who participated were in the study for three to five years and were randomly assigned to groups that either received free care or care that required incremental levels of cost-sharing (up to 95 percent). While some researchers used data to conclude that increased cost-sharing resulted in less care utilization without serious health consequence (Manning et al. 1987), others pointed out that decreases in care included necessary and preventive treatments and disproportionately affected the poor (Chernew and Newhouse 2008: 412). For the poorest participants, free care also resulted in improved control of hypertension, better vision, increased receipt of dental care, a reduction in serious symptoms, and less overall stress about health. Increased cost-sharing also failed to improve participant health behavior (RAND 2006: on-line).

Today even RAND questions HIE findings. The benefits of cost-sharing are no longer valid due to changes in the system such as an increased use of managed care, increased use of pharmaceuticals, and greater emphasis on preventive care. RAND acknowledges that the high cost of the system is primarily driven by the use of new technologies once care is sought. The original study found that no money was saved once people actually went to the doctor (RAND 2009: on-line). Care for chronic conditions such as diabetes is also much better now than when the HIE was conducted and likely results in improved health

outcomes and lower costs for those with consistent care (Chernew and Newhouse 2008: 413). Later RAND studies have found that money is saved and health improved when copayments are reduced (Goldman, Joyc, and Karaca-Mandic 2006).

Cost-sharing benefits insurance companies because it ensures that the poorest and sickest do not use medical services. Several studies indicate high co-pays and deductibles lead people to avoid or delay care and reduce or eliminate prescribed medications (Stone 2008: 655-656; Hall and Moore 2008; Committee on Consequences of Uninsurance 2002; Fontstin and Collins 2006; Goldman, Joyc, and Zng 2007), which can have serious consequences and lead to the need for greater medical intervention (Goldman, Joyc, and Zng 2007: 64-65). Data also indicate that high cost-sharing reduces the use of preventive screenings for conditions where the time of diagnosis can affect the extent of needed medical services and a person's final health outcome (Trivedi, Rakowski, and Ayanian 2008).

For insurance companies, the point of cost-sharing is not just to push costs onto customers but to limit provided services. Because high cost-sharing results in increased medical expense later on, it may appear counterintuitive that companies support it. After all, they should bear the brunt of later, greater costs as well. This is not the case. Individuals in this system, specifically those at the bottom, change insurance providers or intermittently lose their insurance (Madrian 2005: 25; Cebul et al. 2008: 95). Medicare for those over sixty-five means people also age out of this system (Cebul et al. 2008: 94). The frequency with which people change their health insurance provider increases provider's incentive to reduce care and limit reimbursement for preventive/diagnostic services as well as disease management (Cebul et al. 2008: 94; Herring 2009: on-line). Within the insurance industry, providing such care to a customer who will not be a customer in the future is likened to providing that person's future insurance company a "free ride" using free market logic (Herring 2009: on-line). As is predicted from such logic, there is an observed increase in cost-sharing for industries with greater employee turnover. These employees received less preventive care and, in retirement, have higher overall medical expenses (Fang and Gavazza 2007).

To limit customer use of services and how much they have to pay for them, insurance companies also sometimes place riders on plans that stipulate how much a person can spend for care over their lifetime as well as within a specified time frame. Limits are often not only for total care but also for specific services such as prescriptions. Limits affect people with chronic conditions the most. They are also socially detrimental because persons with chronic illnesses spend about 75 percent of the money spent on care, an amount that can be reduced with proper health maintenance (Thorpe 2006). Consider that caps on prescription drug benefits for such persons result in increased visits to the emergency room, hospitalizations, and make people with chronic conditions less likely to have control over key health determinants such as blood pressure (Hsu et al. 2006: 2349).

Insurers also limit or refuse services to persons with preexisting conditions. Such a condition can be something someone is born with, such as cystic fibrosis, something the person develops over time, such as cardiovascular disease, or an injury or disease exposure such as paralysis or HIV infection. Coverage of such conditions varies under plans, but federal and state laws prohibit exclusion of care for pre-existing conditions under group or employer provided plans completely. Most group plans have state regulated time limits that allow insurers to refuse care for a certain period (three to twelve months in Kansas and three to eighteen months in Missouri) unless the person has continuous coverage without a break of more than sixty-three days. If they have coverage and no break, the company has to credit the amount of time they were in their previous plan toward the exclusionary period. For example, if a person was enrolled in a plan for six months, lost her job for forty-five days, and then found a job with another plan that had an exclusionary period of nine months, the person should receive coverage for preexisting conditions after three months.

Persons with preexisting conditions who are left to the individual market have a much harder time. Many are denied coverage, while others pay exorbitant premiums for policies with high deductibles and copayments. Various states have different programs for those considered uninsurable due to preexisting conditions. These most often come in the form of state high-risk-pools. These exist in thirty-four states and are federally subsidized programs designed to cover the sickest of the sick. They are

expensive. The Commonwealth Fund reports that in 2003, the average per capita cost to maintain a pool was more than \$7,500, only about half of which was covered by premiums. Most states assess state insurance companies to cover their losses. They also charge between 125 and 200 percent of normal individual premiums, charge high deductible or coinsurance, and limit coverage for services like prescription drugs and maternity care. Due to their expense, enrollment in pools is small (Pollitz and Bangit 2005: 2).

Many people who are enrolled in pools pay so much for limited services because they are afraid of being uninsured (Hall, Carroll, and Moore 2010). It is well documented that the uninsured, around 50 million in 2008, have a difficult time accessing care, suffer poorer health outcomes than the insured especially if chronically ill, and are often plagued by medical debt (American College of Physicians 2008: 55; Schoen et al. 2008: on-line; Broyles, Narine, and Brandt 2002: 95; Collins et al. 2006: ix, 3). Most were also insured at one time and thus paid into this system. Many will also be insured again. A study of persons under sixty-five years old, conducted from the beginning of 1996 to the end of 1999, found that of the 84.8 million people who went without insurance for some period in that time, only 10.1 million were uninsured for the entire four years (Short and Gaefe 2003:247). Although those without coverage were likely to find it again, the pattern was revealing. Individuals with incomes below 200 percent of the federal poverty level were more likely to be uninsured or to experience repeated gaps in their coverage than individuals with higher incomes. Persons aged fifty-five to sixty-four were most likely to remain uninsured for the entire period. The poor were also more likely to buy insurance and lose coverage before it paid out (ibid: 248).

Shifting Resources

After adjusting for taxes and inflation, over the past 30 years health insurance premiums increased around 300 percent and corporate profits around 200 percent, while the average worker's wages decreased 4 percent (Emanuel and Fuchs 2008: 1057-1058). There was a cost-to-wage tradeoff, with increased prices for health insurance policies being passed on to employees through lower incomes (Eberts and Stone 1985; Sheiner 1999; Royalty 2003; Madrian 2006; Gruber 1994). In addition, the

number of workers covered by private-sector employer based health care plans where employers paid at least a part of their worker's health insurance costs declined from 69 percent in 1979 to 56 percent in 2004. The percentage of employer plans that paid all of their employee's health insurance costs also decreased by 50 percent from 1980 to 2004. At the same time, the proportion of premiums paid by workers with employer-based coverage increased. In 2006 dollars the average employee paid \$155 per month for family coverage in 1996. In 2006 the same employee paid \$226 for the same coverage (Perrucci and Wysong 2008: 60).

Health insurance premiums increased for several reasons. Principal among these was an ever increasing cost of care. The US health care system is grossly inefficient and costs more per capita than any other system in the industrialized world, even though it has the worst health outcomes (American College of Physicians 2008: 63). In 2007 the US spent \$2.26 trillion, or \$7,439 for each person, on care. This was just over 16 percent of the nation's gross domestic product (GDP). The share of the GDP spent on care rose faster than any other sector of the economy and was expected to continue to rise. Without reform, by 2017 the proportion of the GDP spent on care was predicted to be 19.5 percent, or \$4.3 trillion (CMS 2007: on-line). In 2009, one country spent more of its GDP on health care, the military dictatorship of East Timor (WHO 2009: on-line).

The differentiation in cost between the US health care system and other systems is that the US system has to generate profits across multiple industries. Profit is the key driver in rising health care costs (Kuttner 2008: 549). Among insurers, this is demonstrated by a reduction in what are known as medical-loss-ratios or, more benignly, as benefit-loss-ratios. Medical-loss-ratios (MLR) are the percentage of each premium dollar that an insurance company pays toward a medical claim. Money spent on claims is defined as a loss because it reduces profits. Higher ratios mean a better product for customers, while lower ratios are better for insurance company investors (Rockefeller 2009: 1-3).

MLRs show how social class is deeply ingrained into the structure of the US health care system. Insurers have different MLRs for different types of policies, what they called segment-specific products, and work to keep information about these proprietary. An investigation by the Senate Finance Committee

found that ratios for group policies were higher than those for individual ones, as were the ratios for not-for-profit insurers, when compared to for-profit providers and the ratios for large groups when compared to small ones (Rockefeller 2009: 2).

Individual policies are what Senator J. Rockefeller called the mobile homes of the health insurance market and are generally considered the worst products available (Hall 2000: 173). They are usually sold to individuals who are excluded from group plans because they are either unemployed, self-employed, or have jobs that do not provide them with benefits. During the research, individual insurance policies are the least regulated of all market segments and are controlled primarily by state, not federal, mandates. In 2000 individual insurance loss ratios were in the sixty to mid-seventies. People with these policies also do not receive the same federal tax breaks on premiums that people with group plans receive, although they do receive a smaller deduction (ibid: 175). In most states, individual market insurers can refuse to cover someone deemed too sick or can limit coverage to exclude their preexisting conditions.

Small group plans are the condominiums of the insurance market and are better than individual policies but are still more expensive and less inclusive than larger group plans. Small group plans are offered by companies with fewer than fifty employees. Small group plans are like individual plans in that they are primarily state regulated, although regulations are augmented by the federal Health Insurance Portability and Accountability Act (HIPAA), and there is increasing uniformity across state-level mandates. Insurers are not allowed to deny coverage altogether but can limit plans to avoid certain ailments. Like those left to the individual market, companies that use small group insurance have limited choices in terms of plans, but the money employees pay in premiums is not subject to income tax. MLRs for these plans were 75 to 85 percent in 2000 (ibid: 175).

Large group plans are the single family homes of the insurance market. These plans cover people employed at companies with more than fifty workers. Large group plans account for over two-thirds of the insurance market, so these are what most Americans think of when they talk about health insurance. The regulation of large group plans depends on whether they are self-insured. Self-insured companies collect premiums and pay employees claims, usually through a third-party administrator. Because they

bear most of the financial risk, self-insured companies are able to avoid many state and federal regulations. Insurance subscribers are able to choose from a large number of options and premiums are not subject to state or federal income tax. In 2000 these plans had loss ratios in the upper eighties and low nineties (Hall 2000: 173-174).

When this metaphor was created, individual policies were seen as the worst products on the mass market. Over the past decade, large insurance companies began to purchase smaller ones and sell their products to a larger customer base, which led to the wide-scale use of limited-benefit plans. Following this metaphor, limited-benefit plans are the travel trailers of the insurance market. These policies are sold to low-skill, transitory workers and use such strict criteria for medical reimbursement that they almost never pay claims. Insurance providers also bank on the likelihood that people who have them cannot maintain them long enough to reap any benefits. Limited-benefit plans bring in huge profits (Potter 2009: 8). While testifying before Congress, former insurance industry executive Wendell Potter explained how these plans worked,

Preexisting conditions are not covered during the first six months, and the employer must have an annual employee turnover rate of 70 percent or more, so most of the workers don't even stay on the payroll long enough to use their benefits. The average age of employees must not be higher than forty, and no more than 65 percent of the workforce can be female. Employers don't pay any of the premiums—the employees pay for everything. As Consumer Reports noted in May, many people who buy limited-benefit policies, which often provide little or no hospitalization, are misled by marketing materials and think they are buying more comprehensive care. In many cases it is not until they actually try to use the policies that they find out they will get little help from the insurer in paying the bills.

The worse a health insurance segment is for its customers, the lower its corresponding MLR and the more that it collects in premiums without social redistribution through claims. While individual, small group, and limited-benefits plans have higher overhead than large-group plans, many of the expenses that are associated with worse plans come from insurance company attempts to avoid claims such as the increased need for underwriting in the individual market (Rockefeller 2009: 10-11). Bad plans cost people more and are a worse value, but they are all that is available to many of America's poor. From 2000 on, insurers lowered loss-ratios across all market segments, causing bad benefits to trickle up.

Profits over People

Only thirty-two states require insurers report MLR information for at least one of their products. Only some of these states set standards for medical loss and, among those that do, ratios are often allowed to fall as low as 60 percent (Rockefeller 2009; Families USA 2008). In states that set standards, insurers also fall below them sometimes, which indicates that further regulation is warranted (Rockefeller 2009: 3). Reported ratios are rarely for specific plans and, unless required by state law, providers refuse to tell customers how much of their premiums are paid in claims. When the Texas legislature required its insurers to disclose individual policy ratios upon request, one Houston firm found that in 2005 its provider paid only 9 percent of the money it collected in their premiums for their claims. In 2006 the same insurance provider demanded the company pay an additional 22 percent in premiums (Potter 2009: 6).

Insurance providers try to avoid disclosure of medical loss data to policy makers and consumers. However, investors require it. It allows them to predict how much money an investment might generate. Investor's best values are companies with the lowest ratios (Zucchi 2009: on-line). During the 2008-2010 health care reform debates, MLRs gained prominence among policy makers. America's Health Insurance Plans (AHIP), an insurance industry lobbyist, responded by saying that insurers tried to keep ratios high to benefit consumers. AHIP cited figures from a 2008 study they commissioned that showed the average proportion of premiums spent on claims was 87 percent. The study also showed that around 13 percent was spent on administration (Pricewater-houseCoopers 2008:12). This implied companies made little or no profits.

Security and Exchange Commission (SEC) filings revealed that among the six largest insurers, none had ratios as high as 87 percent. Instead their ratios were in the low eighties. Because of the large sums generated by premiums, the discrepancy between the AHIP's cited 87 percent and real ratios was billions of dollars (Rockefeller 2009: 7). An independent study by the same firm hired by AHIP, published the year before their commissioned study, found that most insurance company's medical loss ratios were in the low eighties and that they declined steadily from the 90-95 percent range over fifteen

years (Pricewaterhouse-Coopers 2007: 42). In his 2009 congressional testimony Potter explained why he believed ratios continued to decrease,

The top priority of for-profit companies is to drive up the value of their stock. Stocks fluctuate based on companies' quarterly reports, which are discussed every three months in conference calls with investors and analysts. On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical-loss ratio, or medical-benefit ratio, as the industry now terms it. That is the ratio between what the company actually pays out in claims and what it has left over to cover sales, marketing, underwriting and other administrative expenses and, of course, profits. To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9 to 79.4 percent a year later (3-4) [*sic*].

The money generated by premiums also flows into the bank accounts of top insurance industry executives. In 2008 Forbes reported that the top executives of America's largest insurers had annual compensation packages well into the millions (Forbes 2009a, 2009b, 2009c). In 2002 it would have cost the American people \$33.9 billion to provide people without health insurance with it. Instead, insured Americans transferred an unknown amount directly from their own pockets into the pockets of for-profit insurance companies and then paid an additional \$65 billion to \$130 billion in lost productivity for people who could not access care and \$100 billion in tax breaks to subsidize employers who offered some of their worker's some kind of health insurance (Sered and Fernandopulle 2007: 192).

Health insurance companies also influence how health care is administered. While some insurers reward physicians for following standard medical protocols and offering preventive screenings or counseling patients to change unhealthy habits, this is not the norm. Instead, insurers emphasize cost containment and shift costs to physicians and hospitals. The amount insurance companies agree to pay care providers is repeatedly negotiated and renegotiated. When physicians receive less compensation per patient, many attempt to offset lost income by reducing the amount of time they spend with patients and

increasing their daily patient load. Less time leads to more mistakes, a larger number of diagnostic tests, and an increase in the number of unnecessary referrals to specialists made just to get patients out of the office (Kuttner 2008: 550). In addition, some physicians are beginning to offer “boutique medicine,” where people pay higher fees from their own pocket to receive better care (ibid: 551). Hospitals try to make up losses from departments with the lowest reimbursement rates, like emergency rooms, by investing most of their assets into the facilities for more lucrative procedures, like cardiology programs (ibid: 550).

Social Burden

Americans believe that employers, the government, and individuals all contribute equally to the costs of health care, what Emanuel and Fuchs (2008) have identified as the myth of shared responsibility. Americans do not see that the money spent actually comes entirely from them. As discussed above, workers pay for insurance in the form of lost wages in the cost-to-wage tradeoff. Because government sponsored care is funded by tax dollars, Americans also pay what the government pays whether in the form of higher taxes or through a reduction in other social programs. Just as there is a cost-to-wage tradeoff, there is a cost-to-public service trade off (Emmanuel and Fuchs 2008: 1057).

Shared responsibility is a popular phrase. Politicians, employers, and union leaders like this phrase because it implies that they give people care through government programs, employment perks, or won concessions (Emmanuel and Fuchs 2008: 1057). The myth is problematic because people who think they receive care through their employer do not want to give up this imagined benefit and thus refuse to change the system. This myth also hides the effect of health care inflation. “The myth of shared responsibility perpetuates the belief that workers are getting something while paying little or nothing. This undercut the public’s willingness to tax itself for the benefits it wants” (Emmanuel and Fuchs 2008: 1057).

In 2006, 32 percent of state budgets were spent on health care. Medicaid alone accounted for 22 percent (Emmanuel and Fuchs 2008: 1058). In 2009, after the onset of the economic crisis, Medicaid spending remained at 21 percent even with a 15.9 percent increase in federal contributions and several

cuts in services (National Governor's Association and National Association of State Budget Officers 2009: 11-13). Before the crisis, the money spent on Medicaid and other health care expenses increased dramatically, outstripping the amount of revenue states earned in taxes. While some states raised taxes to make up the difference, most cut services. Many changed Medicaid eligibility requirements or reduced provider reimbursement amounts, but states also cut other programs. A Rockefeller Institute of Government study found that the most common place for states to cut was financing for public institutions of higher education (Emmanuel and Fuchs 2008: 1058; Fossett and Burke 2004). Such cuts led to higher tuition and made it harder for poor students to attend college.

Everyone pays for insurance company profits, whether through their premiums, taxes, or lost social programs. They also pay because the fragmented system allows care to cost more in the US. For example, in 2003 the US spent more on medication per capita than any other nation (\$728 per person). In relation to total health expenditure US drug spending was below average, 12.9 percent vs. 17.7 percent (OECD 2005: on-line). Americans did not use more or better drugs. They just paid more for the drugs they used (Niebyl 2007).

As discussed above, the insurance industry works hard to collect premiums and avoid paying for care. It spends billions of dollars on a bureaucratic behemoth that was designed to limit patient services, control provider payments, practice risk selection, and shift costs to consumers (Kuttner 2008: 549). However, the waste within the industry was only a small part of the waste in the system. Excluding how much was paid by insurers, Americans spent \$293.4 billion, or \$1,059 dollars per person, on medical administration in 1999. This was \$752 more per person than Canadians paid. Because providers have to deal with multiple insurers and their products, each provider has to determine a person's eligibility for care and then the rate of reimbursement for that person based on the person's policy (Woolhandler et al. 2003: 768, 772-773). Additional costs include negotiation and mediation between insurers and providers, claim submissions, and claims tracking.

Eventually everyone also pays for the deteriorated health of those who cannot access adequate care. People over the age of sixty-five or who successfully apply for federal disability benefits receive

Medicare, which is a form of social insurance paid for with tax dollars. McWilliams et al. (2007) found that when the previously uninsured go on Medicare they spent significantly more than their previously insured counterparts. Just as medical loss ratios reflect there is better insurance among the higher classes, different rates of disability suggest there is widespread differentiation in care based on class. Minkler, Fuller-Thompson, and Guralnik 2006 found that as incomes declined among people over age fifty-five the likelihood they would have a physical problem that limited ability to function increased.

In their ethnography of the American uninsured, Sered and Fernandopulle (2006) identified a death spiral where those of lower socioeconomic status were left without care, allowed to become ill, and to have their health deteriorate to such an extent that they died, often in the emergency room, at far greater expense than if they were simply provided adequate care from the beginning. Their unpaid hospital bills, which were much higher than the bills of the insured because the uninsured were unable to negotiate rates like insurance companies, became tax write-offs for hospitals (Walsh 2004: 201-203). The US provided the uninsured with a lot of money for care but did it in a very inefficient way (Sered and Fernandopulle 2006: 192).

Class and Health

It is difficult to track how increasing inequality affects health in the US because unlike other Western nations the US does not routinely report health related statistics based on wealth (Bravemen et al. 2010: s186). Instead, researchers use race or ethnicity as their primary indicator of social position (Schroeder 2007: 1225). This is partially due to real differences in disease rates between whites and other racial or ethnic groups but is also because data on race are more readily available than data on class (Jemal et al. 2008: 5).

The lack of class based statistics is unfortunate. Race and ethnicity are important determinants of health (Smedley, Stith, and Nelson 2003: 123), but discrimination is a class issue (Aronowitz 2003: 40). In hierarchical societies, complex social divisions that operate outside the class system, referred to as status earlier, are mechanisms of social control. Racism, sexism, and the like keep the lower classes apart, so they do not realize they share common problems caused by the same institutions and structures.

To successfully challenge repression, such constructed divisions are the hardest thing to overcome (Gramsci [1971] 1999: 423-427). Consider as an example a recent study by Jemal et al. (2008) that looked at differences in US life expectancy based on race, ethnicity, sex, and education. The study found that in the year 2001 nearly half (44 percent) of the deaths among people aged twenty-five to sixty-four would not have occurred if all of the segments of the population had the same mortality rate as college graduates. Black Americans had the highest mortality rate and number of years lost, but disparity was found for all groups. The number of avoidable deaths was four times higher in white Americans than it was in black Americans (161,000 vs. 41,000 respectively) and was attributable to the larger population of whites at every education level (ibid: 5). Consistent data on class and health would be a powerful tool to assess the overall health effects of rising wealth disparity.

Researchers generally agree that the best way to improve health is to alter individual behavior, as was successfully demonstrated by campaigns to reduce cigarette smoking (from 57 percent in 1955 to 23 percent in 2005) (Schroeder 2007: 1221-1222). However, changing behavior is difficult because behavior interacts with other factors, such as a person's environment. People who are in the lower classes are more likely to engage in unhealthy behaviors than people above them on the social spectrum. Poor people engage in unhealthy behaviors more for multiple reasons, among them are higher rates of psychosocial stress and an inability to physically access the resources needed to engage in healthier behaviors.

Class, Risk, and Health Behavior

A lifestyle not conducive to good health often represents the structural constraints put on people in their daily lives (Nguyen and Peschard 2003: 458). This is because what health researchers call lifestyle is part of what Bourdieu called *habitus* or the habitual, unconscious practices people need and use to survive in their daily lives (Bourdieu 1990a: 11). In terms of behaviors related to health like diet and exercise, people like what they can access. Taste is about availability, or in the words of Bourdieu, "virtue made out of necessity which continuously transforms necessity into virtue by inducing 'choices' which correspond to the condition of which it is a product" (Bourdieu 1984: 175). Lifestyle is a convergence of the kinds of capital discussed above, which make these kinds of capital not only

dependent on but also representational of a person's social position. Taste, lifestyle and associated body types are symbolic signs of social position and status (Bourdieu and Wacquant 1996: 104-105; Bourdieu 1990a: 112; Jenkins 1992: 141-142).

Unhealthy behaviors are identified as risks in the US, but risk is a cultural construct. People see risk as natural or existing outside of culture because this concept is so deeply ingrained into how people understand the world. It is a way of explaining and, as such, is seen as common sense (Douglas 1997: 123). Within social reproduction, common sense structures are identified as political-economic controls so deeply embedded in the social universe that they are beyond question. Their taken-for-granted acceptance helps maintain the status quo across generations (Bourdieu 1977). The things that are identified as risks are socially selected based on how dangers affect valued cultural institutions (Douglas 1992: 29). People's perceptions of risk constitute such a structure, which reproduces social patterns because they constrain or bound behavior (Douglas 1990: 7). Medical descriptions of disease risk deny social responsibility in disease manifestation and replace features of social identity with risk markers that blame individuals for their poor health (Sobo 1995: 13-14). In this way, risk defines normal, pressures people to conform, and forces them to act as self-regulating agents in such a way that current social use of risk is comparable to past social use of sin (Douglas 1999: 284-309; 1992: 29; 1990: 7; Cartwright and Thomas 2001: 219). This turns disease burden into an individual characteristic and makes the unequal allocation of health resources morally acceptable (Fassin 2007). Risk is thus tied directly to the moral economy and is not only about the production of health but also the production of indifference (Fassin 2005: 365-366).

Much of the anthropological work on risk was written by Mary Douglas (Althaus 2005: 574) who began work on this subject more than five decades ago with the seminal text *Purity and Danger* (1966). In this book, Douglas considered the symbolic aspects of things socially seen as polluting and found it was the things that did not fit how a society understood the world that were seen as dangerous. Once such a thing is identified, it is labeled with a concept like sin or taboo and is made acceptable through rituals, which contain the disorder and strengthen social ties through shared experience. Concepts of pollution

act as social glue and protect societies from behaviors that could undermine their stability. They reinforce society's rules, help maintain its moral values, and legitimate those in power. Douglas suggested studies of contagions also reflected on larger societal fears because the human body acts as a conceptual model for the social body. *Purity and Danger* did not address risk specifically, but it was crucial to Douglas's later work because risk is the way Western societies identify and label things they saw as polluting.

Douglas wrote *Risk and Culture* (1983) with political scientist Aaron Wildavsky to consider the cultural use of environmental risk in the US. Because ideas about risk were pluralistic, Douglas analyzed how different social archetypes (i.e., hierarchical, individualist, and sectarian) thought about risk. She used Grid/Group, a type of analysis she developed in her earlier works on pollution and purity, to focus on two spheres that expressed how people related to society and how that affected their beliefs about risk. Grid considered who people interacted with and the strength of their allegiances. Group looked at how they interacted and how much influence the group had over its members. This type of analysis worked for populations but not for individuals, who tended to fall into different categories depending on the type of risk considered. For example, an auto worker may consider job risks from a hierarchical standpoint, smoking risk from an individualist standpoint, and the power plant near his home from a sectarian standpoint (Tansey and O'Riordan 1999: 78-79).

Douglas published *Risk and Blame* in 1992. This book began with the premise that in societies where even the most mundane choices can lead to disaster, it is inevitable that dangers become moral and then political, as people seek to assign blame when bad things happen. In this book, the presentation of risk differed from Douglas's earlier work because she said that while risk was similar in concept to sin and taboo, it was more their "reciprocal" than a reflective image of them. This is because sin and taboo are about protecting communities, while risk is about protecting the community and the individual (ibid: 28). Douglas thus acknowledged an individual aspect to the risk concept but failed to address risk as an individualizing construct. Her focus on individual risk was primarily about the use of risk to challenge authority, which meant she did not recognize that what makes risk an effective tool for individual protection also makes it an effective tool for individual control (Althaus 2005: 574; Douglas 1992).

Douglas's analysis of risk was missing the incorporation of class analysis or social reproduction and an understanding of how cultural constructs like risk were used, however unintentionally, to allocate and maintain power by some members of society over others. Class, gender, and status affect one's ability to identify and manage risks (Tulloch and Lupton 1997: 6). "Risk is the primary mechanism through which social inequality is embodied and is visible in different prevalences of diseases and outcomes between different social groups" (Nguyen and Pescahard 2003: 458).

The position risk has in US society means that risk messages are individually and institutionally incorporated but not necessarily in the way that public health workers intend. Rayna Rapp (1998) demonstrated how human logic deviated from scientific ideas of the rational and people reacted to risk messages in unexpected ways. Studies also show that statistical calculations alter existing ideas so something once understood becomes new and hard to grasp (Fassin 2004: 172). Humans use cultural information and their past experiences to try to understand danger and predict future outcomes (Douglas 1992: 56-59). They look at an array of related or corresponding risks, weighing possible results against one another to make decisions based on their interpretation of those prospective outcomes (ibid: 31). Sometimes it is the very transformation of something into a risk that makes it desirable. People engage in risk behaviors because they are a kind of performance that reaffirms an aspect of personality (Leonard, Green, Erbeling 2007: 160).

In 2008 CVD was the leading cause of death and a major cause of physical disability in the US (Rosamond 2007). CVD includes several related conditions that affect the circulatory system; primary among these are heart disease and stroke. There are several known risks for CVD. Because of population-level prevention efforts, the best known are behavioral factors that include things such as eating fatty or high cholesterol foods, being overweight or obese, being sedentary, and using tobacco products (Milner 1998: 24). In the social construction of CVD risk, people are presented as independent, self-regulating agents who should shoulder the blame for their own poor health (Cartwright and Thomas 2001). Public health campaigns almost exclusively target behaviors, but people who experience CVD do not always engage in these behaviors (Milner 1998: 24). Medical researchers agree that psychosocial

stress is likely as important to disease development as behavioral risks, but the complexity of the CVD/stress relationship makes this risk difficult to quantify (AHA 2005). Several interrelated, individually variable factors such as the types of stress a person is exposed to and how that person reacts to stress are implicated in the likelihood a person will develop this disease (Milner 1998: 24, Steptoe and Marmot 2004, James and Brown 1997).

The association between stress and CVD is often made based on higher rates of this disease among people of lower socioeconomic status. Low social status is known to increase the amount of time needed to physically recover from stressful situations. In addition, the body's ability to break down catecholamines, which increase heart rate, blood pressure, and alter blood chemistry, is associated with several factors affected by lower status, such as increased disease load and poor nutrition (Steptoe and Marmot 2004). The association between stress and CVD is also structural, related to the ability of people of lower socioeconomic status to access health-related resources (Steptoe and Marmot 2004). Obesity, which is considered highly indicative of the likelihood someone would develop CVD, is also strongly associated with socioeconomic position. The same calorie dense foods that put people at higher risk for CVD cause obesity (Drewnowski and Specter 2004).

Obesity is caused by a number of interrelated behavioral, genetic, and environmental factors. At its most basic it is the result of an energy imbalance: a person consumes more calories than they use (CDC 2010b). A person is obese if that person has greater body weight than is healthy for their height caused by an excess of adipose tissue, which is better known as fat (CDC 2010b). Obesity is epidemic in the US, affecting more than one third of the adult population. Besides CVD, obesity is also linked to several chronic health conditions, such as type II diabetes, chronic musculoskeletal problems, infertility, large-bowel cancers, gallbladder disease, and complications in pregnancy (WIN 2006). Because overweight and obesity are most often caused by eating an excess of calorie dense, low-nutrient foods, people who are obese are sometimes simultaneously deficient in important nutrients like iron and calcium (IOM 2004).

Obesity as a Class Issue

Obesity is an economic issue. The US has an overly abundant food supply, enough to feed each citizen twice the amount of calories he or she needs to survive each day. To make money with all of this available food, the companies that produce, process, manufacture, sell or serve food, have to convince people to eat more than they need. Individual companies also need to convince people to eat primarily their food, which they do through large scale marketing campaigns that say their foods taste better and are healthier than their competitors' products (Nestle 2007: 11, 1). The result is that Americans eat more. Beginning in the 1970s, consumption of all food types increased, and, by the end of the 20th century, the food industry generated more than \$1 trillion in sales each year, which was 8 percent of the nation's GDP (ibid: 11; French, Story, and Jeffrey 2001). This increase was true of healthful and unhealthful foods but was most pronounced among foods that were high in fat, sugar, and salt or the foods most likely to increase the development of CVD. Foods with these ingredients are also the foods that are the most profitable for the food industry (Nestle 2007: 9-10).

These calorie-dense foods are more profitable because they are less expensive to produce. Sometimes the expense is even offset through government subsidies. Calorie dense, processed foods are easier to store and ship than healthier alternatives. Corporations can also charge more for them because of the value added through the processing procedures. Corporations make more proportionally from these foods than they do from healthier alternatives (Drewnowski and Darmon 2005; Drewnowski and Spector 2004; Nestle 2007: 18-19). Not surprisingly, modified foods are the foods marketed most heavily (French, Story, and Jeffrey 2001: 316).

People in the US are weary of discussing the role the food industry plays in poor health. Politicians and public health agencies are afraid to anger corporate donors, while members of the general public do not want to believe they are manipulated by advertising. Members of the public prefer to think they choose what they eat based on taste, convenience, and cost (Nestle 2007: 2). How people decide what they like is much more complex, based on these things as well as on what they grew up eating, what

they know how to prepare, and what is available for them to select from their grocer. Food tastes reveal other cultural categories, and in the US are rooted in class hierarchies (Douglas 1984: 4-6, 30, 8-9).

Obesity and the consumption of high-calorie, low-nutrient foods are strongly associated with poverty (Sheldon et al. 2010; Drewnowski and Spector 2004). People who live in impoverished areas have less access to grocery stores and are often forced to purchase foods either from convenience stores or small, locally owned grocers. Such retailers prefer to stock processed foods because these foods have longer shelf-lives. In addition, smaller retailers have less overall variety and charge more for what they have, so food for the poor is often more expensive overall. Added expense is especially true of fresher, healthier options that spoil (Sheldon et al. 2010:4). In addition, energy-dense foods are often cheaper per calorie and more filling. This makes people with less money more likely to select them. Food insecurity is heavily associated with obesity (Drewnowski and Spector 2004: 7, 11; Sered and Fernandopulle 2007: 167).

The Hegemonic Body

Society directly influences the manifestation of the physical body, both in terms of the resources available to it through the different kinds of capital outlined above and in how a person purposefully alters his or her appearance. A socially acceptable appearance provides status (Meinert 2004: 22; Schilling 2003: 111). This makes the relationship between the body and society more complex. As a way to help conceptualize this relationship, Mary Douglas (1970) identified two kinds of bodies, the social and the physical. The social body represents the “use of the body as a natural symbol with which to think about nature, society, and culture“ (Scheper-Hughes and Lock 1987: 7). The physical or individual body is “the lived experience of the body-self” (ibid: 6). Douglas (1970: 69) explains that, “the social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experience so that each reinforces the categories of the other. As a result of this interaction, the body itself is a highly restricted medium of expression.”

Nancy Scheper-Hughes and Margaret Lock (1987: 7-8) added the body politic to this concept. The body politic is “the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and in leisure, in sickness and other forms of deviance and human difference.” The body politic offers a way to incorporate power relations within the metaphorical body construct, which coincides with the use of risk as a way to maintain power over the lower classes by blaming people for their ill health. Scheper-Hughes and Lock built off of Michele Foucault’s idea of the docile body or that power and politics affect bodies in stratified societies where power is the primary reason for activity, which is a form of productivity controllable as a means of production (Wuthnow et al. 1984). Bryan Turner (1984: 2) explains that to survive societies must reproduce their populations as well as regulate and control the people in them. He (1992: 36) points to medicalization, specifically the development of preventive medicine, as a primary means of social control in Western societies comparable to religion in societies of the past, a thought that mirrors Douglas’s (1992: 25-28) observation that current social use of risk is comparable to the past social use of sin.

The three metaphorical bodies not only allow for analysis of how the social and political bodies affect the individual body, they also allow for consideration of how each of the bodies respond to and act on the other two. Gramsci sees modern society as continuously engaged in class conflict. The state or political body responds to the individual and social bodies to diffuse conflict and maintain power. This happens in different ways. Often the state forms alliances with social groups that oppose it. In so doing, the state incorporates and institutionalizes some of the values of outside groups. In this way, the state is actually produced through social struggle. Within states, some forms of capital receive greater value than others, but values change as people attempt to maximize their symbolic capital. The fat acceptance movement, a national movement that seeks to eliminate discrimination based on body size (see: [http:// www.naafaonline.com](http://www.naafaonline.com)), is trying to change the social and political bodies based on the symbolic value of physical appearance.

Popular use of the term hegemony refers to the process where the interests of the powerful are institutionalized and internalized by the rest of society. For Gramsci, hegemony was a theory of social reproduction that tried to explain what actually made reproduction possible. Hegemony adds to the social reproduction of health because it allows consideration not only of how Western medicine is used as a mechanism of control. It also allows consideration of how Western medicine is used, negotiated, and transformed by non-medical members of society. People use medicine to maximize their health and to avoid physical distress and pain (Lupton 1997: 95). They also use it to maximize their symbolic capital (Bordo 1993: 15). If risk only turned poor health into a punishment for failing to abide by society's core values (Sered and Fernandopulle 2007: 165), people would not support it. The survival of all forms of structural violence, including the way that health care is made accessible within the US, requires ideological support (Rylko-Bauer and Farmer 2002: 493).

Inequality is not only experienced and embodied by those at the bottom. To understand all of its effects, as well as how it is perpetuated, analysis is required at every level. Use of the social reproduction of health shows whether underlying cultural beliefs perpetuate disease in some members of society to the benefit of others and, when this happens, how it is explained and made socially acceptable. Studies do this through the exploration of theories of disease causation, people's use of treatment and preventive therapies, and the focus and scale of how therapies are applied within the context of people's material circumstances (Janzen 1992: 157, 154).

Originally this research intended to look for differences in how women thought about and understood CVD risk based on their access to health care, and how that was incorporated into their daily lives. Over the course of the research, it was found that ideas about CVD risk were very complex and tied into the issues discussed above, specifically body image, social class, and morality as viewed through the lens the American ideology of the Horatio Alger myth. Because this information was obtained through questions about CVD and CVD risk, previous studies of the lay interpretations of CVD and CVD risk are reviewed as well clinical risks for the disease.

Epidemiology and Lay Epidemiology of Cardiovascular Disease

Several studies over many decades have identified numerous factors implicated in increased risk for CVD. Because there are so many factors that vary in importance and people’s ability to modify them, they are assigned to different classifications. There is controversy regarding how some factors should fit within this classificatory frame. Major risks are those statistically shown to significantly increase the chance of CVD. Contributing risks are those that are statistically associated with CVD but have not been shown to increase risk independently. Additionally, some risks can be modified through behavior change while others cannot. The more risk factors one has and the greater their level, the more likely one is to develop CVD (American Heart Association 2007).

Table 1 - American Heart Association (AHA) Known Risks for Cardiovascular Disease

<u>Major, Non-modifiable Risks</u>	<u>Major, Modifiable Risks</u>	<u>Contributing Risks</u>
Increased Age	Tobacco Smoke	Stress
Sex (Male)	Physical Inactivity	Alcohol
Heredity*	Cholesterol**	
	Blood Pressure**	
	Obesity**	
	Diabetes Mellitus**	

*AHA includes race in this.

**May also be influenced by age, sex, and heredity

From: American Heart Association (2007)

Anthropological studies of CVD go back more than twenty years, but older studies focused on specific aspects of the disease or looked at differential trends in morbidity and mortality based on factors traced to local cultural or societal attributes (see: Dressler, Grell, and Viteri 1995 and Conduit 2001). More recent examination of African American, Mexican American, Native American, and rural Anglo American narratives about diabetes found people resisted biomedical explanations for disease development as they simultaneously integrated them into their beliefs about causation (Schoenberg *et. al.* 2005: 175 and 184). Among aboriginal Canadians, lay narratives on diabetes had a broader spectrum of

casual factors than biomedical explanations, and people associated disease development with personal morality as it related to health behavior (Sunday, Eyles, and Upshur 2001: 65). Although respondents said lifestyle was the predominant cause of CVD, many also believed genetics were important and were able to combine two oppositional explanations for disease occurrence (ibid: 75).

Among people in Western countries, lay theories of disease causation are a fusion of scientific and experiential knowledge (Davison, Smith, and Frankel 1991: 5). Lay epidemiology is the individual interpretation of disease risk through observation, discussions with others, and evidence from outside sources like the media (Frankel, Davison, and Smith 1991: 428). Past studies consider nonmedical perceptions of CVD risk, but these studies are primarily from the United Kingdom (Frankel, Davison, and Smith 1991; Davison, Smith, and Frankel 1991; Hunt et al. 2000; Preston 1997; Wiles 1998; Emslie, Hunt, and Watt 2001; Lawlor et al. 2003), Australia (Ritchie, Herscovitch, and Norfor 1994) or Canada (Strain 1996; Angus et al. 2005; Angus et al. 2007). Because people who engage in healthy behaviors sometimes die young, while people who engage in risks such as smoking live longer, people in studies concluded that CVD causation was a combination of behavior, fate, and heredity (Hunt et al. 2000: 132-133, 141; Davison, Smith, and Frankel 1991: 14). The people in studies also focused on physical activity and personal appearance and their ideas were formed by their everyday experiences as well as by medical professionals. People's perceptions also changed over time (Angus et al. 2005: 2118-2119; Walter et al. 2004: 592). Behavioral risks had a strong moral dimension, but hereditary ones were associated with luck (Davison, Smith, and Frankel 1991: 12-13). Decisions about behavior change were often based on how they affected immediate and not long-term survival (Lawlor et al. 2003: 269).

Summary

This chapter provided a review of theoretical concepts used throughout the rest of the text. Theoretical concepts that help to explain how the body can become a form of capital, which is reaffirmed by public health messages that associate disease risk with age and body weight. For the poor, the quest for the ideal body type is often out of reach because everyday products with real health benefits like fresh fruits and vegetables are expensive and are sometimes seen as undesirable because they are unfamiliar.

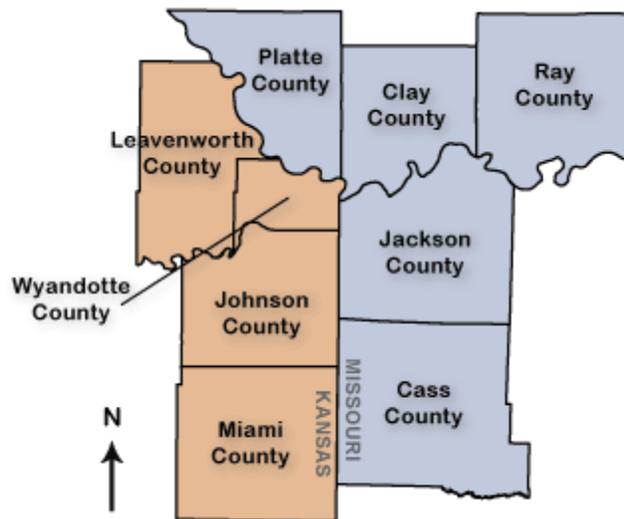
This leads to real, observable differences in the bodies of high and low-status people (Schroeder 2007). The association between the ideal body type and social status increases the desirability of this body type as a marker of social class. Beliefs about body form integrate into existing ideas about why society is hierarchical and why people at the top deserve greater access to resources.

Chapter 3 – Kansas City

Kansas City Basics

Kansas City is a metropolitan area that straddles the border of two states, Kansas and Missouri (Figure 1). It is the largest metropolitan area in Kansas and the second largest in Missouri. Although different public agencies define its boundaries differently, women along the state-line include seven counties. In Missouri they are: Cass, Clay, Jackson, Platte, and Ray. In Kansas they are Johnson and Wyandotte (Figure 1). The 2004 population of these seven counties was 1,707,358 people. With the addition of Leavenworth, which added 72,439 persons, most residents were non-Hispanic white (76.3 percent), followed by black (13.1 percent), Hispanic (6.5 percent), and Asian (2 percent). Less than 1 percent reported that they were American Indian or Native Hawaiian/Pacific Islander respectively (MARC 2005: on-line).

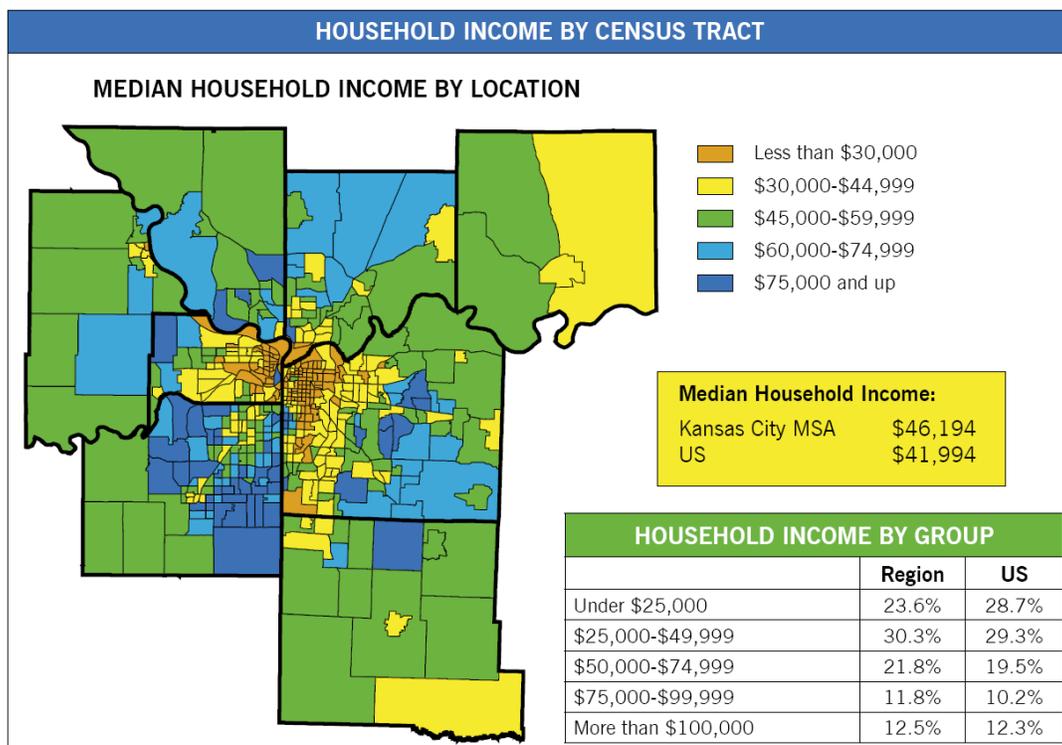
Figure 1
Kansas City Counties
Used with permission from the Mid-America Regional Council (2010)



In this area people with high incomes and wealth have traditionally concentrated in older suburbs and high growth areas away from the urban core (Figure 2) (MARC 2009). In 2009, the Mid-America Regional Council (MARC), a bi-state association of city and county governments formed to ensure cooperation for planning and problem solving across the state line, reported that income disparity between neighborhoods was greater in Kansas City than in other metropolitan areas around the country. On the

Missouri side of the state line, Troost Avenue was most often referenced as the dividing line between rich and poor. Troost was one of the first streets in Kansas City, Missouri. Although once a major industrial thoroughfare, it became the legal boundary between black and white neighborhoods before the Civil Rights Movement. It has remained a prominent marker of racial as well as economic segregation (MARC 2009). The east side is often mentioned when people want to reference the extreme of poverty. Along its eastern side, neighborhoods are dilapidated, full of abandoned buildings and other indicators of poverty such as pawn shops and payday loan locations. However, within a block or two west of Troost are some of the nicest, most expensive homes in Kansas City.

Figure 2
2005 Household Income by Census Tract for Kansas City MSA
 Used with Permission from the Mid-America Regional Council (2005)



Upscale residences flow west from Troost through the Country Club Plaza area into Mission Hills, a town in Johnson County, Kansas. These neighborhoods were built as part of the Country Club District by Jesse Clyde Nichols in the early 1900s and, at the time of the research, retained the same level of prestige and high incomes that Nichols intended and that the name of the district implied. Mission

Hills was built as a place for wealthy families to live. The Plaza was built as a place for them to shop and, as Kansas prohibited alcohol at the time, drink. Upscale residential neighborhoods were also built to surround the Plaza, and a third neighborhood, Indian Hills, was built to complete the area. In 2008 the median annual household income in Mission Hills was \$220,170, compared to \$47,451 for Kansas and \$45,114 for Missouri (City Data 2009: on-line).

Social Division

Many of the neighborhoods in Kansas City were once independent towns with unique histories and were associated with specific cultural or economic groups. In 1951 a flood wiped out large chunks of industry, especially around where the Kansas and Missouri Rivers meet. Many areas, especially those associated with minorities, never recovered. Flight from neighborhoods associated with minorities further increased after the 1968 riots that followed the death of Martin Luther King, Jr. While local municipalities tried different revitalization techniques throughout the 1970s, most failed and several areas along the state line never recovered.

Kansas City residents generally consider Wyandotte County as another poor part of town. Not all of Wyandotte County is as impoverished as areas of this region's urban core along the state line. During the building boom that preceded the 2008 economic crisis, this county saw significant development along its rural western edge. A large shopping and entertainment district was completed that included The Legends at Village West and The Kansas Speedway. As the research ended, a large casino was also planned, but developers had begun to question whether or not to proceed in the economic downturn. Construction of Schlitterbahn Vacation Village, a \$750 million resort akin to a water park version of Disneyland began in 2009 and opened with limited rides in 2010.

Media reports and political commentary presented Wyandotte County's development as a major economic boon and the beginning of its financial recovery. However, informants from the area complained that major developers secured tax incentives from the county and then provided little in return. For example, county residents said Schlitterbahn brought in its own workforce from Texas instead of hiring local applicants. Nebraska Furniture Mart, another large company, was also criticized because it

disputed and failed to pay county taxes. Most of the jobs brought were low-skill, low-paying service positions without benefits. They did little to permanently affect the economic fate of Wyandotte County residents or improve its reputation in the rest of the metropolitan area. One Wyandotte County resident who participated in the research explained,

Everybody knows that if you live in Wyandotte County then you are the armpit of the metropolitan area and that nobody has disease in Johnson County, so they would never want to have unproductive, unemployed, uninsured citizens down there or by any means pay for anything. And I'm being quite sarcastic, but you have to live in Wyandotte County to know how people feel about being in the pit.

Two interviewed Wyandotte County residents with annual household incomes over \$100,000 reported addresses in the more affluent towns and neighborhoods of this county. They indicated that they were insulted that so few outside of their neighborhoods remembered these more affluent areas existed. One woman said, "So what, I don't have the good address. I can live in a house that costs them \$300,000 and only cost me \$150,000." These women, as well as those with high incomes who commuted from more affluent parts of the metropolitan area to Wyandotte County for work, held the professional positions available through the government, local hospitals, clinics, or other large businesses.

There are services available in poor areas that are not available in other parts of the metropolitan area. For example, a clinic in a notoriously bad neighborhood offers all of the necessary vaccinations required to go to Africa for \$150. While at the clinic, I met several individuals who came for vaccinations because they were going on a mission through their school, church, or a health care facility. Less often they had business or planned to visit family that lived abroad. These individuals always came from Johnson County and usually asked whether their car was safe in the parking lot outside.

Initial Interviews and Participant Observation

Kansas City was selected as a research site for two reasons. First, it was geographically close to the University of Kansas. Second, it had a strong history in the promotion of women's heart health. Kansas City was home to the first women's cardiac center in the US, established at St. Luke's Hospital in 1994. This center focused on the prevention and treatment of CVD in women and remained a model for

similar centers around the country. In 2003, the national Heart Truth Campaign was also launched by First Lady Laura Bush at the Hallmark Crown Center in Kansas City, Missouri (MARC 2003).

I used participant observation and interviews at public locations such as community centers and libraries to consider what women identified as CVD risks. There was no preplanned sample size for preliminary interviews. Instead, the research relied on a grounded theory approach, collecting data and analyzing it until there was theoretical saturation for identified risks (Sandelowski 1995: 181-182; Strauss and Corbin 1998: 212). The information obtained was used to create a question protocol for later interviews (Bernard 2006: 492 and 210). Initially I identified little environmental CVD information, so data provided by women were all that was used to create the question protocol for later interviews. Later I realized that, because of the way women associated CVD with food and the body, there was relevant information in locations in the form of food and weight-loss advertisements. This was incorporated into later stages of the research.

During informal interviews I spoke to over seventy women, although some only briefly. I asked these women to free list CVD risks and their responses were used to create cards for pile sorting (Bernard 2006: 301-304). The question asked was, "Please list anything that you can think of that puts someone at risk for cardiovascular disease." Several women listed only three or four things, and it was rare for someone to list more than six, so data were not useful for a planned proximities matrix. When I created cards to pile sort, I used all, even uncommon responses, and began to ask women to free list things that were protective or prevented CVD. I made fifty-nine cards for pile sorting (Bernard 2006: 310-315).

Secondary Interviews and Participant Observation

Once the question protocol and pile sort cards were complete, I began formal interviews. I originally planned to interview forty non-Hispanic white, working, women without medical training, recruited from similar public locations as well as clinics, community centers, and workout facilities. Half of the forty women were to have health insurance and half were not. Alterations occurred because the original frame was based on an assumption that having insurance was equivalent to having health care. This was not the case. In addition, while the majority (n=41) of interviewed women remained non-

Hispanic white, interviews also occurred with women who were black (n=7), Hispanic (n=5), Native American (n=1), and Asian (n=1). The decision to do this occurred because there were a variety of women of different races and ethnicities intermingled at recruitment sites who wanted to be interviewed. It seemed best to include more variation in the sample than to lose the ability to recruit at a location due to perceived discrimination. This meant that the final sample was one of convenience. Changes allowed for a comparison of responses between white and nonwhite women. Ten medically trained women were also added because, after listening to lay women talk about the way they used health care, I wondered what medical women might add. Questions were similar to the standard protocol but included additional cues, such as whether patients asked for specific medications.

While preliminary interviews occurred in the public domain, secondary interviews were more often at locations that required contact and approval of gatekeepers, such as a small business owners, pastors, nuns, or community leaders. Potential gatekeepers were contacted first by letter and then telephone to gauge their interest in allowing me to perform participant observation at their locations and helping with participant recruitment (see Schoenberg and Drew 2002: 462). Recruitment for secondary interviews began June 1, 2008. Locations were initially contacted if they were places women identified as places they went for services in preliminary interviews.

I began to recruit for secondary interviews at three clinics that charged patients on a sliding scale. These clinics are owned by a charity organization that originally started to provide health care to people in developing countries. The organization opened a clinic in Kansas City in 1992 because there was a similar need for care among the poor in the US. Over time, the organization expanded to include multiple clinics. From safety-net clinics, I went to a women's center run by the Benedictine Sisters and located in a large Catholic Charities building in an impoverished part of Kansas City. The center is a haven for diverse women from all over the region, as more affluent women commute to the center to volunteer. Women at the center told me that the YMCA was the best place to exercise in the area, so I went there next. A large proportion of the women also told me to attend area farmers markets. A number of communities throughout Kansas City have them. When asked, women indicated that they had visited

their local markets as well as City Market, a farmers market that opened in the heart of Kansas City, Missouri in 1857. Women said that they were more likely to go to City Market than the markets in their neighborhoods, which often offered little beyond homemade baked goods, handcrafts, or products sold through companies like Avon. Based on what they said, I attended the farmers market in Wyandotte County and City Market.

At the end of the research period, I visited a free-clinic run by local medical students and other volunteer providers. Patients were not charged for exams and clinic staff tried to provide no-cost treatment, such as free medication, when possible. It took several months to receive permission to use the clinic as a study site because the committee that oversees it meets infrequently. Once I had permission I was only able to attend one time. The clinic was open for five hours two nights a week beginning at 5:00 p.m. The doors were shut and locked when the waiting room was full or at 5:15 p.m., whichever came first. On two occasions I was unable to arrive in time.

The lack of medically oriented CVD information in observation areas led me to seek out health-related events. I attended three events in low-income areas, which were free, open to the public, and held at churches and community centers. I also attended three events where the majority of women were low- to mid-level professionals such as administrative assistants or office managers. These events were sponsored by corporate or local medical offices. One was at a local community center, one at a convention center, and one at a meeting hall. All charged admittance. The cheapest was \$25; the most expensive was \$70. I attended two health events that were sponsored by large medical providers where I met high-level professional women such as executives or business owners. They were at hospitals and business offices and were free but required permission to attend (my name was checked off a list when I arrived). I also went to seven health classes at local hospitals that provided information about specific health topics, such as stroke, diabetes, and gastric bypass surgery or that offered basic health information for particular demographic groups such as middle-aged women.

Women were recruited from these locations and were either interviewed immediately or were contacted later for an interview appointment. I often offered to interview women over a meal. Some

women may have participated in interviews strictly to receive a free meal. However, women often preferred to be interviewed in their homes and, of those that preferred a restaurant, most refused to let me pay. Eight women were interviewed multiple times over the course of several days or weeks due to the frequency of our contact at recruitment locations or because we developed a friendship over the course of the research and spent additional time together. When possible and women granted permission, interviews were recorded.

Besides the question protocol, women were asked to pile sort cards created from the original free list exercise. During the pile sort, I asked women to make three piles, one pile of things that increased risk, one pile of things that decreased risk, and one pile of things that were irrelevant to CVD. I asked them to free pile sort each of the initial piles, making as many new piles as they wanted as long as each new pile had more than one card. Weller and Romney (1988: 22; Bernard 2006: 313) point out that when asked to do this, some people are inclined to make very few categories, choosing instead to let each item stand on its own. To help overcome this, I asked each woman why she put particular cards in the piles that she created.

I asked women to, “Draw a picture of a person at risk for CVD” to obtain CVD and CVD risk metaphors. Similar studies find participants create complex images laced with metaphors that integrate multiple cultural factors (Weiss 1997: 460). Due to their complexity, women were asked to explain pictures as they drew them (Weiss 1997: 460). As each woman drew, she was also asked, “Why are you drawing that?” The first woman found the differentiation between CVD and CVD risk problematic. To her, being at risk for CVD and having CVD were the same. Because of that, I also asked women to draw someone with CVD after they drew someone at risk.

Television Observation

Medical beliefs often come from what people see on television, so a sample of the evening news and commercials that aired during it was also reviewed. I chose to observe the news because it was meant to attract a general audience and was believed by most to convey trustworthy information. I watched a random sample of the local and national news including episodes at 5:00, 5:30 and 6:00 p.m. on each

major network (ABC, NBC and CBS) for six months in 2008. I also watched the local news on Fox, which did not have a national news program at that time. Episodes that were watched were selected by numbering each day on a calendar from July 1, 2008, to December 31, 2008, and then using SPSS (Chicago, IL) to generate a list of random numbers. Each episode was recorded using a digital video recorder (DVR). Some days were pre-empted due to sporting or weather events. The sample totaled eighty episodes, twenty from each network. During the news, commercials that discussed health and health-related topics were also observed and noted. Information from a Kaiser Family Foundation (KFF), Pew Research Center study was used to create a checklist for news and then, with modification, commercials that included information such as the length of time each segment or commercial aired and the general topic of the segment or commercial. In addition, commercials with relevant topics that were on during popular shows, such as an episode of *The Oprah Winfrey Show* several women told me to watch, were observed and noted.

Analysis

Scratch notes were recorded in the field and then turned into formal field notes as soon as time allowed (Emerson, Fretz, and Shaw 1995). Similarly, notes were taken on news programs and commercials and then written up after watching them. Formal interviews were recorded, reviewed, and pertinent portions were transcribed. Field notes, television notes, and interview transcripts were downloaded into Atlas.ti qualitative data analysis software. Analysis proceeded in several steps. In the first, text was coded for substantive ideas. In the second, codes with similar meanings were clustered to create categories. Relationships between categories were explored and themes identified. Data were reanalyzed and coded based on derived themes (Strauss and Corbin 1998; Bernard 2006). Once data were recoded, quotes were considered with specific codes, cross referenced, and grouped into categories described below. Written memos were used to keep track of ideas, assumptions, and preliminary reflections during analysis (Glaser and Strauss 1967; Emerson, Fretz, and Shaw 1995).

Category Creation

While coding interview transcripts, I noted there were patterns in the data based on how women talked about their and other people's bodies, food, and exercise. I used women's responses to the following questions to break interviews into groups:

- Tell me about your health insurance. For example, what is good or bad about it? What does it cover or not cover?
- Can you tell me about an experience you had with your insurance company that stands out to you?
- Was there ever a time you needed to go to the doctor but didn't go because of the cost? Was there a time a loved one could not go? Was there another reason that prevented you from going to the doctor?

Interviews were broken into eight insurance categories: (1) none, (2) none-bad, (3) bad, (4) mediocre, (5) good, (6) good-very good (7) very good, and (8) great. Women were designated as none if they lacked health insurance. They were designated none-bad if they had a policy they described as having a very high deductible that made it impossible for them to use. The three women in this category also only had their policies for a limited time (maximum period two weeks), were previously uninsured, and had unmet medical needs. Women were assigned to the bad category if they described their policy as having a high deductible that limited their ability to go to the doctor or if they said their insurance refused to pay claims. In addition, these women all expressed medical need, saying they currently needed to go to the doctor but could not due to cost. Women in the mediocre category described health insurance policies with out-of-pocket expenses that were high in one way but low in another; that is, they had low premiums but high cost sharing or vice versa. Women in this category also said they were able to go to the doctor for basic care but could not access more expensive health care products or services. These women also reported delaying or forgoing some form of treatment in the past due to an inability to pay, usually prescriptions. The good category applied if women had policies with reasonable out-of-pocket expenses, but they indicated they still did not receive the care they thought they should, such as if they thought they needed and were denied a referral to a specialist. Very good insurance allowed women to go to the doctor when they wanted and those with it reported no unmet health need. Very good insurance also had what women

described as reasonable out-of-pocket costs. This category differed from great only because women with great insurance paid even less out of-pocket, such as when their employer or spouse’s employer paid their premiums and deductibles.

I used the Network View feature of Atlas.ti to consider all of the quotes that related to a specific code, such as healthy foods, based on the identified insurance categories. This feature is a computer generated whiteboard that allows researchers to pull chunks of coded text onto it in text boxes. Boxes can be moved around and linked to one another in different ways (e.g., associated with, comes from), to topics, or to new and different codes. I was able to consider the quotations for each code, and for related codes, and visually manipulate them as needed. While I never had a code where every woman in an insurance category indicated the same thing exactly, I identified concept clusters. I created a separate network view for each topic and then compared the clusters in network views to confirm patterns. The different body groups--cultivated, managed, neglected, and forgotten--came from review of these patterns as they revealed differences in how women talked about medical care, diet, exercise, and the body. There was overlap between insurance categories and body type (Table 2). Initially women with government insurance coverage were excluded. They were added at the end based on how their responses corresponded to body groups.

Table 2 – Fifty Three of Fifty-Five Interview Participants Body Type, Insurance Category and Demographic Information (Page 1 of 2)*

Body Type	Insurance Category	Income Level	Age	Occupation	Education	Race
Forgotten	None	< 5,000	42	Student/Volunteer	Some College	Native American
Forgotten	None	10,001 - 20,000	24	Receptionist	High School	Latino
Forgotten	None	10,001 - 20,000	60	Substitute Teacher	Graduate School	White
Forgotten	None	10,001 - 20,000	52	Assisted Living	High School	White
Forgotten	None	10,001 - 20,000	46	Home Maker	< High School	Latino
Forgotten	None	20,001 - 40,000	58	None (SSDI Application)	Tech. Certificate	White
Forgotten	None	40,001 - 60,000	38	Hair Stylist	Trade School	White
Forgotten	None – Bad	10,001 - 20,000	20	Billing Clerk/Waitress	High School	White
Forgotten	None – Bad	20,001 - 40,000	35	Accounts Receivable	High School	White
Forgotten	None - Bad	40,001 - 60,000	41	Demo Associate	High School	White
Neglected	Bad	10,001 - 20,000	47	Sales Person	4 year degree	White
Neglected	Bad	20,001 - 40,000	59	Services Coordinator	4 year degree	Latino
Neglected	Bad	20,001 - 40,000	60	Box Office	4 year degree	White
Neglected	Bad	20,001 - 40,000	62	Administrative Assistant	Some College	White
Neglected	Bad	40,001 - 60,000	21	Receptionist	High School	White

Table 2 – Fifty Three of Fifty-Five Interview Participants Body Type, Insurance Category and Demographic Information (Page 2 of 2) *

Neglected	Bad	40,000 - 60,000	34	Pediatric Nurse Practitioner	Graduate School	White
Neglected	Bad	80,001 - 100,000	64	Job Coach	4 year degree	White
Neglected	Bad	80,001 - 100,000	55	Book Keeper	Some College	White
Neglected	Mediocre	40,001 - 60,000	60	Childcare Provider	High School	Black
Neglected	Mediocre	60,001 - 80,000	49	Registered Nurse	Some Grad School	Asian
Managed	Mediocre	20,001 - 40,000	32	Utility Clerk	High School	White
Managed	Mediocre	40,001 - 60,000	58	Educator	Graduate School	Black
Managed	Mediocre	40,001 - 60,000	31	Non-profit Director	Some Grad School	White
Managed	Mediocre	40,001 - 60,000	45	Bookkeeper Box Store	Graduate School	White
Managed	Mediocre	80,001 - 100,000	50	Computer Data Analyst	4 year degree	White
Managed	Good	40,000 - 60,000	56	Registered Nurse	Graduate School	White
Managed	Good	40,001 - 60,000	57	CPA	Graduate School	White
Managed	Good	40,001 - 60,000	57	Accounting	High School	White
Managed	Good	80,001 - 100,000	36	Accounts Receivable	4 year degree	White
Managed	Good	80,001 - 100,000	47	Business Owner	Some Grad School	White
Managed	Good	80,001 - 100,000	27	Sales	4 year degree	White
Managed	Good	100,000 - 150,000	49	Nurse Practitioner	Graduate School	White
Managed	Good/very good	10,001 - 20,000	23	Medical Student	4 year degree	White
Managed	Good/very good	100,000 - 150,000	53	Vice President – Banker	Some College	White
Managed	Good /very good	100,000 - 150,000	30	System Administrator	4 year degree	White
Managed	Good/very good	100,000 - 150,000	62	Medical Technologist	4 year degree	White
Cultivated	Very Good	40,001 - 60,000	31	Marketing/Sales	4 year degree	White
Cultivated	Very Good	60,001 - 80,000	31	Administrative Assistant	Some College	White
Cultivated	Very Good	80,001 - 100,000	67	Office Support Staff	4 year degree	White
Cultivated	Very Good	80,001 - 100,000	56	Homemaker & Volunteer	Graduate School	Latina
Cultivated	Very Good	80,001 - 100,000	43	Architect	Graduate School	Black
Cultivated	Very Good	150,001 - 200,000	42	Computer Engineer	4 year degree	White
Cultivated	Great	10,001 - 20,000	39	Substitute Teacher	4 year degree	White
Cultivated	Great	80,001 - 100,000	39	Services Liaison	4 year degree	White
Cultivated	Great	100,000 - 150,000	47	Home Health Aide/Homemaker	4 year degree	Latina
Cultivated	Great	150,001 - 200,000	58	Office Administrator	Some Grad School	White
Cultivated	Great	300,001 - 400,000	55	Executive	Graduate School	White
Neglected	Medicaid	< 5,000	28	Clothing Store Clerk	< High School	White
Neglected	Medicaid	< 5,000	46	SSI	High School	Black
Neglected	Medicaid	10,001 - 20,000	51	SSI	Some College	Black
Managed	Medicare	< 5,000	74	Educator	Some Grad School	White
Managed	Medicare	40,001 - 60,000	71	Retired/Journalist	2 year degree	Black
Managed	Dual Eligible**	< 5,000	71	Retired/Sales	Two Year Degree	White

* Two persons refused to answer demographic questions

**A person who is dually eligible has Medicare and Medicaid

The four identified body types were *Cultivated*, *Managed Bodies*, *Neglected*, and *Forgotten* (Table 2). Groups are discussed independently in Chapters 5 through 8. While groups were based on women’s health insurance, there were similarities in each category based on income and education. For example, only two of the seven women with no health insurance went to college, while all five of the women with great health insurance did. This could indicate that what I identified as a product of

women's insurance was really a product of one of these other variables. Consideration of specific cases where women had lower incomes and better insurance or higher incomes and worse insurance supported the conclusion that identified patterns were a reflection of women's health insurance for this sample. However, the possibility of confounding warrants attention and suggests use of these results to construct future studies.

Body types were a spectrum that women moved up and down throughout their lives. They carried experiences from one part of the spectrum to another and this influenced how they and the people around them thought about health and health-related information. The insurance categories and body groups are heuristics that come from women's information and fit their data as well as the other data collected in Kansas City. However, the usefulness of the categories is limited. Reporting these groups is not meant to imply that all women with the same access to care, education, or type of employment will have the same beliefs, attitudes, or behaviors. Descriptions show differences in access and how this can translate into projected attitudes and behaviors. Individual women rarely fit the description of their groups perfectly because these groups are from larger themes that come out of an aggregate. Each woman had several characteristics that match her group but differs in at least one or two ways based on her background and past experiences.

For example, if I classify myself using these groups, I am in the managed bodies group based on my current access to care, diet, and exercise habits. That being said, I also reflect characteristics of women with cultivated bodies because I only eat fresh fruits, prefer fresh vegetables, and take long walks almost daily. This reflects my childhood when money and time were never an issue for my parents in terms of diet and physical activity. On the other hand, I am like women with neglected bodies in that I sometimes put off going to the doctor due to my copayment. This reflects the couple of years in graduate school, before I met my husband, when I was impoverished and thought of basic health care as a luxury that should be paid for with "fun" money (or whatever was left over after bills and groceries). When the differences in women are noteworthy because they are unique or add to the larger picture in some way, they are included.

Analysis of picture data proceeded along the same lines as analysis of text. Based on the work of Meira Weiss (1997), pictures were reviewed for shared structures. Repeated structures were clustered into themes. The work differed from Weiss in that after the identification of themes, similarities of artists were considered for each theme. Although Atlas.ti has a feature to assist with this kind of analysis, it was largely done by printing duplicates of the same pictures and circling the elements identified as pertinent. In addition, pictures that corresponded well to themes identified in interviews were noted.

Analysis of pile sort data remains superficial. The information obtained was helpful in contextualizing other data. For example, women's creation of the piles, *things you can control* and *things you cannot control* helped me understand how women thought about CVD risk.

The Sample

Fifty-five women were formally interviewed (Table 2). Ten had medical training. Only fifty-three filled out or answered demographic questions. The sample was mostly white (n=40) but also black (n=6), Hispanic (n=5), Native American (N=1), and Asian (n=1). Ages ranged from twenty to seventy-four. Household incomes were less than \$5,000 to more than \$300,000. Education started with women who had less than a high school diploma to women who completed graduate school. The majority of women worked, although seven were unpaid volunteers. Of the two who did not work or volunteer, one had an application in appeal for Social Security disability insurance (SSDI) due to a number of chronic health conditions that made her long-term survival unlikely. The other had recently become a homemaker when her kidneys failed because of her diabetes. Women worked in a range of professions from sales clerk to bank executive. Of the women who refused to answer demographic questions, one was black and one white.

There were eleven women with cultivated bodies (Table 2). All were enrolled in large group health insurance plans. With one exception, all had at least a four-year degree. The oldest of the women was sixty-seven; the youngest was thirty-one. Annual household incomes fell between \$40,000 and \$400,000, but most (nine) women reported that their families made between \$80,000 and \$100,000. There were nineteen women with managed bodies. All had group plans, although some were smaller than

the plans of women with cultivated bodies. Nine went to college. The oldest was seventy-four; the youngest was twenty-three. Annual household incomes fell between less than \$5,000 and \$150,000; most (seven) made between \$40,000 and \$60,000. Thirteen women had neglected bodies. Their coverage was mixed between individual and group plans. Eight were white, three black, one Asian, and one Latina. The oldest was sixty-four years old, the youngest twenty-eight. Annual household incomes began in the \$10,000 to \$20,000 range and ended in the \$80,000 to \$100,000 range. The income range with the most women in it tied with three each for \$20,000 to \$40,000 and \$40,000 to \$60,000 per year. There were twelve women with forgotten bodies. Two refused to fill out a demographic questionnaire, but all reported that they lacked health insurance. Eight of the twelve women were white. Two were Latina; one was Black; and one was Native American. Of those that filled out a questionnaire, the oldest woman was sixty and the youngest twenty. One woman had a graduate degree, one was a student, and two graduated from trade school. Annual incomes ranged from less than \$5,000 up to \$60,000, but the most often reported income range was from \$10,000 to \$20,000 (five women).

Kansas City in Transition

There were very few differences in women's general beliefs about CVD based on the variables they reported that were associated with social class, such as income and education (Table 2). More complex beliefs varied a great deal based on these variables, but the variations related to women's ability to access resources. Overall women shared similar ideas about the body and about CVD. Women talked about changes in their lives that indicated they moved up and down the socioeconomic spectrum. Based on these conversations, it was much easier to move up the spectrum in the past and many of the women who were over forty told stories of growing up poorer and changing their social position through hard work and education. However, only one woman's more recent tale of social mobility was about moving up the class ladder. Instead most tales of mobility focused on slipping down.

During the research, Kansas City was in economic flux due to the so called Great Recession, which officially began in the fall of 2008. Thousands of people in the metropolitan area lost their jobs, including at least three of those who were interviewed. For many who participated, economic hardship

began long before the Great Recession. The Kansas City economy has been a rollercoaster since the 1970s. The series of ups and downs ended in 2003 when, like the rest of the country, the economy in Kansas City went consistently down. Economists in the area reported the 2008-2009 decline was worse than declines in previous years (MARC 2009).

Kansas City residents suffered, in part, because of the way that the area is laid out and navigated. Land around Kansas City was always inexpensive, and in combination with a vast network of highways, has created extreme urban sprawl. The Kansas City metropolitan area has more per capita highway miles than any other urban area in the nation (MARC 2009). Area growth exceeded population growth by three times for two decades. Sprawl happened as people from the city took advantage of cheap land and the easy to get mortgages that precipitated the recession to flee the more impoverished areas of the urban core. The most growth occurred in Johnson County, while Wyandotte County was the only county where population declined (ibid.).

Without a vehicle and money for fuel, it is difficult to find employment in Kansas City. Industry is spread throughout the urban core and in pockets that stretch along major interstate corridors. With complex public transportation routes operated independently by different counties, this vast highway system leaves residents without motor vehicles stranded in specific counties or neighborhoods. It also creates a deep emotional attachment in people to their vehicles. This attachment, combined with bad experiences using local buses, led some people to view public transportation in a negative way. Residents fought over potential improvements to the public transportation infrastructure for more than a decade. Divisions occurred primarily along economic and geographical lines as those in upscale areas resisted improvements that would make it easier for people from less affluent areas to travel into nicer neighborhoods.

Population loss in impoverished neighborhoods made existing poverty worse through a lower tax base. This further weakened neighborhood economies just as larger economic events spread financial pain throughout the region. Spikes in gas prices were hard on people who moved to the suburbs but maintained employment in urban areas. Many people failed to budget for the rapid, extreme rise in fuel

costs. Large, low-mileage vehicles are also popular in Kansas City, in part, because some of them were manufactured there. The rise in gas prices led to frequent complaints among Kansas City residents. In urban areas complaints were most often directed at the government for allowing prices to soar and at oil companies for their perceived greed. In the suburbs complaints were also aimed at the government because the government was seen as manipulated by environmentalists trying to control people and take away their cars.

Class Free Fall

Beth slipped down the class ladder. White, twenty years old, a part-time clerk, she worked at a safety-net clinic in the heart of Kansas City, Kansas. Because she could not live on the income from this job alone, she added to it with money from a second job as a waitress at a local bar and grill. Neither job offered benefits or the possibility of promotion. Tiny, rail thin, she stood about five foot two inches tall and weighed maybe a hundred pounds. Beth came from well-educated, professional parents who lived in a nice Johnson County suburb. Beth's hair was brown and curly. She had sharp blue eyes and skin prone to breakouts. She told me that her parents put themselves through college and thought she should do the same. They did not save money for her to go to school. She said she could not afford to pay tuition. Due to more than a decade of cost increases at state schools, she was probably right. Beth moved out of her parent's house and lived with her fiancé and his family in Wyandotte County. Angry about her prospects and declining social position, she blamed the government as well as people more impoverished than her and with less power.

Although Beth came from a "good middle-class family" and worked at a clinic, her access to health care was limited. This came out as we talked. She asked to see my interview questions (Appendix I). When she saw the one that said, "Has there ever been a time you needed medical care but were unable to access it due to cost." She let out a bark-like laugh and said, "Well, that's about always." She and another woman in the room told me they were uninsured until just recently when the clinic began to offer a high-deductible, low-premium policy. Beth added that she might use the policy if she was hit by a car.

I asked if she ever used the clinic where she worked and she shook her head and said, “Absolutely not. I won’t come here. I’d rather see a regular doctor and it’s too uncomfortable because I know everyone.”

She blamed a previous miscarriage on the government because she felt that the county where she lived provided her inadequate prenatal care when she went for help. Beth complained about the time and difficulty enrolling in Medicaid. She said the only thing the county people did was sit with her while she filled out Medicaid paperwork. Beth only sought their assistance after she called several clinics and found she could not afford to go to a private doctor. When she finally sought care from the government, she said she received inadequate treatment but knew that other women who made less money or who did not retain a relationship with the father of their child received better services. Instead of identifying with other poor women, Beth believed that the government discriminated against her because she was white and her parents were middle class. This perceived distance from people born into poverty kept her and her parents from recognizing how societal changes limited their ability to reproduce their class.

I met other young people like Beth who live in poor parts of the metropolitan area because they could not afford to live where they grew up. These individuals had college educated parents and said that, when they were younger, they assumed they would go to school as well. Some tried, taking one or two classes at a time, while others gave up because it was too hard and too expensive. They indicated a promise was made to them while they grew up that was broken when they reached adulthood. The promise was not a college education. It was simply the promise of a chance to go to college. All were angry but directed their anger differently. Beth blamed the Democratic Party and people who were poor.

Young people were not the only individuals who found themselves in free fall down the class ladder. Others came to safety-net clinics from outside the county because they had lost their insurance. Either their company let them go, cut back on their hours so they were only part time, or cancelled their benefits. Patients in clinics talked about struggles they said they never knew before. A woman I met briefly, who was out of work for several months and living off her diminishing savings, complained that higher gas prices made everything more expensive, especially food. “I used to pay \$3.50 for milk. Now I

pay five. You have to decide whether you put gas in your car or you eat or you buy your medicine. You can't do all three. Sometimes you can't do two."

Chapter 4 –Circulating Health Information & Shared Beliefs about Disease

Introduction

This Chapter reviews the health information circulating in Kansas City. It begins by comparing four health related events meant for four very different audiences. It discusses the information that was presented on television news and in commercials about this disease and about related topics such as obesity. Finally, it considers women's shared beliefs about cardiovascular disease (CVD).

Venues for the Presentation of Environmental Health Information

There was very little formal health information in places where I conducted research. Events tailored toward health had more formal information, but what information was shown varied based on its intended audience. Information for women in the lower classes was often so general it did not provide any way for them to incorporate it into their daily lives. These women were told that CVD was caused by a poor diet high in fat and cholesterol. It also resulted from too little physical activity, being overweight, or obese. Consider the following example from a health fair for indigent women.

The fair was held in a neighborhood that was old, filled with forlorn and forgotten buildings boarded up with sheets of plywood messily spray-painted with undecipherable words in shades of black, blue, red, and green. Long cement sidewalks separated the rows of three-and four-story buildings, built more than a century before, from the tar scarred streets that cut through these silent structures the way that rivers cut through rock to form canyons. It was a barren place: no trees, no flowers, no shrubs. Not even a weed dared poke through the chipped, cracked concrete.

The fair was in a building that was a combination church and community center that spanned both sides of an entire city block on the Missouri side of the state line. I parked my car in an empty square of dirt at the end of the block where a building had once stood. All that remained of this past structure were large chunks of concrete that stuck out of the dirt at odd angles. Beside these manmade rocks were piles of loose gravel and scattered fragments of beer bottles. I pulled my things out of the car. Having agreed to host a booth at the church's first women's health fair in exchange for admission, I brought a portable crate filled with American Heart Association (AHA) brochures donated by the campus health clinic as

well as a table cloth, poster, and other assorted goodies meant to attract women's attention. There was no one else on the street. All of the brick buildings had steel doors sealed shut with large deadbolts. Their windows were dark, covered by thin sheets of plywood or heavy metal bars. I wondered what I would do when I reached the door that corresponded to the street number scrawled on a post-it note in my pocket. As I neared the door, a thin black woman with thick white hair pulled into a loose bun stepped outside.

The woman was brisk. She ushered me inside as she reprimanded me for using the incorrect entrance. She was the pastor I spoke with earlier on the phone. After she let me into the building, she called to another, younger black woman to walk me to a row of portable picnic tables across the room. The young woman showed me my table. An identical table on my left was draped with a large, royal blue cloth. A young white nursing student I had shared a class with at the medical center sat behind it busily preparing tools to draw blood. An unclothed table on my right held a large poster that asked in bold print, "Are you a victim of sexual violence?" In smaller print it explained how to recognize sexual violence and what to do if one was a victim of it. Another young white woman stood nervously beside it. She was a recent graduate with a degree in clinical counseling and had just started a job at a nearby not-for-profit organization. Two white nurses' aides in their mid-forties stood on her other side ready to assess blood pressure and measure lung capacity.

Several portable card tables were set up in a checkerboard pattern in the center of the room. They were covered with crisp white clothes and had chairs on each of their four sides. Tiny bud vases held short pink carnations and beside these vases were disposable salt and pepper shakers. It looked like the dining area of a small, inexpensive café. Against the far right wall was a makeshift buffet offering bottled water and trays of assorted lunch meats, cheddar and Swiss cheese, rolls, and a bowl of honeydew melon. There was also a coffee urn and two large pitchers of iced tea. On the left wall was a small seating area with a TV, beaten up brown couch, and sixties-style hexagon coffee table.

As we waited for the fair attendees to arrive, I spoke with the women around me. All were from outside the area. The nursing student chatted about her last European vacation and plans to travel to Peru over the summer. She told me she was at the fair because it was the last part of a community outreach

assignment she had to do to graduate. She would test women's cholesterol, blood sugar, and blood pressure and write their results on a form to take home. Beside the line for each result was a four or five sentence explanation of it. More in-depth information was available on a different table to her left where she had set stacks of notebook-sized paper densely covered with rows of single-spaced text in black, twelve point font. She told me that at other fairs no one ever took these handouts. She asked if she could have my prettier AHA brochures on cholesterol. I handed them over and asked what she thought women did with the results sheets she gave to them. She thought they took them to their doctor.

Women began to arrive. Nearly all were black. Most were overweight and appeared to be over forty years of age. At least one was a pregnant teenager. All were casually dressed in baggy jeans or pants and tee-shirts. Their clothes were faded and stained. They wore no makeup. Their hair was short or worn simply in buns or ponytails. They entered in small groups of three or four and stayed in these groups the entire time. When they came to the tables, they were not shy but hesitated before speaking to the professional women. Many also averted their eyes from everyone except the women they came with. As they entered, they walked through each of the four stations quickly before finding the food, preparing their plates, and settling in to eat. Few worked, most had no health insurance and less than half had a regular medical provider, even though all of those I spoke with said they had at least one chronic health problem that needed attention. Many of the women were homeless.

The information given to women at this fair could not be integrated into their lives. Only the information provided by a series of classes at a women's center in Kansas City, Kansas differed. The woman who taught the series was from the area and certified as a master food volunteer by the local Kansas State University Extension office. She understood the lives of the women in her classes and offered them comprehensive but easy to understand information with simple themes such as their need to eat foods high in calcium. Women in her classes, as well as those who attended them in the past, told me they were able to incorporate her lessons into their routines. For example, at the calcium class the teacher told the women not to put sugar into their children's powdered milk because their children did not need the extra, empty calories. She said that if children were hungry and needed more calories, they should have

more milk or another healthy snack. One of the women in the class raised her hand and said her children would not drink powdered milk without sugar. She could not afford fresh milk at the end of the month. Other women in the class agreed. The instructor said she knew it was hard but told them there were a couple of different things to try. First, instead of waiting until all the fresh milk was gone they should add powdered milk to the gallon each night, keeping it full. Younger children would not notice that the carton never ran out and the taste would transition slowly, so it was less noticeable. Second, was to keep the milk as cold as possible because the colder it was, the less the children would taste it.

Health information was so complex it was often difficult for women to understand. This was not only true for women of the lowest classes but also for women just above them in social position. Consider the following vignette, which comes from a presentation offered to the parents of obese children. Not part of a formal health intervention, the presentation was given to augment data collection for a study of obese children. Researchers who ran the study hired a local nutritionist. I recognized her from earlier research and similar events in the Kansas City area.

“I’m just here to give you education and awareness. You have to decide. We need a healthy nation,” the woman said from in front of a large portable screen that showed a giant image of the United States Department of Agriculture (USDA) food guide pyramid. The event was in Missouri, a working-class neighborhood near the state line. “Parents come to me all the time and tell me their kids won’t drink anything but Coke. They won’t eat anything but chips and fries. It makes me angry. You have to be parents. Be a mom. Don’t cook something special for the kids. They can go to bed hungry if they don’t like what you’ve fixed. But if they want more of what you made, they can have it. Kids know when they’re hungry and when they’re full. They can eat more if they need more because they’re kids.” She walked across the room to stand in front of a small black boy sitting shyly in his mother’s lap. “Does that mean your mom can never buy some cake with icing?” The boy tightens his arms around his mother’s neck and burrows his head deeply into her shoulder. The woman answers for him. “No it doesn’t, but moderation. You have to start thinking about ways to be healthy.”

It was late evening in early June. A nurse who worked at the clinic where the event was located turned off the lights, so people could better see the images on the screen. The darkness made it hard for the youngest children to stay awake. Tired and bored, they fussed and squirmed in their seats. Some had to wait at the clinic for a couple of hours before the presentation began and, although the private Christian school located next door had a large and tantalizing playground, they were not allowed to use it for “liability reasons.” Before the presentation each child was weighed, measured, and had blood drawn. Traumatic for some, the needle stick resulted in tears that made the small children even more exhausted.

The speaker was an older woman with curly white hair and a thick Venezuelan accent. She thanked everyone for coming and asked if the parents received their certificate for a free six-month family membership to the YMCA as payment for their children’s participation in the research study. People nodded. She smiled and said she wanted them to live longer, happier lives. The image on the screen changed to show a car and a human body, “Food for the body is like gas for the car. When we eat we’re tanking up,” the woman told the audience. “A calorie is a measure of energy like a gallon is for gas. A calorie is the amount of energy required to raise one gram of water by one degree. Does anyone know how much a gram is?” When no one answered, she leaned toward them and said in a conspiratorial tone that it was hard for Americans to think in grams because they do not use the metric system. Seeming an afterthought, she added that every other country in the world used metrics but that Americans were stubborn and refused.

The audience was racially mixed. Many people knew each other and, as the adults also began to grow restless, chatter filled the room. The women wore polyester, permanent press pants, cotton jersey shirts, and bland uniforms in shades of grey, khaki, and tan. They were administrative assistants, hair dressers, and waitresses. Some had health insurance; others did not. It depended on where they worked and if they were part-or full-time. Even among those with health insurance, many said they were often hesitant to go to the doctor because money was tight and the cash that they needed for an office visit copayment or to meet a policy deductible was better spent on things like food, clothes, and school supplies. Most of these women were married or, at the very least, involved in a long-term relationship. A

couple of the women brought their husbands with them, but most laughed when their spouse came up in conversation because this was about their kids, food, and health, so it was meant for them and not for the men in their lives.

The next slide showed the stomach as a chemical processing plant with food entering one side and glucose leaving the other. The speaker pointed to the image and explained that sugar was energy used by the body with the help of insulin. She explained that when people had too much energy they stored it, which she equated with the storage of stuff. She asked the audience what they did when their garage was too full. A couple of women called out that they had a garage sale, but the speaker rebuked them saying no they didn't. They filled their attic. After the attic was full they rented storage units. She pointed to her hips and thighs and said that these were storage units. She told the women and their children not to worry too much about kids storing energy because they were young and growing, but people should eat to match their energy needs. It was when they failed to eat within their caloric boundaries that there was trouble. She took a breath to insert a dramatic pause before she told them it was up to the parents in the room to end the obesity epidemic.

"Have you heard of carbs, proteins, and fats?" She asked. "One hundred percent of carbs go towards the production of glucose, 50 percent to 60 percent of proteins do and 10 percent of fats." She looked at a child in the front row. "Does water provide energy?" The boy shook his head. "No," she agreed and then told the mothers, "Carbs take fifteen minutes to three hours to process to glucose, proteins three to nine hours, and fat nine to twelve hours." The more technical the information, the more the women lost interest. Half an hour into the presentation, several conversations were in progress. The speaker ignored the people talking and said that the Atkins diet was bad because when people only ate protein they didn't lose fat. They lost water.

A picture of a food label appeared on the screen. She said it was important for everyone to look at labels and know how many carbs, proteins, and fats they ingested. They should know how to figure out how many calories were in something. She spent several minutes going over mathematical formulas. Some of the women who were trying to pay attention look confused. One held up her hand but was

ignored as the speaker said, “Of course on American food labels they’ve already done the math, so at the top it says how many calories. This isn’t that useful when you’re trying to keep track of what you’re eating though. People should just count out the grams of how much they need per day. Why does America have to tell Americans everything? Why do they need to know all of this information? To be healthy. It isn’t rocket science. We need to take responsibility.”

She pointed to a line on the food label, “Make sure you look at how many servings per container. You have to figure out how many servings. I want you to know how dieticians think. Fifty percent of calories should come from carbs but from good carbs like crackers, noodles, spaghetti, tortillas especially corn tortillas, or fruit and grains. It doesn’t mean you can only eat whole grains, you should have variety. I really like white bread especially when I eat an open-faced sandwich. I love corn tortillas. We also need fat. At least 30 percent of our calories should come from fat and 20 percent from protein. There are dietary guidelines for Americans and if you are an American you should know them, so everyone should go and look them up and learn what they are. Fat Americans are bad Americans. We need a healthy nation.”

She continued for several more minutes introducing increasingly complex mathematical equations and calling on people in the audience to answer questions that often they could not answer. When her talk was over, the women stood quickly, gathered their children and their children’s things, and moved quickly toward the door. It was late, past bedtimes, and there was school in the morning. A couple of women stayed and asked the speaker to review the mathematical formulas with them because they could not work them out correctly. She sat with them for a few minutes before one was able to reach the same solution as the example. The other continued to struggle until the speaker told her not to worry about it, she could just “Google it” when she got home.

Health for Sale

Women from the next higher position on the class ladder were given health information that was meant to sell them products. Similar to the first example, the information was usually general, but it was

direct and easily implemented. Women were told to use a product because it was good for them in some way. Consider the following.

Speaking of Women's Health was at the Overland Park, Kansas, convention center. The ticket price was \$40. The following is from an advertisement for it,

It's not a health fair or an expo, it's a unique learning environment featuring top local and national experts on women's health. Add to that a relaxing spa-like atmosphere, health screenings, extraordinary gifts and an elegant lunch and you've created an experience that one attendee describes as "an incredible day to focus on me and my health. I look forward to it each year" (<http://www.shawneemission.org/women-s-health/kansas-city-speaking-of-women-health.html> - 2010).

I arrived just after 8:30 in the morning. For the first half hour around 1,000 women wandered around the large lobby eating from tiny black plates filled with food from a long line of tables covered with black clothes, crystal bowls, and silver platters. The women were professionals. Most were over forty years of age. They dressed in slacks and cardigans, flowing cotton skirts and organza blouses. Many were in small groups, little clusters of friends there for a fun day of discussing their health. All of the women I talked to said they had health insurance, but the type varied based on their job. Before breakout sessions began, women perused tables that were set up along the room's edges by the event sponsors. The tables offered health information and advertisements for everything from nutrient shakes to organic teas. When they checked in, women received a carry-on suitcase complete with wheels. It was full of samples, but women took even more goodies, like happy trick-or-treaters on Halloween.

At 9:00 a.m. we were told to move into small rooms where the breakout sessions were located. They covered everything from the latest fashions at a local department store to ways to improve sexual satisfaction. Sessions lasted around an hour and were followed by a ten to fifteen minute break before the next round of sessions began. During breaks women continued to visit the various tables or received one of a handful of health screenings such as a bone density or lung capacity test. There were also two cosmetologists available, sponsored by a line of beauty products, for five-minute make-up makeovers. At noon the sessions stopped for an hour long sit-down lunch in the ballroom, decorated with balloons, flowers, and banners proclaiming the conference logo, "Be Strong, Be Healthy, Be in Charge." The

luncheon speaker, a female comedian, talked about the difficulties associated with being a woman over forty. After lunch, sessions began again and lasted until 4:00 p.m. when the keynote speaker, a female cardiologist, gave a talk about the uniqueness of the female body. After the address, women trickled outside after massing around two small tables that continued to offer samples of breakfast cereal and fruit juice.

Selling Services

The health information offered at events for women of the highest social position accessed for this study was meant to sell services or solicit donations. These events were free but required an invitation. They also provided women with food and gifts, but the gifts were not samples. They were fun novelties and trinkets that followed the event's theme, such as a heart shaped ballpoint pen. Consider the following.

Change of Heart was organized for women executives and held at the new facilities of a for-profit hospital. I was invited by the Women's Chamber of Commerce after I contacted it about my research. Eager to help, chamber staff quickly welcomed me and seemed interested in my dissertation. Most of the women I spoke with to obtain the invitation, as well as at the event, had at least one master's degree. A couple lacked formal education and said they worked their way up through the ranks of their companies to top positions. All who said they had children between eighteen and twenty-four years old indicated their children were in college.

When I arrived, my car was taken by valets. I walked away from the carefully manicured entrance, passing through two sets of silent automatic doors, into an atrium where I soft light reflected off the black polished granite walls and floor. Rows of round tables were dressed in black and white linen and artfully placed by a bank of large plate glass windows. The tables overflowed with platters of smoked salmon, shrimp, canapés, slivers of mango, pineapple, melons, and an assortment of cheeses, and other tasty treats. One table sat slightly askew from the others. It was layered with trays of strawberries coated in milk, dark, and white chocolate. Cocktail waitresses, most of whom were young, Hispanic

women, stood between the tables. They were dressed in crisp uniforms that shared the black and white motif of the table linens. Several held trays of white and red wine.

Just over two dozen white and black women trickled in and approached the food tables. Nearly all were dressed in carefully tailored black, blue, and red suits either with straight legged pants or modest skirts. A few wore bolder prints and less tailored outfits, but all were carefully and expensively coifed with perfectly placed hair, often tinted with highlights, and understated, impeccable makeup. Most were thin, their muscles toned. Nearly all were over thirty-five and, through later conversations, I learned those that were younger were assistants to the older women. Most came alone, but many already knew each other. They mingled, moving gracefully from table to table, unafraid to meet each other's eyes or offer a firm handshake. All the women I spoke to about their health insurance had it through a preferred provider organization (PPO), which allowed them to see a number of different specialists for their preventive health care needs on a regular basis.

Prior to entering the atrium, we sat in a large auditorium listening to an hour-long presentation on the dangers of CVD, the importance of heart health and CVD prevention, and the wonderful new facilities available at the hospital for both. Messages about health were about the importance of self-control and the individual's ability to maintain her health through appropriate behaviors and the purchase of diagnostic and treatment services. At the talk, women were offered ice cold bottles of water, pens with the hospital logo, and folders that included brochures for hospital services as well as small pads of paper. Although they were not given any medical tests, they were encouraged to make an appointment for a heart health assessment, not usually covered by insurance, available for \$60. Gift certificates for an assessment were also available for friends and family members. Women were encouraged to give certificates because, in the words of one speaker, they were "such a better present than a gift card to a restaurant or the like because with this present you could actually save someone's life and help us bring heart health awareness to the forefront for women at the same time."

The speakers promised this easy assessment would provide all of the information a woman needed to know her exact risk for CVD and included a cholesterol and blood glucose test, blood pressure

and pulse rate check, and body mass index and waist circumference evaluation. The assessment provided women with a private review of their results with a licensed nurse as well as the emotional support and education needed to change their lifestyles. The assessment could be completed in 90 minutes and would not force women to do anything that could “mess up their hair or make them sweat.” One woman stood and announced that for Christmas that year she purchased all of her employees an assessment to give in place of their usual bonus. “It’s so much better,” she said. “It’s the gift of life.” Women were also invited to purchase tickets for an upcoming, annual event that was meant to raise women’s heart disease awareness. This secondary event provided a “slumber party” atmosphere where women could “hang out” with their friends, enjoy gourmet food and cocktails, and listen to special guest speakers share ways to improve their heart health and fitness. Tickets for the second event cost \$50 to \$175.

Other Venues for Health Information

The health information at events that were not targeted toward health but were in locations for health-related activities such as gyms, usually had pamphlets or small posters with general health information similar to what was available at events for the less affluent. More general locations like libraries lacked health information. Food vendors showed descriptions, images, or actual high-fat, low-nutrient foods such as cakes and cookies to solicit their purchase. They rarely had nutrition information available. When it was, nutrition information was printed on pamphlets placed in nondescript holders in out of the way places. Food ads for less expensive vendors were also seen in the general environment, such as a Quick Trip billboard that showed a picture of a large, gooey cinnamon roll with the words, “life is too short.” These were similar to TV ads discussed below.

Television News

Observing health information on television differed from interacting with women as discussions with women were about their ideas and beliefs. Conversations were directed by them, followed their logic, and centered on what they thought was important. With news segments, it was up to me to decide what was relevant and how to interpret it. No heart health information was covered by the national news on observed days. Based on a joint Kaiser Family Foundation, Pew Research Center (2008) study of the

health information presented by the media from January 2007 through June 2008, this was not surprising. The study considered every episode of the evening news that aired on ABC, NBC, and CBS during the study period and coded stories for content identifying them as health related if at least 50 percent of their material was about health in some way. The study found that of the news stories only 8.3 percent were related to health and only 6.7 percent of these were related to heart disease. Most of the health stories (18.7 percent) were about cancer, followed by diabetes or obesity (7.1 percent). Information about risk and prevention was also sparse; only 25 percent of health stories related to public health and these included stories about tainted vaccines and food recalls. The majority of health stories were about treatments, most (61.3 percent) for a specific disease. Fourteen percent were related to health policy or problems with the US health care system (ibid: 3-4).

It is impossible to say why news stations did not include more health-related stories without asking them, but past research suggested it was either because such stories would have cast a negative light on station owners and sponsors or because such stories were not entertaining enough (Pratkanis and Aronson 2001: 272-273). Various sectors of the health care industry are prominent sponsors of the local and national news. In the US, stations that broadcast the news are predominantly owned by large corporations and tend to favor stories that are either pro-business or neutral but business oriented. In the past, reporters said they were told not to follow stories that hurt sponsors or to pull stories that sponsors did not like (Perrucci and Wyszog 2008: 212-217). Stories also rarely address controversial class issues because class information is thought too difficult for the general public to process or they would not like it. Stories that are preferred by networks are those that ignore or favor corporations while simultaneously involving dramatic action, conflict, and, if possible, famous people (Pratkanis and Aronson 2001: 272-273, Perrucci and Wyszog 2008: 205-207, 212-213). This means that stories about heart disease are not newsworthy unless they are about someone famous who died unexpectedly from the disease, such as Tim Russert in 2008.

Kansas City's local news had forty-nine segments related to health from July 1, 2008 to December 31, 2008. Using KFF categories, most were related to public health (Table 3), but these were

usually public service messages such as a story about a free child vaccination clinic. Less were about health policy, also a major topic in political campaigns of the time. These stories were short and did not address complexities in the US health care system. For example, one was about a radio DJ criticized after he made on-air jokes about people without health insurance possibly being forced to give up driver's licenses because they lacked coverage. There were segments related to the treatment of a specific disease that emphasized the importance of health care. These segments showed people who received care as better for it or told stories of people who did not seek care and had serious consequences because of it. Only a small portion of health stories were about CVD, including a story about heart attacks in women and a story about a woman who survived CVD. There were twice as many stories about breast cancer as heart disease. Only one story mentioned CVD risks. Its primary focus was obesity.

Table 3 – Percentage of Evening News Stories by Kaiser Family Foundation (KFF) Topic

Story Topic	Percent (n=49)
Public Health	31%
Disease Treatment	20%
Health Policy	12%
Cancer	12%
Diabetes and Obesity	6%
Cardiovascular Disease	4%

The large percentage of messages about successful disease treatment made it more likely that when audience members thought about a disease, they thought about the health care available to treat it and not what caused it or the experiences of people diagnosed with it. These stories gave the impression that through Western medicine diseases were always treatable and, if not curable, at least controllable. They rarely addressed the limited ability of some segments of the population to access care. When they looked at social stratification and care, they looked at it from an individual perspective, not a societal level. Consider a story that aired on KMBC, the ABC affiliate, at 6:00 pm on October 23, 2008.

The story began by saying that the economic downturn caused people to either skip doses or stop taking their prescription medications to save money. They interviewed a diabetic man who said he never missed a dose of his insulin but skipped his other eleven medications regularly. He said money was tight because he had a daughter in college and a son in law school. The reporter told the audience there were risks to skipping doses of medication. She interviewed a nurse practitioner in her fifties who said people should not skip their medications because if

they are sick there is no one there to take care of their family. If the primary breadwinner cannot work then the whole family suffers. The reporter added that women were especially bad about skipping medications in order to pay for things their children needed but, the nurse practitioner explained, that mom had to be selfish because if she could not work then there was no one to feed her children. The reporter said that the diabetic man saw a doctor every four months and so far there was no change to his health. The nurse practitioner said if someone was having trouble paying for their prescription they should talk to their doctor. The doctor might be able to combine some of them to reduce costs. The story ended when the anchorwoman appeared and said everyone can cut their health care costs by eating right and exercising. She then put up information about Missouri Rx and Community Rx, the Missouri and Kansas prescription assistance programs (Chapman 2008a).

While the news story brought attention to a problem of health care access, it failed to mention that people skipped doses of their prescription medications because they could not afford them before the 2008 economic downturn. Analysis of focus group data collected in 2007 from forty-two underinsured people in the Kansas City area found that skipping doses, as well as forfeiting prescriptions, or taking prescribed medications until they were used up even when a doctor changed their prescription were common strategies to reduce health care costs. They rationalized skipping drugs by saying that drug companies understood complete compliance was impossible and made drugs so missing doses was not harmful and viewed skipping medications as an issue of personal responsibility. One male participant said, “It’s not like you’re really taking risks; you’re taking responsibility for your own medical care” (Hall, Carroll, and Moore 2010: 308).

Although Americans across the income spectrum reported skipping medications to save money in the past, more low-income people used this strategy than people of average incomes (34 percent vs. 20 percent respectively) (Morgan and Kennedy 2010: 5). Unlike the man in the story, it was unlikely that people with lower incomes had a child in law school who could go without tuition money to help pay for his parent’s drugs. This example diminished the reality faced by those in more desperate situations.

In addition the story presented state prescription programs as a solution for people who could not afford their medicine. Community Rx covered only a short list of predominantly generic medications. In a phone conversation in the spring of 2008, before the story aired, Community Rx also said it could not take any new enrollees until 2009 because it lacked funds. Because only those who needed the program

called and found out it was no longer available, the rest of the people who watched this story were left with the impression that help was available to those who needed it.

Commercials

The total number of commercial I watched from July 1, 2008 to December 31, 2008 was 1,372, although many ads repeated several times. Because part of the period spanned the 2008 elections (25 percent of ads were for political candidates), data from November 6 through December 31 was also considered independently. In that period, 365 commercials were observed. Around 10 percent were for fast food (Table 4). Between 6 and 9 percent were health related (e.g., Healthy Choice Frozen Dinners), and only a small percentage were for prescription drugs (e.g., Plavix, Lipitor, Advair) or over-the-counter medications (e.g., Tylenol, Miralax, Bayer). The rest were for things such as upholstery cleaning and gutter replacement.

**Table 4 – Percentage of Local News Commercials
by Kaiser Family Foundation (KFF) Topic**

Commercial Topic	Percent for Period (n=1,372)	Percent for 11-6-08 to 12-31-08 (n=365)
Fast Food	7%	11%
Health Related	6%	9%
Over-the-Couther Medications	1%	4%
Prescription Drugs	1%	2%

For the period from July 1, 2008 to December 31, 2008, there were 1,020 ads on during the national news. Many of these were also repeats of the same ad aired numerous times. Over 20 percent were for health-related products. Nearly 20 percent were for prescription drugs. Because only a small percent were election related, an independent sample after November 6 was not considered. Local and national news programs were often sponsored by health care companies or companies that related their products to health such as pharmacies, hospitals, and clinics.

Table 5 – Percentage of Evening News Commercials by

Kaiser Family Foundation (KFF) Topic	
Commercial Topic	Percent (n=1,020)
Health Related	21%
Prescription Drugs	18%
Over-the-Counter Medications	8%
Political Candidates	4%
Fast Food	2%

The most prominent theme in health-related commercials was the promise that a product could help a person establish, reestablish, or maintain control over her body in some way. Ads sold an active, engaged lifestyle, the lifestyle people could have if they were in control. This was true of prescription drugs, over-the-counter medications, and health-related products. For example, an ad for Lipitor began with the image in black and white. A man said he had a heart attack at fifty-seven after his doctor told him he needed to do more to lower his cholesterol. Like other heart-related prescription drug ads, the announcer said the drug was for people “when proper diet and exercise are not enough,” but it did not seem that the man did these things before his attack based on his next statement which was, “what was I thinking.” The scene changed to color and showed him walking his bicycle next to a river. The new image implied that after his heart attack he engaged in appropriate behaviors, which included “trusting his heart to Lipitor.” An ad for Plavix showed a man stalked by a metal hospital bed, a metaphor for lost control. He talked to his doctor about Plavix, a drug that stopped cholesterol from accumulating in arteries. Once on the drug he stayed out of the hospital bed and in control of his body.

Ads for over-the-counter medications promised to control pain and give people their lives back. These commercials often showed people with a headache or body ache, they took the medicine, and they were “back to normal” quickly. In some commercials, such as one for Excedrin, normal was work. In others, such as one for Tylenol Rapid Release Gels, a drug with the slogan, “Back to normal whatever your normal is,” normal was playing with water guns on a green lawn during a hot summer day, skateboarding next to a bus, riding a horse on a race track, and several other fun activities. Tylenol PM Rapid Release Gels ads also said that this drug not only gave people control over their bodies and over

aches and pains so they could sleep but did it without making them dependent or taking away their long-term control like other drugs might.

Commercials for nonprescription products not only promised to help people gain or maintain control, they promised to do it even when people failed to engage in the behaviors that were required to maintain control themselves. Some were presented as a way to be good when it was otherwise impossible. For example, a commercial for Ensure began as an announcer said, “It really is no surprise people don’t eat right. They just have too much on their plate to think about what they should have on their plate.” A man was shown walking through a lobby with a pile of papers and a donut. “Delicious Ensure is a source of balanced nutrition to have as breakfast, lunch, or just a pick me up. So when you can’t eat right, eat smart; delicious Ensure, nutritious for a better you.” Others advertised that they were a way people could maintain their health even when they did not engage in healthy behaviors. A commercial for Activia yogurt showed a woman in front of her refrigerator. She explained that because of her busy schedule she could not always eat right. Junk food slowed down her digestion, but Activia helped her stay regular.

Women in Kansas City said that what put people at risk for CVD the most was being overweight or obese. Because women put such emphasis on excess weight, I paid special attention to commercials for weight-loss products. There were very few of these on during the evening news, but they ran frequently during other programs. Weight loss products included medications, vitamins, pre-made meals, diet plans, or physical activity at a paid gym or with home exercise equipment. All promised to give people control over their bodies by either helping them change their behavior or by making their bodies lose fat without behavior modification. The following is from Weight Watchers,

A woman came into her living room, sat on her couch and turned on the TV. An anonymous female spokesperson said, “When you’re on a diet hungry always seems to get in your way.” A little orange monster popped out of the woman’s TV, holding a chocolate cake in one hand and playing a trumpet with the other. The spokeswoman continued, “That’s why Weight Watchers created the brand new Momentum Program.” A sign slid onto the screen pushing out the monster. The monster pushed back but, with the sign’s second push, was removed from the screen. The picture changed to show the monster on a table as various unhealthy foods appeared beside him and the spokeswoman said, “Now you can conquer hungry and other things that stop you from losing weight.” The monster directed a miniature dump truck full of candy directing it

to unload its sugary cargo. “Call 1-800-number now.” The white number appeared on a red screen before the monster took its place. It stood on a chair and the announcer continued, “Learn new strategies like eating filling foods so you don’t eat when you’re tempted or bored.” The words appeared over the monster as he held up cards saying tacos, burgers, pasta, and noodles. A sign that said “New Momentum Program” appeared dropping down over the monster. The screen turns orange and the spokesperson says, “Weight Watchers stop dieting start living” (Chapman 2008c).

Others emphasized how easy it was to lose weight with products that people could use to control their bodies without changing their behavior. Drugs were supposed to suppress appetite, block fat absorption, or speed up metabolism. Programs with meal plans such as Nutrisystem and Jenny Craig emphasized the similarity of their foods to foods that were traditionally identified as fattening like pancakes. Food products offered themselves as less fattening or healthier alternatives to unhealthy fattening foods. The following comes from a series of Yoplait Yogurt commercials,

A woman appeared on the screen in gray workout clothes. She was talking to someone on a cell phone as her husband did something on the kitchen counter in the background. She said, “My diet, well, yesterday I had an apple turnover. Mm-hmm, well it’s sort of my weakness.” The camera showed a close up of her husband looking toward her with surprise and desire. He looked at the refrigerator. The woman continued, “I always keep it in the house.” The man dropped what he was doing and opened the refrigerator door quickly. There was an entire shelf of Yoplait Yogurt, but he was oblivious. The woman told the person on the phone, “Well that and Boston cream pie, white chocolate strawberries, yeah, yeah, and the key lime pie.” The husband had gone through every inch of the refrigerator. He was on his knees because he had just finished searching the bottom shelf and the drawers. The woman said, “Yeah, I’ve already lost some weight.” The camera showed a close up of his angry face as he looked to her confused. An announcer said Yoplait Light with fourteen delicious flavors at just 100 calories.” The man moved the yogurt over oblivious to it. Tiny white letters appeared on the screen. First they read, “As part of a reduced calorie diet and regular exercise.” They changed to, “Some flavors are 110 calories.” The woman looked at her husband and said, “Babe, what are you doing.” He looked at her sheepishly. The screen changed to show the Yoplait logo, “Yoplait, it’s so good.”

Like the Yoplait commercial, other products told people to eat them instead of other, less healthy alternatives. There were Pop Tarts with added fiber, flavored waters with added protein, and candy bars with added fiber, protein, or both. Commercials told people that as long as they chose a product that advertised it was good for them, they were doing the right thing for their body and what they could for their health. Some women in Kansas City (thirteen who openly discussed it) indicated that they believed this was true. As long as they chose the “healthy Pop-Tarts,” they had good dietary practices. These women did not consider the intricacies of how food components like fiber and protein worked together.

For example, they did not think about people's daily requirements for fiber, they just assumed that products with more fiber were healthier. Those who openly stated this had mixed income levels, but they were not as well educated as other women in the group: the highest degree obtained was an associate's degree. Nine were over the age of forty and five were over fifty. Eight women with this belief had chronic health conditions such as type II diabetes. Several others led me to believe that they too only looked at what products advertised about themselves and not their actual nutrition information. The same women simultaneously talked about the need to look more closely at the nutrition in processed foods because foods lied or misled about their health benefits, but these women did not have time to be constantly vigilant. "I don't have six hours a week to waste on grocery shopping," one woman said as we talked about food labels.

Food makers are aware of their ability to manipulate consumers by marking a food as healthy. In 2008, General Mills, Kellogg's, and Kraft Foods used a program called Smart Choices to emphasize the healthier aspects of their processed foods, such as the use of whole grains to make breakfast cereals. They labeled them with a sticker or picture of a white box and green checkmark that said Smart Choices and produced commercials that told consumers to look for this label. In 2009 the FDA announced it would investigate these claims, along with several other manufacturer front-of-package logos that were supposed to indicate a food was a healthier option after a consumer group complained that some products with the Smart Choices label, like the children's cereal Froot Loops, were almost 50 percent sugar (Stark and Kahn 2009).

Ads that targeted women often played on gender stereotypes. Aside from Subway Restaurant ads that featured Jarod, a man purported to have lost 245 pounds by eating sandwiches, weight loss ads rarely showed men. When they did, such as in a Nutrisystem ad featuring former football player Dan Moreno, they acknowledged that seeing a man in such a role was unusual. More recent Jenny Craig ads with comedian Jason Alexander also acknowledged that a man using such weight loss products was new. Several other product commercials continued to contend that it was much easier for men to lose weight

than women, such as ads for the diet supplement Slimquick, which showed cartoon images of a man and woman. In one ad the woman began,

“This is my husband Todd, he’s fat and happy. I’m fat, not so happy. It’s not easy to diet when you eat out as much as we do, so we started ordering salads instead of fries. This is what happened to him.” The image of Todd shrank several sizes. “This is what happened to me.” The image of the woman’s breasts shrank several sizes. “Now we’re both unhappy.” A female announcer’s voice said, “New SlimQuick designed for women’s weight loss.” As the voice spoke the cartoon image of the woman walked around a giant box of SlimQuick and became skinny. The announcer continued, “SlimQuick helps address six reasons women have trouble losing weight.” The reasons appeared inside circles around the box of SlimQuick. They were: (1) water, (2) hormones, (3) stress, (4) metabolism, (5) energy, and (6) appetite. The announcer said, “SlimQuick with diet and exercise, how women lose weight. SlimQuick in pills and now a new drink mix” (Chapman 2008d).

Ads for women’s products emphasized the need to put themselves first and to take care of their health before they took care of the needs of others. For older women, the implication was that they had spent their lives taking care of others and had earned this right. A commercial for Bayer Aspirin used a spokeswoman in her mid-fifties. The woman sat on a couch and addressed the audience as one would address a friend: “I never thought I would have a heart attack, but I did.” She instructed members of the audience to talk to their doctors about aspirin, saying that people needed to be their own health advocates. An announcer said that people should talk to their doctor before they began an aspirin regimen. A black and white dog appeared on the couch with the woman as she smiled at the camera and said, “You took care of your kids. Now it is time to take care of yourself.” Younger women were told they must take care of themselves, so they could continue to take care of others.

Everyone in the commercials was relatively affluent, living in upscale single family homes or condominiums with high-end décor and state of the art appliances. Commercials for foods not advertised as healthy were deemed wholesome. Interviews showed these foods were most often eaten by poorer women, as were foods that had ads that said they were healthy because they contained hidden vegetables. Although these foods were used by the poorer women in the sample, most of whom worked (Table 2), the ads for them showed images such as a perky, thin, stay-at-home mom with happy, healthy children eating at a large table in their bright, roomy kitchen. Stouffers differed because when it advertised its line of frozen family meals (e.g., lasagna), it did so as a way for busy, working moms to bring their families

together for a meal. Stouffers used images more reflective of the working-class mothers observed in Kansas City. Besides being shown as healthy or wholesome and good tasting, most prepackaged meals were also shown as easy and convenient.

Social Reproduction and the Media

Food makers profit more from processed foods than fresh ones because they can charge more for foods modified through relatively inexpensive techniques. The corn in a box of corn flakes accounts for less than 10 percent of the product's overall price (Nestle 2007: 17-18). Food producers also save money on processed foods because these foods have longer shelf lives and require less expensive methods of storage and transportation. It makes sense that the largest food manufacturers prefer to sell processed over non-processed foods and advertise accordingly. Ads for whole foods were not observed. Ironically, whole foods are associated with health and processed foods that are identified as natural in some way sell much better than those without this kind of labeling (Pratkanis and Aronson 2001: 159). The USDA and Food and Drug Administration (FDA) do not allow food makers to label foods as natural if foods contain anything artificial or synthetic. Food manufacturers maneuver around this by using phrases with the word natural in them, such as use of the phrase, "made with all natural ingredients" in ads for high fructose corn syrup. They also use natural heuristics, such as images of waving wheat on boxes of cereal. Past research indicates that people prefer foods they identify as natural because they think something that is natural is more wholesome and healthier than something processed (ibid: 158-160).

People believe they can affect their physical appearance through diet and physical activity, a message found throughout the environment, repeated on the news and in commercials. People in society are known to attempt to change aspects of themselves to become more socially desirable (Meinert 2004: 23). They also change parts of their lifestyle if they see changes as both possible and desirable. Marketers manipulate people's desire to have an acceptable, healthy body and their willingness to change their habits to sell products. Marketers reaffirm the idea that whole foods are more difficult to prepare than processed foods and that they taste worse because ads present these points as accepted knowledge.

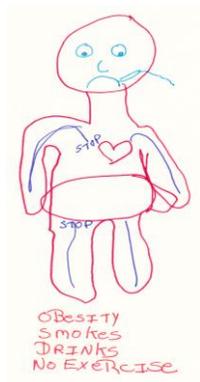
The interviewed women believe marketer messages to varying degrees, but the burden associated with belief in these messages was borne disproportionately by the poor.

Women’s Beliefs about Cardiovascular Disease

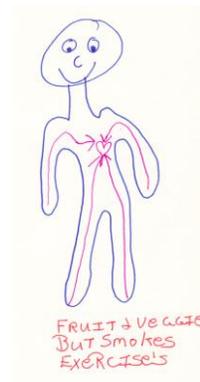
Women associated CVD with the heart and indicated they knew exactly what it was, the part of the body it affected, and its long-term consequences. They referred to it primarily as a heart attack, a quick, painless, and good death. “My grandmother, she went to bed one night and never woke up, just lay down and went to sleep. It sounds like a good way to go,” one woman explained. Interviewed women also saw the heart as the center of emotion and sometimes represented it as a valentine (Figure 3). Ten of the fifty-five women drew it this way; eight drew it as a four chambered pump; three as a valentine turning into a pump. Images of a valentine turning into a pump may have represented a change in how women saw the heart. Instead of being the center of emotion, it was becoming just another body part (Weiss 1997: 469). Five women drew the heart as an indiscriminate circle, which might have indicated that this organ was becoming more amorphous to women who did not see it as biological or metaphorical or simply that they could not draw. The rest of the women did not show the heart in their pictures at all. Instead, they showed people who were overweight or obese, sometimes engaged in what the women identified as unhealthy behaviors.

Figure 3
Interviewed Woman’s Image of a Person “At Risk” and Diagnosed with Cardiovascular Disease

At Risk for CVD



Diagnosed with CVD



Besides pictures of people with CVD, women drew pictures of people at risk for it. Images showed people engaged in behaviors women identified as bad, such as smoking, drinking, and eating low-nutrient foods like french-fries. In pictures, CVD was a disease that people brought on themselves because they lacked the discipline required to stay healthy. Although women indicated this was true for other people, nearly all of them also explained that they believed they acted the way they should most of the time. Women who thought they did not act in appropriate ways had a lower social position, but even among these women few worried CVD would affect them. It was a disease that happened to other people.

Past research has shown that people view CVD differently from other diseases, particularly cancer and AIDS. In these studies, people saw CVD survivors as normal, while they saw cancer survivors and people with AIDS as contaminated. People in these studies drew those with cancer and AIDS as transformed into polluted, undesirable beings (Weiss 1997: 469, Sontag 1988: 38). Interviewed women also described CVD as transformative, but instead of survivors becoming undesirable, they were reformed. Interviewed women described survivors as if these people went through spiritual awakenings. Consider the commercial for Lipitor. The man had a heart attack. He changed his lifestyle and repented for his past ways. He was saved. As she drew the picture in Figure 3, the woman said, “Well, you know this person is so much healthier. They eat better, get more exercise, quit drinking and smoking. Well, maybe not smoking. They will quit, but it takes longer because it’s harder to do.” Figure 3 was representative of many themes found throughout respondent’s pictures. In the image, the “at-risk” person was unhappy while the person diagnosed was happy even though the “at-risk” person engaged in behaviors that were more fun and the diagnosed person had a serious disease. Diagnosis gave a person the desire to take control.

The Balanced Body

As women talked about CVD and CVD risk, they talked about balance. In the West, the association between balance, diet, exercise, and weight originated in Kenneth Cooper’s (1982 [1968]) book *Aerobics*, which is credited with helping begin the movement that made the desire for physical fitness a cultural obsession. In his book, Cooper called for “a balance between proper diet and exercise,

as well as other lifestyle changes, such as the elimination of smoking, addictive drugs, and excessive alcohol, along with stress reduction and regular physical examination” (Eng 2000: 250). A Kansas City nutritionist told me that balance and moderation were about balancing a person’s caloric intake with her energy output to maintain a healthy weight. In her training she learned that balance is a process of making good food choices in relation to individual energy expenditure.

Lay women did not see balance the same way. They added to this concept any transitory, unhealthy but emotionally uplifting deviation from a healthy lifestyle. One of the women I talked to told me, “I have a hotdog when I go to the ballpark like twice a year. They are delicious, I love them and it makes me feel good to indulge. I don’t eat them at home because they’re disgusting. You might as well wrap a stick of butter in a bun, but once in a while at the ballpark. Balance, you know.” For lay women, balance was more reflective of eating a little bit of every kind of food. They rarely included exercise in this concept and tended to associate it with Eastern medical traditions and philosophies. None followed these traditions. The only woman who brought them up also enjoyed an occasional hotdog. “I’m a big believer in you’ve got a whole boatload of things you can use for health care and I’m a big East-West, you know. I think acupuncture and herbs are important.” In the 1970s a prepackaged, commoditized version of Chinese medicine came into fashion in the US. This Westernized version of Eastern thought stands in opposition to Western medical models that treat the body like a machine (Unschuld 2009: 197-200). People in the West use it to humanize health care. Women’s association between caloric balance and Eastern tradition lends the concept legitimacy as it also allows women to soften the more Western idea with the incorporation of unhealthy foods and physical pleasure.

While the balance concept allows for the incorporation of a more humanistic understanding of the relationship between food and people into people’s beliefs about lifestyle, it does so in a controlled way. At its core, the balance concept is about control. When women talked about balance, I sometimes envisioned a tightrope with fast-food on one side and fresh vegetables on the other. Women indicated that they were trying to eat their fast-food french-fries and their fresh apples to be emotionally happy while simultaneously maintaining a thin, smooth body. Occasionally a woman would even talk about

using healthy foods to negate the effects of unhealthy ones. As we sat in her favorite café one woman said, “Well, yeah, I’ll eat these chips, but I’ll eat the apple too so there is balance.”

Out of Control Fat

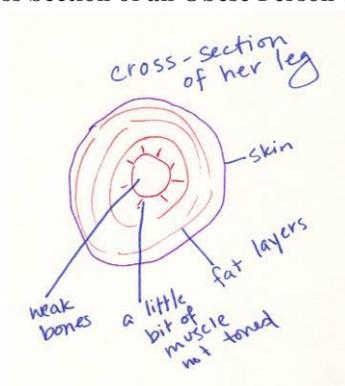
For the women I talked to, a person who is out of balance is a person who is overweight. Excess fat was the most common element found in women’s drawings of CVD risk, but women’s ideal form was not just a thin body. It was a smooth one. Women wanted smooth bodies because they saw fat as something different than other types of tissue. When women described the perfect body it was sleek, slender, and tight. Fat is out of control. It is lumpy and makes a body lumpy. A woman who began to exercise a few months before we met and subsequently lost several pounds said,

On this one you’d see lumps. And I still have bumps in here. These are like cellulite, yeah. Now a man being obese, and my husband probably has a good 30 pounds in his belly, I hate to say it, but it’s like he’s pregnant because he has nothing here [points to legs], but all this is cellulite. It is fat just hanging [points to belly]. So that’s where I’m seeing that fat on me and that’s the same thing here [points to thighs], but you know what? Losing that weight from that elliptical, it is flat. It’s smooth.

Interviewed women described fat as an ugly, disgusting substance that stuck together in blobs, lumps, and clumps. It stopped the body from working properly and caused physical weakness. The woman who drew Figure 4 explained,

So I think you’d see the bone and I don’t think it would be very strong. Like I don’t think the bone itself would be very strong and I think you’d see a little bit of muscle there, but then like layers and layers and layers of fat before you got to the skin. And I think the fat would look like Crisco, but more like gelatin Crisco. Not as greasy. I think that it would be very, it would look like chicken fat.

Figure 4
Cross Section of an Obese Person’s Leg



Fat is also an invader, part of a team of enemy combatants trying to destroy healthy body tissue. Another woman explained, “Antioxidants eat up free radicals, which, the free radicals are out attacking your arteries, trying to make holes so that the fats can come in and invade the different layers of your blood vessels creating openings and stuff.” Once inside fat clogs arteries the same way that hairballs clog drains. “Yeah, the arteries are beginning to clog up with fatty material and she is about to have, she may have a heart attack if she doesn’t get to the doctor soon and stop eating so much,” Another woman said as she drew her picture. Fat went into places it did not belong and made it harder for the body to work: “Blobs of fat throughout, and the heart working really, really hard, stressed out from working so hard because of all the fat.”

The media showed images of thin, smooth bodies and identified them as beautiful, homogenizing and normalizing a single physical form. Women in the study compared themselves to and tried to imitate the bodies they saw in the media and then used these images to judge the bodies of others. As they did this, the body became “a symbol for the emotional, moral, or spiritual state of the individual” (Bordo 1993: 193). Women saw a person with too much fat as a person who was out of control. For these women, the body represented a person’s inner being. Excess weight was a moral failing particularly among the lower classes who were identified as lazy, indulgent, undisciplined, and unable to conform (Bordo 1993: 195). As she drew, one woman explained, “I’m drawing this person because she is obese. She eats a lot of greasy foods, a lot of fattening food. She is out of control. Her eating habits are out of control” (Figure 5).

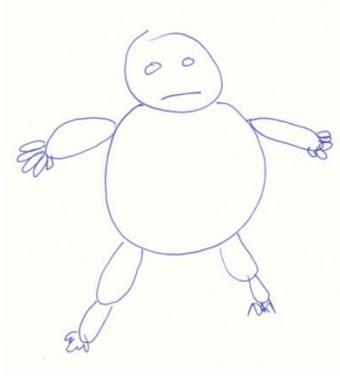
Figure 5
An Out-of-Control Body



The statistical association between excess body weight and CVD legitimated women's beliefs. Being overweight was not the same as being tall or short, having big feet or small hands. It was a representation of individual health. CVD was also the primary disease women associated with being overweight. Interviewed women indicated that they often thought of CVD risk and being overweight as synonymous. One woman explained this while she drew her picture (Figure 6).

He [her father] did happen to die from liver cancer that probably came from the prostate, but I always expected him to have a heart attack because there were plenty of heart problems in his family and I just couldn't imagine how he could be that fat and not have a heart attack. And then my mother's mother was a very short little person, and years later I saw pictures of her when she was thin and she was absolutely gorgeous, but as I knew her she was always this little, little, tiny, round, fat person. Definitely not pretty. Didn't mean she didn't love me, but you know it was not, and she died of a heart attack. And when I think of that well, she was just in her sixties. And so I guess even though I'm struggling with weight myself, and probably always have, I associate fat with heart disease.

Figure 6
An Out-of-Control Diseased Body



Very few women questioned the association between fat and CVD risk. Those who did knew someone who experienced the disease without being overweight. Because of this, women believed that someone who was thin could also develop the disease, but it was because they had a bad diet or because of other bad behaviors. Only one woman questioned whether excess weight was always associated with CVD. She was the only obese woman with health insurance ranked as very good or higher (Table 2).

When asked if a medical professional ever talked to her about CVD, she said,

No, I think that has a lot to do though with my, even though I'm overweight and would be considered morbidly obese, I have extremely good blood pressure. I have extremely good cholesterol, good and bad. I mean they are both in good shape. My doctor used to say I was probably one of the healthiest obese people you'd ever meet and he'd always be like, there should be more things wrong with you besides your back.

Even as she refuted the idea that her excess weight increased her risk for disease, she indicated that she believed excess weight caused disease in others. She felt that obese children were particularly at risk. When I asked her to draw a picture of an at-risk person she looked at the paper in front of her and explained without touching it, “I think of even small children especially the obese children and the way the diabetes, the issues with diabetes, weight and how that’s affecting our children.” As we talked about specific types of CVD risk, she recognized that her thoughts and experiences were contradictory and acknowledged there was a socially ascribed bias against fat people,

This is a prejudicial concept with it because I myself being obese think it’s interesting I would sit there and do this, but I think of laziness and the unwillingness to lose weight. And that is not always the case.

In the past, people were considered responsible for disease because they were weak. AIDS introduced a more direct kind of responsibility for disease development. People with AIDS were ill because they indulged in dangerous, disgusting, debaucherous behaviors (Sontag 1997: 232). Women continued to talk about CVD and overweight as matters of personal weakness, but they also talked about them more harshly. They were not just a result of individual bad behaviors, but they were contagious. Individuals “caught” fatness from the people in their social circle. A woman with excellent access to care and a moderately high household income told me about her sister who lost and then gained back several pounds,

She lost a person. I mean an entire person and then she called me. She was complaining to me about it because she didn’t like where she was at again, and I said, “Well you chose to start eating that way because you were hanging around with friends who did and out drinking with them and you just started, started all those bad habits right back up again. You can stop. Take a choice.”

According to another woman,

People eat what their friends eat. They do what they do, so if their friends are going to go out and eat like eat at Old Chicago or something and have all that heavy food then they’re going to go out and eat all that heavy food and if their friends are going to smoke while they’re out drinking a beer then they’re going to smoke and have a beer too because that’s what people do. They do what their friends do.

Other women said fat spreads through families. Part of this was a result of genetics, but transmission was also caused by people learning their health habits from their parents. If someone's parents did not exercise and ate poorly when the person was a child, then they would fail to exercise and would eat poorly when they grow up. Women often emphasized their parents past health consciousness and how this influenced them. While talking about where her health knowledge came from, one woman explained,

My mom being a nurse we, oh my gosh, we ate very healthy. There was no chocolate. There was no, you know I was a fat kid. I was a carb junkie, but we didn't have cookies and cakes and chocolates. That was not in the house at all. No soda, the occasional ginger ale on Sunday. Otherwise it was just no soda, so a lot of it for me is just what I've picked up.

Women who said they had lost weight talked about how they changed their habits and overcame what their parents taught them. One who lost over forty pounds the year before we met said,

We couldn't afford a lot of fresh vegetables and stuff, so we didn't learn how to cook and how to eat. We just ate because that's what filled us up. And like now if I would have ate properly, you know, and a lot of my problems, my health problems, they wouldn't be as bad. I'm not saying they wouldn't be there, but they wouldn't be as bad with the diabetes.

Sinful, Evil, and Addictive Diets

Mary Douglas (1992: 7) compared the modern social use of disease risk to past social use of sin. Among women who participated in this research, the behaviors that caused CVD were not just risky. They were sinful. While most of the behaviors women identified as sinful were things that they also believed hurt other people, such as smoking and drinking, being overweight was also sinful. It is difficult to determine exactly when body fat was first associated with sin in Western society. Among Christians, being overweight is associated with two of the seven deadly sins, sloth and gluttony. In the US, the belief that individuals are morally obligated to maintain their health and thus an appropriate weight for good health is at least as old as the Puritans, who identified earthly pleasures like the foods now identified as unhealthy as forms of vice. They also saw most disease as a consequence of violating physiological laws. Maintaining laws was a matter of duty (Eng 2000).

When interviewed women used the word fat as an adjective for other people, it was almost always in a pejorative way that indicated the person was responsible for excess weight. Even overweight

women often spoke about fat in negative ways. Although women never used the words sloth and gluttony, it was clear that fat continued to represent both of these sins. Contemporary words and phrases that are synonymous with these older terms were often used, and included identifiers such as lazy and out of control. One woman said, “She just sits around all the time and does nothing. That’s why she’s fat.”

Another woman concurred that being overweight was a direct result of laziness. As she drew she said,

This is a sedentary person who sits on their rear end and so they are fat. These are people who are diminished. I mean really diminished. I mean these aren’t morbidly obese people. They need to lose fifteen to thirty pounds and their lives would change, so they need to lose weight.

The woman who drew Figure 7 struggled with her weight but still said,

It’s an obese woman in a wheelchair. I don’t know if she’s old or young; [she] just kind of let herself go. She’s probably in a wheelchair because that’s what separates me from her. I really was thinking of my husband’s grandma. She just doesn’t, she’s like sixty-eight and just doesn’t get up. I put her in wheelchair. The wheelchair being more symbolic I guess of a, she’d probably be on a couch in front of a TV or something. Really I’m thinking someone who is not taking care of herself, not getting up, not moving. The wheelchair kind of being symbolic of that I guess. What it would really be, like really you’d probably see her just around the house not doing much.

Figure 7
An Obese Woman Whose Laziness is like a Wheelchair



The women in this study believed that people who were overweight not only ate too much but ate the wrong things. The kinds of foods they identified as healthy or unhealthy vary based on where women fell on the socioeconomic spectrum, although general categories of good and bad foods were the same. All women identified some foods as evil. These were foods that were likely to tempt them to “sin,” such as sugar, salt, and fat. Women at the top of the social spectrum were the most rigid about diet and were more judgmental about even the occasional variance. Through their interactions with other women from

different parts of the social spectrum, they realized their views were seen as extreme. Such recognition was always followed by a statement that validated their beliefs and indicated a sort of tolerance or pity for those who failed to give the same level of importance to their health. “My secretary thought I was crazy,” one woman said as she explained her diet, which was prescribed to her by a personal nutritionist. “I eat steamed broccoli at ten in the morning and she used to look at me like, how can you eat that at ten in the morning, but I said to her one day, ‘This is what my body needs so it can give me optimum performance.’ It is too bad everyone can’t see Dave [her nutritionist].” After we talked for a while, the one obese woman from the top of the spectrum confessed that she indulged in bad foods at night, in secret when her husband and son were in bed, indicative that this behavior was sinful.

That this woman ate bad foods in secret reflects another metaphor women used when they talked about fattening foods. They often referred to these foods as drugs. For example, women talked about the addictive nature of carbohydrates and referred to themselves as “carb junkies.” One woman told me she was overweight because chocolate was her drug of choice. When women referred to food as a drug, it implied that the people who ate these foods, particularly people who were overweight, were drug addicts.

I think sugar is addictive. I think sugar is the worst addiction on the planet, worse than any drug, worse than anything because it’s just, well, you know it is subsidized by the government overtly and nothing is ever studied. And no studies are ever released that indicate what it does to you.

The association between body fat and food addiction is complex but always relates to control. On one hand, drug addicts bear the weight of terrible a stigma in US society where they are largely seen as responsible for their condition. Many people believe addicts choose whether to take a drug and are thus in control of their behavior. On the other hand, the addition of drug addiction to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and development of organizations like the American Society for Addiction Medicine are changing the way people perceive addiction. The idea that it is a disease of the brain and that people really cannot control it is becoming more prevalent (see Volkow 2008 for a short discussion of this phenomenon). It was often difficult to disentangle whether women wanted to let themselves or others off the hook when they referred to food as an addiction or if they placed the

same stigma on overweight people that they placed on drug addicts. It is likely both ideas came into play when women talked about food as a drug, sometimes simultaneously.

With the exception of smoking, which in terms of health sins and addictions was identified as the worst behavior imaginable, even worse than using heroin in the words of one informant, eating fast-food was the most common element in women's drawings (Figure 8). Participants from the top and middle of the socioeconomic spectrum were especially critical when people fed their children fast-food (Table 2).

One woman said,

I heard one of the, this is kind of going back to Happy Meals and proper feeding of children and not everybody is doing that to their kids, but um eating a Happy Meal is equivalent on your vascular system to smoking a pack of cigarettes. So I mean giving your kids a happy meal from McDonald's with Chicken McNuggets and fries and a soda is basically sitting down and saying "Here, Honey, have a pack of cigarettes." So if that doesn't make a parent feel bad, I don't know what would.

Figure 8
A Man at Risk Because He Eats McDonald's
(note the little M on the french-fry bag)



News stories about scientific research helped validate women's beliefs about fast-food. For example, one story reported the results of a Center for Science and the Public Interest study that looked at the nutritional quality of meals at several major restaurants like KFC, McDonald's, Taco Bell, Jack in the Box, Burger King, and Wendy's (Chapman 2008d). The reporter said that out of 1,400 food choices looked at by researchers, 93 percent exceeded 430 calories, the recommended amount in a meal for a child between the ages of four and eight. The reporter added that obesity rates had tripled among children over the past few years and emphasized that the majority of kid's meals had too many calories. He ended

with the statement that of all the restaurants considered, Subway had the best options. When women identified healthy fast-food, it was always Subway. But Subway was only as healthy as what people ordered. Watching women order confirmed that many of those who said it was a healthy option ate sandwiches off of the unhealthy side of the menu. A six-inch Big Philly Cheesesteak has 520 calories and nine grams of saturated fat without adding anything to it (see: www.subway.com). Comparatively, a Quarter Pounder with Cheese from McDonald's, the restaurant most often identified as bad, has 510 calories and twelve grams of saturated fat. If the cheese is removed, so are 100 calories and five grams of saturated fat (www.McDonald's.com).

Fat People are Poor, Lazy, and Stupid

None of the women suggested that parents fed children poorly on purpose. Instead they indicated that bad diets were due to parent laziness, lack of fiscal resources, or limited knowledge. Two of the interviewed women with high incomes explained that if parents could not afford to feed their children properly, their children should be taken away (Table 2). One of them worked for a national nonprofit agency that assisted low-income families with young children. The other told me, "Will you abort a fetus whose going to have heart disease? I don't really think that's the issue. I think that sometimes it's happily planned and there are ways to protect the child. If you can't afford this child and the ways that you should feed it then maybe we have to put it up for adoption."

Women with low incomes knew that fast-food was bad for their family's health but did not see it as something that required intervention from children and family services. One of the women from the bottom talked at length about how she tried to improve her family's health, even going to a nutritionist that was paid for by the state because her obese daughter was on Medicaid. She explained that it was too hard because of time and expense: "I try to incorporate it [health education], but once again it is very, for me in my position, it's cheaper, quicker, and easier to run up to McDonald's and get some cheeseburgers and bring them home than it is to go to the store and buy some fruit, buy some vegetables."

Women also said that people were not fat just because they were lazy or poor. People were fat because they were uneducated. The women who said this were not uneducated but were college

graduates with incomes that began in the \$80,000 to \$100,000 range (Table 2). These women equated fat with ignorance, often using ignorance as a way to ameliorate the sinful behaviors that caused excess weight. If people did not know any better, then they could not help themselves. One woman put it this way,

I think they, I mean, you know, poor people really, I think they just don't have the knowledge they need. They're ignorant. I mean for whatever reason they just didn't have the upbringing. We didn't have a lot of money. My mom had to work when most moms didn't, but she was educated, you know, she went to college, and she made that extra effort. All of our food was fresh and from scratch. It's about time, money, and education. It's about knowledge because knowledge empowers you to make decisions whether they are good or bad, at least you understand the difference. You know what is the difference between me having that bag of potato chips or eating that apple at lunch time? I mean yeah maybe today I'm stressed and will eat the chips. I need the salt. It is a little comfort food I suppose but recognizing that the apple is much better for me and you know really will make me feel better by the end of the day versus all the salt and fat in the chips. You know, knowledge just gives you the opportunity to make better decisions.

Poor, overweight women indicated they resented the implication they were fat because they were uneducated. This was especially true of women more centrally located in the income and education ranges (Table 2). In nutrition classes, poor women rolled their eyes at the backs of public health educators or made disparaging comments after classes were over. Almost all of them worked hard during interviews to present themselves as knowledgeable about what foods were healthy and how often they should engage in physical activity. They explained that they knew what to do but either choose not to do it or could not because they did not have the necessary resources. Once poor, less-educated women grew comfortable in our discussions, they began to ask for information about nutrition.

Women used ignorance to ameliorate sinful behavior, but self-education about nutrition and physical activity was also thought to be an individual responsibility. Many women with moderate to high incomes presented themselves as very knowledgeable about health (Table 2). At the same time, they sought out new health information but preferred information they could easily understand and that fit within what they already knew about how the body worked. Information that validated their existing behaviors was preferred. Information that called into question their existing beliefs about the body was rejected. Women would hear something they did not like and start to talk about how health information

was always changing and therefore hard to trust. They would hear something they liked, such as that chocolate was good for them, and talk about why they believed it was true.

The Politics of Exclusion

Overweight women worried that people thought they were stupid because they could not control their weight. They made an effort to ensure that others knew they understood what was and was not good for their bodies. They also emphasized their education even if it was only a year in college or a certification through a technical program. The single woman with a master's degree and a forgotten body brought up her degree repeatedly. For the women interviewed, education was important. In the US education is a marker of social class and status (Grubb and Lazerson 2004: 3, 14).

Bourdieu identified higher education as a form of cultural capital. In the US, higher education is also a form of symbolic capital because the better educated someone is the more people see them as likely to achieve a higher social class. In the US, reserve capital, or markers that indicate the potential for upward mobility, are as important as actual capital. This is because of the importance placed on the Horatio Alger myth, or that anyone can raise themselves up through hard work and, after the 1950s, education. An idealized body form is also a type of reserve capital because it indicates a person is likely well educated. It also shows that they are in control of themselves and have the ability to self-manage, a necessary skill if they are to manage others in their employment (Bordo 1993: 190-192). In a time when the social positions of most people are on the decline, real and perceived markers of social status become even more salient. Fat, on the other hand, indicates a person does not have the discipline to achieve upward mobility (ibid: 195). In the words of one public health nutrition educator, "Fat is un-American."

For the women in the research, marriage was also a marker of social status and class. In terms of access to health insurance and income, it was real capital in that the women with the best health insurance and the highest incomes were women who were married. Women with the best coverage also predominantly received their insurance through their husband's employer. Sered and Fernandopulle (2006: 57-59) noted a similar relationship between marriage, health insurance, and poverty. Married women, particularly over the age of thirty-five, had greater access to resources and, as openly discussed

by one divorced woman, more social respect than women without husbands. Because physical appearance is an important element of attraction, something often thought necessary for finding a spouse, the need to find and keep a husband is another area where a woman's body form becomes important.

Chapter 5 --The Cultivated Body

An episode of the Oprah Winfrey show that was shown on January 15, 2009, to coincide with an article published in O magazine, began with Oprah addressing the camera, "You feel flat and you feel tired, you haven't had a good night's sleep in two years, just going through the motions, trying to get through the day. You feel like your life force is being sucked out of you." Her smile broadened. She continued, "We're opening a national conversation about hormone replacement therapy. This is about your hormones being out of whack, and you don't even know. We haven't had a language to talk about it yet." She assured the audience that the topic was relevant to women of all ages because, "if you're a woman who's planning to live past the age of thirty-five, at some point you're going to face hormone imbalance. All women need to be armed with this information." Oprah introduced her special guest, Robin McGraw, wife of TV personality Dr. Phil, who listed several problems associated with her hormone imbalance. "It didn't come because of menopause. It actually started long before I was in the menopause phase of my life."

Robin was on the show to advertise her new book, *What's Age Got to Do with It*. She told Oprah she was like many mothers making her family the priority, not really taking care of herself. She told the camera, "It was through my mother's untimely death and raising my boys that I started to think, Wait a minute, I love my children, so I need to take care of their mother." Robin went to her doctor who said she was in menopause and wrote a prescription for hormones. Robin was uncomfortable taking the medication. As Oprah's website explained, "Instead of blindly following her doctor's advice, Robin decided to take control of her body" (Oprah.com 2010: on-line). The show continued with the addition of a doctor who specialized in hormone health and several women in menopause and peri-menopause. The women complained of several problems from decreased libido and hot flashes to feeling sick, having a bad attitude, or feeling exhausted. The doctor discussed what hormones were and how they worked inside the body. She reviewed the history of hormone replacement therapy and the differences in types of hormones, particularly hormones that were natural versus synthetic. Robin told the audience that with the

addition of hormones she felt the healthiest she had ever felt. The doctor told the women in the studio audience that the wisdom of menopause was “being in the driver’s seat” and “taking charge of your health.”

On January 22, 2009, Oprah had a follow-up show with guest Suzanne Summers. A doctor from the previous show came on briefly to warn the audience that Summers claims in her advocacy of hormone therapy were not scientific and that she was not a medical doctor. His image disappeared from the screen as several women appeared and began to tell Suzanne about their troubles with menopause or perimenopause. As the show progressed, Suzanne invited Oprah’s camera into her home where she explained her routine. She said that her schedule included a daily estrogen cream that she applied to her left arm, another cream with progesterone that went on her right arm for two weeks out of each month, and a daily vaginal injection of estriol, another type of estrogen. On top of these hormones, Suzanne took sixty dietary supplements, controlled her diet with organic vegetables grown in her garden, and exercised.

Another doctor appeared to remind women that all hormones had some danger of side effects. The doctor reminded them they should work with their doctor and that the FDA said women should only take the lowest dosage of hormones possible for the least amount of time possible if medically necessary. Suzanne agreed and said that women must be smart in how they take hormones and just replaced what the body should be making naturally. A woman put on hormones during the first episode came on and said that she already felt better than ever. Suzanne told everyone that hormone therapy was about women living happy lives and was a matter of choice.

Introduction

Bourdieu (1984) explained that as a modifiable entity affected by its environment, the physical body was a symbol of social position as well as a way to restrict people’s ability to achieve higher status. Different classes develop distinct body types based on their access to resources and the activities they must engage in as part of their daily lives. People recognize that certain body types correspond to different social positions. This gives the body its symbolic value and means that how people manage their bodies can directly affect their ability to establish and maintain a position in the social hierarchy.

The symbolic nature of the body means that certain body types, which include mannerisms and dress, are incorporated into people's sense of self. The need to express who one is and the ability of appearance to affect social position leads many to turn their bodies into projects (Schilling 2003: 112).

This chapter explores how women attempt to cultivate their bodies. The women in this chapter used diet, exercise, health care, and health products as a means to maintain their youthful appearance and to try to stay thin, healthy, and in control of their bodies. The discussion begins with a case study of a woman who used more care than most but whose attitude was representative of the others in her group in terms of body cultivation. Excluding income and education, she was also similar demographically to the women presented in the case studies that open the next three chapters (e.g., age, marital status, number of children). A demographic profile of the women in this group follows and then an exploration of their diet and exercise habits. This is followed by discussion of how these women use health care and what they expect from their health care providers. It reviews women's attitudes toward other's lack of health care and then places all of the information presented into a larger theoretical construct.

Jenny

"I'm their [doctors] customer and they have a highly specialized service that I am purchasing whether the insurance is paying for part of it, and they are working very hard to have systems in place that are customer friendly," Jenny explained as she leaned back in the cushioned booth of a small neighborhood café and sipped her imported Hazelnut blend coffee. She was tall and lean, with an athletic body that seemed to bristle with pent up energy. She had blond, shoulder length hair. Her white skin was nearly flawless with the exception of a few small lines that feathered out from the corners of her eyes. A slight tan brightened her already white smile. In faded jeans with a cream colored sweater, she looked much younger than her fifty-odd years. "I've had really good experiences because if I don't, I go find somebody else because I want a customer experience. I'm a customer putting my hard earned money down for their specialty, and I want their undivided attention."

As far as she remembers, Jenny always had health insurance and never went without care. A divorced corporate executive with two teenaged children, Jenny treated her health care in the same way

she treated most things. “I just like to be in control of my own health,” she explained. The premium for her employer-based family medical/dental plan was \$10 a month. She paid an additional \$15 copayment to see a primary care physician, \$30 to see a specialist, and \$100 to visit the emergency room. Her policy had a \$1,500 individual or \$3,000 family deductible for major medical, but her copayments and deductibles were easy for her to afford on her \$300,000 a year salary.

Jenny did not have a primary care physician per se but saw an internist as her primary provider because she felt that a normal primary care doctor was not savvy enough to meet the needs of a woman her age. Her internist was not aware that she sought additional care from a variety of other specialists that included a dermatologist, podiatrist, ophthalmologist, a physician focused on hormonal health and longevity, and acupuncturist. Because she lacked primary care, she called what she received “compartmentalized care,” proud that she knew the needs of her body and was able to manage the providers and appointments required to stay in optimum health. Jenny did not consider herself a sick person, nor did she think her list of providers was a particularly long one. “I’m not an over user of health care, but I know what I need and I don’t think anybody else knows that as well as I do.”

Although she had not worked on the medical side of care for more than two decades, Jenny was trained as a nurse and had more medical knowledge than most of the other interviewed women. When I asked about health risk she said, “I worked on the clinical side. I was in critical care. I get it more than most.” When I asked what put someone at risk for CVD, she quickly told me excess weight, stress, and a sedentary lifestyle. She thought about it for another minute and added outlook on life, diet, co-morbidities like diabetes, and social isolation. Finally she said there were genetic factors too, but these were things people could control by controlling their diet and exercise habits and were thus the least important cause of the disease.

Jenny said that she was a woman in control of her health because she worked hard to maintain control of it. Besides regular visits to her medical providers, she was on a complicated supplement regimen. She said she was “a big believer in supplements,” although she did not care for pills. She was able to find Juice Plus, a vitamin that provided the same level of nutrients as ingestion of seven to thirteen

fruits or vegetables, in gummy form. She took one gummy each day along with Core-Mega, a packet of fish oil she squeezed into her mouth. On top of these she took a 5,000 mg tablet of vitamin D3 to help her body absorb a daily Viactive soft chew calcium supplement. She also took an herb called Stress Palm that kept her calm. She purchased her supplements either from a medical provider or from a friend who was a “rep” in the business. She lamented that it was sometimes hard to remember to take everything and said, “Do I do all of this all the time? No, but I’m die hard on this stuff and this. I’m getting better at it. It’s a process.”

Jenny also had a vigorous workout schedule. She did Pilates twice a week and weight training with her personal trainer twice a week. Her trainer designed a special diet for her that included several small meals a day that were a proper balance of carbohydrates, proteins and fats. Jenny said the way to achieve health and control over CVD risk was through balance across “life’s many levels.” One must balance foods, hormones, and lifestyle. Lifestyle included making sure there was enough time with family and friends as well as time devoted to the self. Over the past year she began to focus her energy on her trainer’s diet and said that because of it she decreased her core body fat. She was proud but laughed and said she would not give up her evening glass of white wine. It, too, was part of balance because she said, “life is too short.”

Cultivated Bodies

Jenny was unique because she was at the top of the income spectrum and used more care than most people, but her desire to control her health combined with her low premium, low copayments and deductible, and high household income were all common among the eleven women who fell into the cultivated group (Table 6). All were enrolled in large group health insurance plans. The five women with the best coverage received their health insurance through the federal government. The other six received their plans from large corporations. Seven of the eleven women were covered by their husband’s plans.

Table 6 – Demographic Information for Women with Cultivated Bodies

Income Level	Age	Married	# in Household	Occupation	Education	Race
10,001 - 20,000	39	Yes	6	Substitute Teacher	4 year degree	White
40,001 - 60,000	31	No	1	Marketing/Sales	4 year degree	White
60,001 - 80,000	31	Yes	3	Administrative Assistant	Some College	White
80,001 - 100,000	67	Yes	2	Office Support Staff	4 year degree	White
80,001 - 100,000	56	Yes	3	Homemaker & Volunteer	Graduate School	Latina
80,001 - 100,000	43	No	1	Architect	Graduate School	Black
80,001 - 100,000	39	Yes	3	Services Liaison	4 year degree	White
100,000 - 150,000	47	Yes	6	Home Health Aide/Homemaker	4 year degree	Latina
150,001 - 200,000	42	Yes	5	Computer Engineer	4 year degree	White
150,001 - 200,000	58	No	1	Office Administrator	Some Grad School	White
300,001 - 400,000	55	No	2	Executive	Graduate School	White

With the exception of one woman who nearly completed her Bachelor’s degree, all of these women had four-year degrees and three had at least one master’s degree. The woman who was the exception had a husband with a graduate degree. The oldest of the women was sixty-seven years old; the youngest was thirty-one. Annual household incomes fell between \$40,000 and \$400,000, but most (nine) women reported that their families made between \$80,000 and \$100,000. One woman, the sixty-seven year old, had a personal history of lung and breast cancer, but otherwise preexisting conditions were nearly nonexistent and were limited to things such as high cholesterol. One woman was obese and one was overweight. All but three, an Ivy League educated architect, a stay-at-home mom, and a home health aide/stay-at-home mom, were white. The architect was black; the stay-at-home mom and home health aide/stay-at-home mom were Latina. Seven of the women were married and all seven received their health insurance coverage through their husband. One woman, a white, college educated thirty-nine year old, who recently lost her job with the county and became a substitute teacher, said she married a man in another state she rarely saw, so she could access his benefits for herself and her four children.

Women with cultivated bodies often had the best health insurance plan their employer, or husband’s employer, offered. While most women could choose a less inclusive plan for less money, premiums were reasonable and hovered around \$100 per month per person. Premium cost was not an issue for the women in this group. All of these women also had dental and vision coverage. None ever

had to pay a percentage of medical bills after they paid their copayment and deductible. These women paid the least but also had the most options available in terms of care. All could see a specialist whenever they wanted without a referral. All had access to at least some nontraditional providers such as chiropractors. Some had access to special services such as twenty-four-hour on-call medical personnel to answer routine care questions.

Body Cultivation

Only one woman with a cultivated body was overweight, only one was obese. Like their access to medical providers, women in the cultivated group had little that constrained their access to food and ability to exercise. Most worked and said they were able to pay for help with household duties, something they justified because their time was worth more than what they paid for the assistance. Many of these women told me they had no trouble with cooking or food preparation and that they learned their skills from their parents, but it was not clear if they truly had skills or simply the ability to pay someone else who had the skills they lacked. The two stay-at-home moms talked about cooking in a variety of ways and had a large assortment of gadgets in their kitchens. Others discussed meal preparation services that took fresh ingredients and combined them or allowed women to come to their locations and combine them to create high-end meals, frozen for later use. Women liked foods from these suppliers because they knew what was in the meals and because they could take their children to the preparation locations and enjoy a stress-free, family-oriented experience that was, “no fuss, no muss, and no mess.” All of the women went to the grocery store at least once a week or had their groceries delivered as often.

Women in this group rejected mass-produced frozen foods due to their additives. They preferred foods that were natural. They categorized vitamin supplements with natural foods because they saw them as a crystallization of the good things that were found in foods, and whole foods, which were whole grains as well as unaltered fruits, vegetables, and lean meats. As I talked to them, I repeatedly heard them say that the closer something was to coming out of the ground, the better it was for a person’s health. These women preferred organics due to the perceived chemical contamination of regular items and rejected foods with chemical additives from high fructose corn syrup and hydrogenated oils to

preservatives and hormones. They not only read labels but made an effort to shop at the grocery store's periphery where fresh items were found. They sometimes purchased foods from upscale grocery stores or local delicatessens that also used fresh or organic items. These women also tried to avoid foods they said were cooked in bad ways such as foods that were fried, but women admitted they did not always eat this way. They adamantly rejected some foods such as fast-food hamburgers and french-fries.

These women liked and ate fresh fruits and vegetables, which dominated their diets; diets that were designed to improve their health by personal nutritionists or personal trainers. Because they had one-on-one assistance with their food, they did not attend nutrition classes. Some basic health information was offered at cocktail events designed to elicit contributions for a new community health campaign and another to solicit the services of a new health care center, but women indicated they already knew the information that was offered. Women in this group rejected canned fruits and vegetables as processed mush with no nutrients and too much sodium or sugar. They also found frozen produce suspect due to the freezing process and how it was grown. Women followed strict, specific vitamin regimens and took supplements that were supplied by their health care providers or vitamin representatives and sometimes attended parties where vitamins were sampled and sold.

As mentioned above, women in this group had personal trainers. Three hired their trainers independently, but it was more common for trainers to be affiliated with a gym where women had a membership. Women could book appointments through the front desk. Among the women who saw a trainer, how often they did so depended on their level of commitment to physical fitness. The least amount was bi-weekly. The most frequent was daily, by a marathon runner. Women in this group often set goals associated with physical fitness and their workouts. The marathon runner's goal was to beat her own time. Jenny's goal was to hike down the Grand Canyon in the spring with friends. Women in this group exercised because they enjoyed it and because it made them feel good. Jenny explained,

That's just physiologic. When you're exercising you're pumping your blood more and getting all of your arteries and veins moving. You're oxygenating and clearing stuff out of your system. If you're exercising you're probably drinking water. Your whole body works better if you exercise and it feels good. I mean the whole endorphin thing of exercise too. I mean it just

contributes to your overall sense of wellbeing. You just feel better. You sleep better; all those things.

Women in this group described diet and exercise as a package. When they talked about diet they followed up with information about exercise and vice-versa. A proper diet and appropriate levels of physical activity were things they did together to keep their bodies healthy. For three of the women, exercise was more important than a good diet because a good diet would follow. The rest of the women did not differentiate one as more important than the other. One woman who did differentiate told me,

I guess it's not true with everybody, but the way I feel when I'm swimming. I can't eat, I can't have a cheeseburger before I get in the pool, nor do I have a desire to have one when I get out of the pool. I feel like all that exercise will be undone, but I guess you have to be in the right frame of mind because I know people who cycle who drink excessively and they smoke excessively and for me I find that bizarre. It's counterintuitive. I mean if you cycle and you're putting all that work in, but people do it and it's almost like a test of wills, like I'm not going to let smoking do this to my body or I don't know what the psychosis is behind it, but I do think if you're really committed to exercise you begin to make better food choices.

Health Care Customers

Women in the cultivated group were not patients. They were "health care customers." They referred to their doctors as service providers for their bodies, in the same way that they referred to their mechanics as service providers for their cars. If the women in this group had a health care experience that failed to meet their expectations, they simply found a new provider. Only one woman in this group had a history of serious disease, Rachel, a sixty-seven year old semiretired office worker was a breast and lung cancer survivor. Even for Rachel, the most common reason to go to the doctor was for preventive care. Women in this group expected their doctors to keep their bodies in optimum condition or to help improve their bodies' condition.

All of the women in this group were enrolled in a preferred provider organization (PPO) insurance plan. All saw at least two providers for unrelated preventive care. The providers the women talked about most often were nutritionists, gynecologists, general practitioners, and dermatologists. For reasons similar to those given by Jenny, three other women in this group saw an internist as their general practitioner. All three were over fifty.

With the exception of the marathon runner, whose youth and good physical condition made her feel that regular health screenings were unnecessary, all women with cultivated bodies said their standard health routines included an annual exam, mammogram, and physical. More rigorous practices were also reported and some women used routine care in unintended ways. This was usually not to improve wellness or increase longevity but to feel more in control of the few diseases they could not prevent. One woman knew health recommendations did not require she receive a yearly mammogram. She was too young, but she had one each year anyway as part of her annual exam because she was terrified of breast cancer. A woman with large breasts, she complained that the exam was painful, but she was afraid that the year she did not have it, “that’ll be the year I have a lump and don’t know it.”

Women saw their providers when they wanted to see them. As customers, they had very specific expectations for their doctors. Specifically, they would not wait long in reception. Jenny was the most vocal about this and said, “I never wait more than fifteen minutes or so, and I’ve had really good experiences because if I don’t, I go find somebody else.” Erin, a white, thirty-one year old administrative assistant, expressed a similar sentiment when she described a former doctor who left her to wait for more than half an hour, “I was like, why am I here. I guess I just really, the attention to my needs weren’t, it just seemed like I was wasting my time waiting.”

Providers were also supposed to provide women with a significant level of physical and verbal contact in exams. Exams always lasted at least fifteen minutes but were usually around half an hour. Some women told me that they could book longer, extended appointments of up to an hour if needed. Jill, a white, thirty-one year old marketing executive, described her last appointment, a thirty minute routine exam, this way,

She comes in. She washes her hands, which I like. She sat down in the chair and spoke with me, asked me how I was doing, and we talked a little bit about physical health and emotional health. Any concerns or questions I might have. I usually go in with a list that helps me personally and then she’ll move into the exam.

Those in this group insisted on using the appropriate provider for each type of care that they needed. When they had a skin problem, they saw a dermatologist. When they had a heart problem, they

saw a cardiologist. Health needs were most often identified by them, not their doctor. Women told me that it was important for them to address each of their health needs in order to achieve their best possible body or to achieve what many of them called their optimum health. They were willing to make sacrifices to see better providers. For example, Anne, a black professional in her early forties who saw a physician-trained nutritionist bi-weekly for weight loss, told me that she searched for several months to find this doctor and that she would continue to see him even if her federal health insurance policy did not cover his services. Similarly, Jenny paid for her hormone health physician out-of-pocket because her health insurance provider did not cover this woman's services.

Although when they were unhappy with a provider they found someone better, five of the women with cultivated bodies had the same primary physician for more than ten years. Of the six who had not, two changed providers because they had to wait too long in reception. One had only had her insurance for a couple of years; one moved to Kansas City five years before our interview and lamented the loss of her previous provider who she had for fifteen years; one lost a twenty year provider only the month before our interview when he retired; and the last woman was the marathon runner who explained that she went to a clinic located at her work because it was more convenient. She saw whatever provider was there at the time of her appointment.

Scheduling was the only problem that women in this group continually faced and could not overcome even with provider changes. One woman explained, "Oh, if you're trying to get in for your appointments and they're like, 'oh, you got three months out' and you're like, 'well I need it now.'" When I asked if there was anything that prevented her from going to the doctor, Jill said, "Just waiting on appointments but, you know, you call, you get it, you wait. That's how it is." I asked how long she usually waited and she said, "I usually make my annual exam appointment sixty to ninety days in advance. If I have an emergent situation, since I'm in the system, I can just send them an email that I'm having an issue and I can get in to see my doctor right away."

While required to wait for routine appointments, Jenny also talked about her ability to manipulate the system and speed up appointments when necessary. It took effort, but she felt that sometimes the

effort was worth it. She told me about a time when she was diagnosed with a diseased gallbladder and was able to “work” the system so that she could move ahead on the surgery schedule.

After I called five surgeons to get an appointment they took it out. It was early June. They would say, “Well, he can see you in the beginning of July.” I was like, “You don’t understand. I’m sicker than a dog and I’ve got to get this thing out, period end of conversation. I want to see him in a week and have it out the next.” But you know it wasn’t like I was an emergency, but I was like summer’s the perfect time. Let’s get this done. And I was beginning to feel really bad, so I called the doc at [hospital name] who had done my friend’s surgery. I called his receptionist told her the situation and asked for help. And I just negotiated and bargained with her until it worked out. I got her [the receptionist] to pencil me into the surgery schedule even before I saw the doctor. I just manipulated the whole system. When I saw him [the doctor], I told him I was a single mom with two kids and an executive job and was sicker than a dog. He went to his receptionist and moved people around. He bumped somebody from her spot to another and he saw me first thing the next day. You have to manipulate the system to get what you need.

A similar strategy identified for more immediate attention for non-urgent care was to say an issue was more serious than it was, or to say there was an emergent issue as well.

Well they’ve told me I had to wait, and I’ve been like, “you know, I have bronchitis now. In three months it is not going to do me any good to come in and see you.” The nurse will say, “Oh, well then we can get you in this morning at 9 o’clock,” which is fine because once you’re in you’re in. I’m like, “great, thank you.”

The women in this group waited for routine appointments but were never afraid that they would be turned away from care when they really needed it. However, some had trouble when they sought emergency medicine in the past and because of this did not believe that all hospitals were equal. They were particularly wary of large, urban hospitals that they saw as dirty and overcrowded. Sometimes they were forced to go to one of these hospitals because they required a specialty that was not offered at a smaller suburban hospital. Ellen, a white, forty-two year old computer engineer, told me about the last time she sought emergency care. It was for her son who cracked his tooth on a Sunday afternoon. The on-call dentist told her to take her son to a large, urban hospital that staffed an emergency pediatric dentist. When she arrived, she said the waiting room was full.

It was hard to find a place to sit because there were so many people. I should have known then it was a losing battle, but we stayed four hours in the waiting room and the whole time he won’t eat or talk and has his lip over his tooth.

She continued that when her son was seen, it was by the attending physician not the pediatric dentist. The physician took an x-ray and told her there was no problem because the nerve was not exposed. Ellen's frustration was palpable. "I should have just gone to *[Name]* hospital or *[Name Hospital]*. We would have gotten the same conclusion and it would have taken half an hour," she said listing two of the hospitals that were near her suburban home.

Kelly was a nurse at one of the hospitals Ellen mentioned as an alternative to the urban hospital where she took her son. Listening to Kelly describe the hospital where she worked, it was clear why Ellen was upset about her treatment at the urban hospital. Ellen was used to being a health care customer. Kelly said,

It caters more the wealthier in *[Name]* County and they're *[the hospital]* very-very-very acutely aware of patient satisfaction and appealing to them *[the patients]*. Well in *[her ward]* it's not anymore about the care it's about do you have a hot tub? Do you have my suite looking like the Ritz? What's the food like?

When I asked her about the quality of the care she laughed at me and said,

The care is just a given. You better have top quality care. We're not even going to discuss that, but do you have a new, like, window treatments, new carpeting. Do you have, definitely got to have, one of those kinds of TVs? One of those flat screen TVs, you know, refrigerator, just a hotel suite type of environment.

While women with cultivated bodies indicated comfort was their primary concern for minor injuries, more severe ones required a level of quality that was not always available in the state. Some procedures required specialty hospitals. With their insurance, these hospitals were also within reach. When her son was severely injured in a football accident, Kate, a forty-seven year old, Latina homemaker, was forced to use a large, urban hospital for her son's immediate care. As soon as it was medically safe to move him she insisted he receive treatment at a hospital that focused on his type of injury. When the city hospital asked if he would stay at their facility, she said she told them, "Well, no, we are going to go to one of the level, one of the ten model centers. I'm not sure which we're going to go to, but we're not going to stay here."

Those with cultivated bodies choose doctors based on how well they were treated by them and based on what services the doctor provided, but they also looked at the number of degrees a doctor had, where the doctor went to school, and how long he or she had practiced. More degrees were better, Ivy League schools were more reputable, and women preferred doctors who had been in practice for a few years but not so long as to be unfamiliar with new treatment techniques. Women also used a range of alternative or nontraditional therapies and preferred that their alternative care providers were also credentialed medical doctors. For example, Anne liked her nutritionist because he was a doctor. He sold her several different kinds of supplements and herbal diet aids. When I asked if she thought using these was healthy, she scoffed that, of course, the items sold at discount department stores like Wal-Mart were not good, but “For me that’s a lot more credible with him being an MD.”

Women purchased several products from their providers. They told me they bought vitamins from general practitioners, make-up from dermatologists, and Botox injections from gynecologists. Anne found no conflict of interest in her nutritionist selling the products that he recommended. “Well, he has to make money somehow,” she explained. Although keen on the diet aids that he sold and recognizing his need for profit, Anne felt under no obligation to purchase products from him alone. He was there strictly to fulfill her consumer needs. If she could find the items he sold cheaper elsewhere, she would and she did use the Internet to purchase the same brand of supplements at a reduced rate.

Women were not afraid of CVD because it was a disease they could keep at bay with proper diet and exercise. They were afraid of breast cancer. The doctor at a heart health event for corporate executives told his audience that breast cancer was not preventable, only diagnosable. This came up repeatedly among women with cultivated bodies who stressed the importance of early detection. One of the women in this group, whose mother died from breast cancer, said she sometimes considered having an elective mastectomy to eliminate her risk, but she could not bring herself to disfigure her body. She and four of the other women in this group were surprised that I was more interested in CVD than breast cancer and when I said that CVD kills more women, they were shocked. Breast cancer terrified them because they could not control it. Women acknowledged that there was an association between genes and

CVD but dismissed the association as something a person should know about through family history and dealt with using lifestyle modification or brushed it off as superficial.

Fear of breast cancer was passed down from mothers to daughters. Just as the woman whose mother had it wanted an elective mastectomy to gain control over her body, another woman whose grandmother survived breast cancer internalized her grandmother's struggle. After years of stories about it, her grandmother's medical history became her own. She told me, "I have a history of breast cancer" and went on to say that her grandmother had the disease. The woman whose mother died from it and the woman whose grandmother survived it said they were not interested in having a genetic test to see if they were predisposed for the condition. They already knew that they were because of family history. Other women wanted to know if they were genetically predisposed, as this knowledge made them feel more in control. When they talked about it, they told me that knowledge was power. Three women said they planned to have the test done, already knowing where they would go and how much it would cost. It was not covered by their insurance, which one openly resents. None were concerned their insurance companies might find out the results and alter their coverage. One of these women was Rachel, who had a history of breast cancer. She wanted to know so she could tell her daughter if she carried the gene. She believed that if she had the gene and her daughter did not, then her daughter was safe from the disease. If she did not have the gene, which was not present in all cases, then her daughter was simply more at risk.

With the exception of a few conditions like cancer, all of the women in this group believed that they were in control of their bodies and worked hard to maintain that control. When Rachel developed breast cancer, it created a great deal of internal conflict. She repeatedly referred to diseases, even acute, easily transmissible ones like the flu, as a result of bad behavior. She believed that people grew sick when they indulged too much or did not take care of themselves. Their immune systems broke down. She told me she was shocked and horrified when she was diagnosed. It was a complete surprise to her even though her mother and sister both had it. She still could not figure out what she did wrong, but she grew even more careful about her behavior. Still she worried. If she developed it once when she thought

she was in control, it could happen again. Every time she grew ill, she said she thought it was another bout of cancer.

The breast cancer was discovered after I had a series of three very strong sinus infections, so when I look back on it I can see that my immune system was breaking down. So this past fall, when I had three viral, bronchial things I did work myself into a tizzy assuming that my immune system was breaking down again and it wasn't, but I thought it was.

Attitudes about Access

Women with cultivated bodies who told me that they had never gone without health insurance appeared unaware of what it was like for those who could not access care. They were very critical of the uninsured and completely unaware of the underinsured. Rebecca, a married woman in her early sixties with a good education and established career in a lucrative field, grew agitated when I asked her about the US health care system. She said,

I'm probably pretty prejudice, because I know some people who have made decisions, huge decisions in their life and gave up health insurance. One woman decided she couldn't afford it and quit her job. Went to help her husband with his business, and they went uninsured in their fifties and sixties. Granted their kids were out of their health, but this man, they were talking about family members giving them money so he could get some healthcare taking care of his knee and his back. He was a plumber asking family members, and the kids were saying wait we pay 200 dollars a week for child care. We pay this, we pay this and they're asking us to help take care of Grandpa's medical bills. Wait a minute folks. I think a lot of people are making decisions.

We had a gal in here the other day. Age twenty-one, student, six months pregnant, she's on Healthwave. And I said now that goes off after eight weeks postpartum. "Well I hope I can find a job and get insurance," but she quit a job she had earlier in her adult life after she was eighteen where she had health insurance because she didn't like the job. Got pneumonia, her parents made her go to the hospital, duh. She's got an \$8,000 medical bill. Why do people quit one job before they get another one and drop health insurance? There are some deliberate bad decisions being made. That makes me mad. Then she said, "Well they charged \$400 for this test at the hospital." Well now if you figure 95 percent of the people that come in with pelvic abdominal pain in the hospital get a pregnancy test, if 95 percent of them are like you and don't pay sure the cost of a pregnancy test is high.

Rebecca acknowledged there were some people who required assistance paying for health care, but as we talked she made it clear that these deserving poor were a very small group that consisted primarily of the indigent elderly, small children, and infants. She wavered on older children, who were

not as fragile as babies. She also blamed their parents for their inability to access care but did not go as far as the women who suggested that these children should be removed from their homes because of their parent's inability to care for them. Instead, she indicated that the use of government programs was a manipulation of the system.

I would like to strangle the people who are making decisions when they have insurance to go uninsured. Really makes me mad. They're making those, that group of people over there I'd like to strangle because we are going to be paying for hospital accidents. You're going to be paying for a whole bunch of stuff, pregnancies. Now you take the other group of people, them I'm willing to take care of, the low income, some of the others, but this gal sat out here. She sat out here the other day and said I may not be able to get Healthwave for my child if I make too much money so I have to make sure I make less than x amount of dollars. Sat here and she's in an LPN class, so she's not dumb. And sat very naively, very blasé, "I have to make sure that our combined income, if we get married, we know we won't be able to get married because our combined income will be too much." She doesn't want to pay for it. She doesn't want it to come out of her paycheck. If I have to put...never mind she won't have insurance but that's no problem. She's thinking about her kid, so that's commendable. So it'll cost us a couple hundred dollars a month out of her paycheck if she gets a job with health insurance.

Rebecca did not simply blame the uninsured for their predicament. She blamed them for much of the trouble that plagued the US health care system because, since they did not pay for themselves, she believed that everyone else, specifically people like her, paid for them in the form of higher medical bills. They were not casualties of an unfair system but social predators who took more than their fair share at the expense of everyone else. Consider what Jenny said as we discussed the same question,

I think there is a certain amount, number of people in our population, the very, very frail elderly and the very frail little ones who need that safety-net and the families of those frail little kiddos need that safety-net. There are a lot of very wealthy people on Medicare. They can afford health care. Medicare shouldn't be an entitlement for the wealthy retired. Medicaid shouldn't be for people who can get up and work for a living.

Jenny also believed that a majority of Americans without access to private insurance, those on government programs, were unfairly manipulating a system that was designed for people who were much less fortunate. For women who had never gone without, only the entirely helpless disserved assistance. In their view, individuals only obtained the right of social support when they were inactive participants in society. Women with cultivated bodies who had gone without insurance at some point were more

sympathetic toward the uninsured, but even these women viewed a lack of insurance more as a result of bad luck than of society's structure or the social allocation of resources. Consider that when Ellen was asked what she thought of the US health care system she said,

I think it's [people without insurance] a huge problem. It just affects, if somebody has some sort of chronic illness it can devastate their family financially. It is something that we as a country need to take care of. There's been a lot of, I don't know, it is just really frustrating.

Sixteen years before our interview Ellen and her family went without insurance for a period of three years while she and her husband attended college on the GI bill. Both were employed immediately after graduation by the same large technology corporation, which was where she worked when I met her. With their high salaries and the company's excellent benefits package, Ellen's family has been insured since the early 1990s, but she remembered the stress of being uninsured.

The worst thing I remember, her prescription [Ellen's daughter], it was \$21 and I just about freaked out because I had never paid a prescription before because when I was in service, you know, birth control pills, everything you know, they paid for everything. So it was like oh my gosh, \$21. What are we going to do? You know it was a huge, and that was sixteen years ago, and it was a huge amount of money to me. Luckily we didn't have a car accident or anything really bad where we had to be hospitalized or something, but I used to worry that something could happen sometimes. When you have a child, a not very old child, it can make you lay up nights. You try not to think about it. You put it out of your thoughts, but you still worry.

Ellen could not classify her own family as unworthy of care when they were uninsured, thus she did not see health insurance, or the ability to pay for it, as an indication of whether or not someone else should receive care. She also did not view the act of having insurance as an individual responsibility because she understood that some people simply could not afford it. Because of her own experiences, Ellen saw that individual choices were relative to the context of one's life. Much like Rebecca's nursing student, Ellen had quit a job that provided benefits so she could go to school and secure a better future for her and her family. She did not frame that choice as one of giving up health insurance but as a choice of whether or not to pursue a potentially life-improving opportunity.

Health Care Solutions

Jenny's solution to the health care crisis was a complete removal of health insurance from the system. She explained that she did not believe access to care was a human right or that society was

responsible for the health of its citizens. Instead access to care should exist in a free market, where people paid a fee for each service they received. Competition would keep prices low and health care would be earned in the same way other services in a capitalist society were earned, by how much someone can afford to pay for them. Jenny was not interested in social solidarity, that this was an underlying premise behind health insurance made the entire concept suspect from her perspective.

When asked about health care solutions, Jenny immediately thought of socialized medicine. Like other women with cultivated bodies, it was something that she adamantly opposed. She explained, “I am not a big proponent of universal health care. I am familiar with the Canadian system and familiar with the European system because I’ve worked with hospitals in those countries and we don’t want that. Trust me. We do not want that in this country.” Jenny’s confidence that she knew and understood how other systems worked, or failed to work, was also representative of other women in her group. Women with cultivated bodies frequently referred to a single European system, as opposed to the multiple systems that existed within the many countries of the European Union (EU), and believed that they were all socialist and provided inadequate, rationed care, particularly for the elderly or seriously ill. Rachel explained,

We deal with a lot of vendors, interestingly you know from Canada, and you hear so much about their program. Well then you find out, for those that, that it is great if you just have the run of the mill stuff, but if you’ve got something that could be really serious and want to do something about it, they all come across the border and come down here and get their care and get their tests in the first place to see if what they think they’ve got is what they got.

While on *Bill Moyer’s Journal*, Wendell Potter, a health insurance industry insider who testified before Congress, offered one reason for the similarity in women’s views. Potter was in charge of corporate communications for Cigna and explained that his primary function in that position was to discredit industry detractors and paint health insurance companies as a necessity. Insurance companies specifically attacked systems in countries with government run health care.

The industry has always tried to make Americans think that government-run systems are the worst thing that could possibly happen to them, that if you even consider that, you’re heading down on the slippery slope towards socialism. So they have used scare tactics for years and years and years, to keep that from happening (Moyer 2009: 6).

Jenny said her primary problem with health care systems that offered universal coverage was that they rationed care, something Potter said insurers emphasized in the messages they presented to the public. Jenny was aware that in the US access to care was limited for many people, but the way the system benefited her made it difficult for her to fully consider how it hurt others. Because she thought that everyone had equal access to resources, Jenny did not frame her thoughts about US care in the same way she framed her thoughts about care in other nations. She did not see care in the US as rationed, however, she recognized there was rationing based on how much money someone paid. I suspect she was afraid she would lose her place at the front of the line if the system was set up differently. At one point she told me,

People are queuing up for care. It is rationed no matter how you want to say it. It is rationed care [in the EU]. I think we need safety-nets. I think, I have a, for the poorest of the poor and for the frailest of the frail, but I don't think we need a safety-net for every Tom, Dick and Harry.

Jenny believed that people who worked hard had access to care, so people who did not have access must not work hard enough. In the same way, disease was a result of laziness as people failed to cultivate their bodies. Uncultivated bodies needed more care, which was unfair to people like her who worked hard to maintain their health. "I think that people who smoke and are obese and all those things should pay higher premiums. You know if you're going to have a lifestyle that is not conducive to health." She did not see why she should have to pay for other people's laziness or other people's health care.

Rachel was also afraid of how care would be rationed under a government system. She feared that in a government system she would not receive the care she needed to survive. Rachel was so afraid of government health care that she and her husband refused to retire so they would not lose access to their health insurance. They knew that as a government program, Medicare must be substandard. Rachel told me,

When I turned sixty-five my oncologist had said, "Now are you on Medicare now?" And I said, "No I have private insurance." And she said, "Thank goodness. You have no idea how much time I spend trying to talk to them to get them to allow, Medicare, to allow a patient to get the care that they need to have as a result it often doesn't come as timely as it should and sometimes you wonder if it hasn't contributed to a worsening of the situation."

Women similarly indicated that they thought Medicaid was a terrible program. Kate recounted an experience she had at the large specialty hospital where her son was taken after an accident, which left him as a permanent quadriplegic. Due to the seriousness of his injuries, the hospital staff anticipated he would end up on Medicaid and ordered the equipment Medicaid covered based on that assumption.

When we were at [*hospital name*], my son had experienced a skin breakdown and when we got there they wanted to put him in a regular bed. And I said, “No, we’re getting an air bed.” And they said, “No we’d rather put him in a regular bed because upon discharge he’s probably going to have to go home on a regular bed because Medicaid is not going to cover an air bed,” so they said, “We might as well get him used to the regular bed now.” And then they talked about how you’d have to turn him every so many hours and you’d have to do this and you’d have to do that and I said, “Nah-uh.” I said, “First of all his skin is broke down now and it’s going to get worse.” I mean the kid, at the time, was probably five foot ten, five foot eleven and he weighed all of maybe 135 pounds and he was losing weight and I knew that a pressure sore was only going to make his life more complicated. And so luckily I had my way at the hospital and then upon discharge, you know they kept telling me we need to transition him to a regular bed because they’re not going to go for an air bed and I started working with the insurance and they paid for an air bed. They paid for, like a standing crane was recommended, but I was told Medicaid’s not going to pay for that.

Why Cultivate the Body

Women in this chapter made their bodies into projects and the process of trying to create the perfect body became part of their identity. Body cultivation began with the need to show people social position. It became a way to maintain control in an out-of-control world. Women from this group complained about stressful lives, but complaints were not like the women in the groups discussed in the next four chapters who lamented their inability to do basic things like pay bills. Women who cultivated their bodies talked about stress as a physical state. For example, when I asked Jenny to draw someone at risk for CVD she drew a fat person who she said was out of control. Then she stopped and thought about it. She asked if she could draw a second picture (Figure 9). Jenny was the second woman in this group to offer the image of a woman on a treadmill and to explain that the treadmill represented stress. Jenny said, “This is busy women who takes care of everyone else in their lives but themselves, who run on adrenaline and no sleep and take care of the kids and their husbands and their jobs and they think oh I’ll get to me later.”

Figure 9
Life Treadmill



Body cultivation was cathartic and a way to exercise internal control. The more women cultivated, the greater they emphasized their level of personal stress. Bordo (1993) and Nichter (2000) talked about this same phenomenon in terms of eating disorders and the use of rigid bodily control as a way to maintain feelings of order. Nichter (2000: 149) also explored it for women whose eating patterns were not disordered, but who began to diet and exercise when their lives felt out of control. The routines, rules, and rituals that they imposed in their carefully managed, crafted diets and exercise plans provided structure.

For women with cultivated bodies, the idea that access to resources should be based on how much someone could afford to pay seemed normal and natural. They feared systems where access was more egalitarian because they believed these systems would limit the resources they and their children could obtain. These systems would also mitigate women's ability to control themselves. Women also believed that the US was the meritocracy the Horatio Alger myth promised. People who were unable to achieve the same level of access were simply not working hard enough, which justified and legitimated the way they used resources.

In a system that distributes resources based on social class and status, people feel a great deal of pressure to project the symbols of high social position. People who put symbolic importance on the body try to maintain and improve their internal health and outside appearance (Schilling 2003: 115; Bourdieu 1978: 838 & 1984: 212-213). Media messages in the US made physical appearance and internal health

synonymous. Physical appearance was a reflection of internal health. This led women to use products that were meant to alter the internal body such as hormone therapies that promised to make one look and feel younger or vitamin supplements advertised to improve the look and feel of one's skin. It also suggested that those who could may use health care as a mechanism to control the physical body while those who could not wish they could.

Chapter 6 --The Managed Body

Introduction

Women with managed bodies tried to cultivate themselves, but they did not have sufficient access to resources to do so. Several also spoke about their care in terms of maintenance or making sure that their bodies stayed healthy in the way that they talked about tune-ups to make sure their cars ran well. Women in this group showed more signs of physical deterioration and had more lifestyle associated health problems than the women above them. They depended on their physicians for access to care and feared that the care they wanted could be denied if they lacked the means to pay for it. They were also afraid that some doctors prescribed treatments based on profit motivations. When their fears combined with a belief that they should be in control of their health, it created a deep mistrust of medical professionals. Overall they did not like the US health care system, but they were afraid that something different would be worse for them. All of them knew about women with less access to care, but none were aware of the level of access that women with cultivated bodies had.

Ruth

“I got right in. I had maybe five minutes of waiting, but I tried to get the first morning appointment, so I think that helps. I like this doctor and I feel like he’s, you know, knowledgeable about what I’m going through. And I feel comfortable with him.” Ruth, a fifty-seven year old accountant, told me about her doctor as she absent mindedly pushed a mozzarella medallion around on a small salad plate. We sat in a chain café near a busy street in a large suburban neighborhood sharing an early dinner. Ruth was thin, about five feet five inches tall with light brown hair. She looked at me, her blue eyes both curious and hesitant. “In recent, in the last, can’t recall when it was and this is why I changed doctors, well I didn’t change doctors. But I called my doctor’s office to see if he would prescribe the natural hormones because I went to a seminar that was put on by [name] pharmacy and they talked about it, the natural hormones.”

Ruth did not have dental or vision coverage, but these were less important to her than medical coverage. She assumed that she had always had medical insurance because she could not remember not

being able to go to the doctor. She said that her mother worked for a large company that provided excellent benefits, so they must have had it when she was a child. Ruth was divorced and her child was grown. She was unaware of what her premium was because it was paid entirely by her employer. She indicated on her demographic questionnaire that she made between \$40,000 and \$60,000 a year. Her job was to keep track of incoming and outgoing payments. Ruth paid \$30 to see a primary care physician (PCP), \$35 to see a specialist, and \$50 to go to the emergency room. She had no deductible but had to seek a referral from her PCP for everything except emergency care. This bothered her and caused problems in the past. “You used to be able to go to the doctor and say here’s my insurance, you know. And now it seems like they control the length of time you can be in the doctor’s office, who you can go to. And you have to have referrals. You have to. You know that referral thing is kind of a hassle.”

Besides her PCP who prescribed her natural hormones that were not covered by her insurance, Ruth saw a gynecologist and a dermatologist. She said her health was good except for a mild case of high cholesterol and for women’s issues. When she said women’s issues, it included menopause, but it was also a euphemism for general aging and referred to changes in her outward appearance, particularly her face and hands, and to the way that her body functioned, particularly her digestive system. She hoped that the hormones would help believing that these problems were a result of an imbalance caused by a diminished output of estrogen. She knew that synthetic hormones were associated with an increased risk of CVD as well as several other diseases but believed that natural hormones were safe.

Ruth was very concerned about heart disease because her father and grandmother both had heart problems and because she had high cholesterol. Ruth said she went to her doctor and asked for diagnostic tests to detect heart problems after she experienced what she thought were symptoms of CVD. She called her heart a bad heart and said,

I’ve known for several years that my father had a heart attack at the age of fifty-six, although he didn’t die. Combined with my high cholesterol, I have had a few scares with it whether it be the imagination or something I truly felt that wasn’t really anything. I went through some testing to determine if it was anything. I’ve had several different tests. I’ve had EKGs several times because whenever you’re in my age group if you say you have chest pains you got to get an EKG. They can do that in the office, but if they feel like they need to investigate it further, well I’ve had stress tests. I’ve had a thallium test and, a, can’t think of the term but sort of like a

sonogram. You get on the treadmill and then you immediately lay down and they. I can't remember what that's called.

The tests said her heart was fine and became a source of embarrassment. Some people believed her fears stemmed from her imagination or were all in her head. Ruth was one of four women to report heart-related symptoms that, regardless of tests, were never medically connected to a problem with the heart. Two were women with managed bodies; one had a neglected body, and one a forgotten body. As she and these other women talked about their experiences, I was reminded of Margaret Lock's (1990) discussion of Nerva among Greek women who immigrated to Canada. With the exception of chest pain, the symptoms were different, but the association between their physical experiences and feeling out of control were the same. Ruth explained it best,

I believe at the time I was under some strain or stress and I believe it was stress related because it kind of went away but then another time my dad, my dad, I call him my dad, but he was my step dad he was not the one who had the heart attack because he was my step dad. He was going through lung cancer treatment and my sister and I were the caregivers and somewhere during that time I woke up at 5:30 in the morning and thought, I mean I was so scared about my heart pumping. I mean it was just racing and I called 911.

The experience of waking up with heart palpitations or a heart rapidly pumping was reported in all four cases. In all four cases women made an association between the times that they had heart problems and a time they felt extreme stress, fear, and like they were out of control. They also had events that happened repeatedly and in each case sought medical attention. In part, this was because they were afraid they might be having a life-threatening emergency, but it was also because they wanted someone to make them feel better. All of the women indicated they were a little embarrassed but seemed genuinely okay with the idea they had a panic attack. They told me that they just wanted to know what was wrong with them and feel that someone else thought whatever it was, mental or physical, was legitimate.

I just wish they would have, well, they never found anything wrong, but I don't know, every little twinge makes me wonder. I'm fifty-seven now, so I'm like, oh, is this it? Even though I've been tested and determined that I don't have any problems. Even though I know that sometimes with all that testing there still might be something they can't see, so I guess it is in the back of my mind. I just wonder. Doctors never talk to you about it. They don't take very long, and I guess, or tell you what else it might be except maybe stress. I know my ex-husband said it was panic, but they never, you know, they didn't want to embarrass me but still just to know. Maybe I just need to see someone, you know, a mental health person.

Ruth said that when she thought of CVD she thought of older people. When I asked what she meant when she said older, she said someone who was over fifty years of age. She said that she also thought of someone who was snowman shaped with high cholesterol and clogged arteries. She fixated for a moment on the carotid artery, saying that she could not draw it but that she could see it filled with plaque in her mind. Later when she listed risks for CVD she included high cholesterol again but said that just because people had high cholesterol did not mean they would have heart problems. These things were related but that was all. When I asked where her information came from, she said the media. She said she watched *Good Morning America*, which had several health-related segments. I asked if any of her medical providers had talked to her about CVD, particularly interested in her response because of the tests she had to assess her heart health. When she had the tests done someone always sat down with her and reviewed the procedure. They also mentioned lifestyle changes to improve health but focused on physical activity saying, “I mean they go over it and tell you what they found. I don’t recall anyone really ever explaining what I should eat or not eat, but they always want you to exercise.”

Ruth did not exercise regularly. She wanted to but had very little time and was tired when she left work in the evening. She let her community center gym membership expire but planned to enroll in a fitness class at a different community center in another month. The class appealed to her because it mixed cardio work with weight training and was social. A friend of hers was also enrolling in the class. Ruth preferred natural foods but put no additional stock in something because it was organic. Natural simply meant fresh fruits and vegetables. She explained that processed foods were bad but then admitted she ate a lot of processed food and added that almost everything was processed these days. Later she also admitted that she does not like to cook and processed foods were easier. However, she drew a line at fast-food. It was terrible, so she only ate it when she really had to or rarely.

Besides natural hormones, Ruth took a cholesterol medication, a medication to prevent osteoporosis, a woman’s multivitamin, and calcium. She did not like to take drugs, “I don’t want to take any more medication than I have to. I don’t think it is necessary. I feel like Zocore is preventing something else and that is necessary, and then I do have another prescription I take for [osteoporosis]

because I'm at a high risk for osteoporosis, but I mean and some people don't even want to take that stuff, but I don't mind that. But I don't want to take any mood enhancement or something to sleep. I feel like it is something negative.”

The Managed Body

Ruth's beliefs were similar to those of the other women with managed bodies, although her earnings placed her at the bottom of its income range (Table 7). All nineteen of these women, including those on government insurance, had group plans with affordable premiums. One complained that aside from her mortgage her health insurance premium was her largest monthly expense. Premiums ranged from around \$100 per month per person to \$700 per month per person, although the woman whose premium was \$700 did not pay it. Her employer did. Excluding her, the highest per person premium was \$350. Copayments remained at or below \$30 for standard care, \$50 for specialists, and \$100 for the emergency room. Deductibles were \$2,000 or below for major medical, and the highest coinsurance or percent that these women paid out-of-pocket was ten percent.

Table 7 – Demographic Information for Women with Managed Bodies

Income Level	Age	Married	# in Household	Occupation	Education	Race
< 5,000	71	No	1	Retired/Sales	Two Year Degree	White
< 5,000	74	No	2	Educator	Some Grad School	White
10,001 - 20,000	23	No	1	Medical Student	4 year degree	White
20,001 - 40,000	32	Yes	4	Utility Clerk	High School	White
40,001 - 60,000	58	No	1	Educator	Graduate School	Black
40,001 - 60,000	31	Yes	4	Non-profit Director	Some Grad School	White
40,001 - 60,000	45	No	2	Bookkeeper Box Store	Graduate School	White
40,001 - 60,000	56	No	1	Registered Nurse	Graduate School	White
40,001 - 60,000	57	No	1	CPA	Graduate School	White
40,001 - 60,000	57	No	1	Accounting	High School	White
40,001 - 60,000	71	No	2	Retired/Journalist	2 year degree	Black
80,001 - 100,000	50	No	1	Computer Data Analyst	4 year degree	White
80,001 - 100,000	27	No	1	Sales	4 year degree	White
80,001 - 100,000	36	Yes	2	Accounts Receivable	4 year degree	White
80,001 - 100,000	47	Yes	4	Business Owner	Some Grad School	White
100,000 - 150,000	49	Yes	2	Nurse Practitioner	Graduate School	White
100,000 - 150,000	53	Yes	4	Vice President - Banker	Some College	White
100,000 - 150,000	30	Yes	3	System Administrator	4 year degree	White
100,000 - 150,000	62	Yes	2	Medical Technologist	4 year degree	White

Only two of the women in this group were not enrolled in a health maintenance organization (HMO) insurance plan. One recently switched from an HMO to a preferred provider organization (PPO) and had yet to use the PPO's services. Women in an HMO needed a referral from their PCP to see another physician. This restricted their ability to seek care from specialists. Women in this group limited their appointments to a gynecologist or general practitioner, and more than half used their gynecologist as a general practitioner. When referred, they also saw a dermatologist, mental health worker, or cardiologist but always for a specific problem that was either identified or at the very least reviewed by their PCP. Services were discontinued once the provider determines that the problem was resolved.

Fifteen of these nineteen women were white (Table 7). One, a college professor, was black. The oldest was seventy-four; the youngest was twenty-three. Annual household incomes fell between less than \$5,000 and \$150,000, but the range was deceptive. The two women with the lowest incomes were retired and on Medicare. Their social positions were higher before they retired and they continued to receive monetary assistance from their children. The woman with the next highest income was a graduate student who received health care coverage through her parents, both college-educated professionals. The woman just above her in income said that she recently began divorce proceedings and thus lost the inclusion of her husband's pay in her household income. Without these women, household incomes ranged between \$40,000 to \$60,000 and \$100,000 to \$150,000. Two of these women had an associate's degree, two had a bachelor's degree, and five had a graduate degree. Eleven were married, but only three have coverage through their husbands. It was cheaper to use their employers insurance. Four of the nineteen had no dental or vision coverage. Several preexisting health conditions were reported such as diabetes, alopecia, depression, attention deficit disorder, high blood pressure, and high cholesterol. The more serious of these health conditions clustered at the bottom of the income range.

Women in this group often engaged in strategies to improve their coverage. A woman with a master's degree in gerontology worked as a cash handler and floor associate at a large retail chain store so that she and her daughter could access the store's group health plan. A certified public account worked for a small firm instead of working for herself because the firm was willing to pay the full \$700 a month

premium required to cover her, due to her history of breast cancer. Another purchased a federal plan through her retirement with the Veteran's Administration instead of using her current employer's insurance. Her current employer's policy was less inclusive and more expensive, but the federal plan that she paid for was also not as good as the plans of the women in the cultivated group. The plan did provide her access to VA hospitals and, because she was paid an allowance by her current employer to pay for benefits, she paid almost no premium.

Body Management

Half of the women in this group were overweight or obese. Although body size did not always correspond to age, increased weight was predominantly seen among older women. Like women with cultivated bodies, women with managed bodies sought out and purchased items to improve their health. They differed from women above because they were more constrained by time, money, and their skill for preparing foods. Seven of the women with managed bodies admitted they did not know how to cook anything beyond heating it up quickly in the oven, on the stove, or in the microwave. They preferred the microwave. The other twelve knew a variety of ways to clean and cook foods, but their skill levels varied and, due to their hectic schedules, they also preferred the microwave.

Women with managed bodies learned how to prepare food from their mothers. Sometimes they relearned from their mothers-in-law. They also learned new skills from prepackaged food directions. Many of the foods they thought they prepared from scratch were partially prepackaged (e.g., cake mixes) or were several prepackaged foods combined to make something new (e.g., Ro-tel cheese dip). These women attributed their food preparation skills to their family background, specifically whether or not their mothers stayed home, their earlier socioeconomic status, and whether they came from a rural area. One woman who could not cook said that her lack of skill was a result of her father doing the majority of the food preparation when she was a child. Another woman who could cook said she did not learn at home because her mother worked when she was a child, but she taught herself after she married using the Betty Crocker cookbook. The seven who did not cook thought recipes were intimidating because of

unexplained cooking techniques such as julienning, clarifying, and caramelizing. Women with some cooking skill looked up recipes, techniques, and unfamiliar foods on the Internet.

Women with managed bodies did their primary food shopping right after payday but also made quick trips to the store to restock with fresh items like milk or produce. They relied heavily on prepackaged frozen foods that reheated quickly, saying these foods were processed and contained things like preservatives. They worried about additives but believed these were ubiquitous and unavoidable and that there were fewer additives in more expensive brands. Most used prepared foods to save time, except on special occasions like Christmas, and rationalized items were not more expensive than foods they prepared from scratch because, in the words of one woman, “there are so many ingredients in that. You have to buy the sauce and, like, two or three different kinds of cheese and the noodles and then the meat and I bet the meat would be almost as much by itself.” Many also noted that their time was an additional cost that made scratch foods unaffordable.

Natural foods were whole foods, which included fresh fruits, vegetables, and whole grains, as well as frozen fruits and vegetables and foods prepared in a homestyle way. Most women with managed bodies purchased frozen vegetables because they were less expensive than fresh, were already cleaned and chopped, and had not sat around and “deteriorated.” They did purchase some fresh items but limited these to salad fare (e.g., lettuce and tomatoes) and things that were either not found or were hard to find frozen. They rarely bought canned produce because it had too much sodium, no nutrients, and tasted like mush, although three of them later admitted that they preferred the taste of canned vegetables because they grew up eating them. Four of the women with managed bodies made jokes when they talked about canned vegetables in a way that indicated they associated these with people who were lower class, two were from the three who preferred their taste. When I asked women with managed bodies specifically about organics, they usually said that they were too expensive and not worth the money. One woman told me, “If it comes out of the ground it’s organic.” Others purchased one or two organic items. “I like organic milk because regular milk has too many hormones in it. It isn’t good for my daughter,” one woman explained. Women in this group tended to label foods as either good or bad and were particularly

critical of carbohydrates. When I asked them to explain what they meant by carbohydrates, they explained that these were processed grains like white bread and rice. None specifically mentioned sugar, but it might have been that sugar was too obvious to warrant mention. As she talked about her new diet one woman said, “When they want to fatten up farm animals, you know cows and pigs, they feed them carbs. Why would people be any different?”

Women on this part of the spectrum not only attended but paid for nutrition courses. They preferred health events that offered them swag bags with free samples and that declared the importance of a uniquely feminine approach to health. When possible through their health insurance, they also sought out appointments with nutritionists. Appointments were usually provided if women had a related condition such as diabetes. Some women in this group read labels and rejected items based on what they included. As one woman said, “You know I found out my favorite tomato soup had high fructose corn syrup in it. *Campbell’s Tomato Soup*. I was devastated ‘cause I was, like, well, that ain’t coming back in my house. Now I don’t have tomato soup.” Others focused specifically on calorie, fat, and carbohydrate content and did not worry about the actual ingredients. Three of the women indicated that they did not know what high fructose corn syrup was when it came up in conversation. Nearly all of the women in this group took some kind of vitamin supplement, but their regimens were simple. They took their vitamins once a day, usually in the morning. They took a multivitamin, often designed specifically for their gender and age group, followed by a calcium tablet, and sometimes an Omega 3 capsule.

Women with managed bodies joined gyms, a lot of gyms. One woman was a member at three separate facilities. She never went to any of them, but she was about to join a fourth and was sure this would be the one. Ten worked out regularly, but it was more common for them to say they wanted to exercise but rarely got around to it. Their days were long, their work sedentary, and they felt tired after sitting behind a computer for hours on end. Four of the women who I interviewed in the summer months told me how much they enjoyed riding their bike, their exercise of choice, because it was something they enjoyed as children. It felt like play. When I pressed them about how often they actually rode, only one did it more than once a week. Two admitted they had not ridden yet for the summer (one interview in

June and one in July). Only three of the women with managed bodies reported they did not get an appropriate amount of exercise, but they also did not see themselves as lazy or in danger of being like the overweight people they drew and described as at risk for CVD. As one woman explained, “Like I don’t think of myself as sedentary, but I know that I don’t get enough exercise.”

Talk about exercise often indicated it was a form of penance for bad food behavior. One woman explained, “I wish I exercised more, but it’s really hard to be consistent. I do though, I do try to make sure that when I eat that doughnut, or that piece of cake at work, I go to the gym that night, or at the very least go for a walk with my husband, to make up for it. Sometimes I can’t, I can’t really get to it until the weekend and then I’ll try to do something really active to kind of like atone, you know.” A couple of the women also talked about healthy foods this way, explaining that when they ate something bad they also tried to make sure they ate something good. “If I know I’m going to eat an ice cream after dinner then I make sure I have some broccoli,” one woman said.

Health Care Users

All of the women with managed bodies had physicals, although younger women sometimes limited these to their annual woman’s exam. Initially all of them also indicated that they had the standard preventive tests recommended for women their age but, unlike the women who cultivated their bodies, they rarely knew what these tests were. Excluding mammograms, most only received diagnostic tests when ordered by their PCP and assumed their doctor would give them the tests that were appropriate for them. They also did not really know the results because, although they were sent in the mail, they assumed their doctor would bring them up if they were problematic. Two of the women who trusted their doctors to take care of tests also knew their cholesterol was high because they gave blood. Only one had a cholesterol test performed by her doctor, which was more than a year before the interview. He had not checked it since she refused to take medication to lower it. Another woman in this group found out her cholesterol was high while she was pregnant but had not had another test because she assumed her levels normalized after her baby was born. Several women with managed bodies also had doctors that never

spoke to them about CVD, which the women thought was because they were healthy. This included women who were overweight, obese, and who had high cholesterol.

Body cultivation efforts were made by women with managed bodies but efforts differed from those made by the women in Chapter 5 because they cost less, women spent less time on them, and they expected less than perfect results. Women with managed bodies sought out nutrition information, but only one sought preventive care from a provider who was not her PCP. Joan was fifty, single, and a computer data analyst. She saw the same hormone-balancing physician Jenny saw, although she and Jenny never met. Joan did not care for her insurance-assigned physician and said that she saw this doctor instead because this doctor spent an hour with Joan at each appointment, the hormone treatments made Joan feel rejuvenated, and Joan believed the treatments increased her longevity. Joan also saw a dietary specialist who emphasized the importance of a high protein, low carbohydrate diet for weight loss. The specialist was neither a doctor nor a nutritionist. Joan was unaware of any problems that might arise from her diet, such as increased cholesterol, and did not discuss it or her hormone treatments with her insurance assigned physician. Like the women above, Joan compartmentalized her health care because she saw her body as a conglomeration of parts. She did not realize that a treatment designed to influence one part might also influence another.

Except for Joan, women in this group did not talk about their bodies in the same way as those who cultivated their bodies. While some parts were seen as separate from the rest, others were seen as part of a system and recognized that a treatment meant to fix one problem could result in another. This influenced the treatment choices they made and was the reason one woman gave for her refusal to take a Stanton for high cholesterol. It was also why another woman, who attempted to cultivate her body by going to her PCP for weight loss, said she no longer took a medication that her doctor prescribed. She explained a previous experience with the medication.

So I was telling my doctor I need to cut these pills out because, I mean that's also one of the side effects. He was, like, no-no-no you need it. You'll be sorry if you stop taking it. I didn't really feel that much pain with the endometriosis. I mean maybe I have a high tolerance or something, but I just thought I would rather just not take these pills. You know, and then the second blood clot, I just threw them in the trash. I was, like, forget it. He said that the

endometriosis would hurt and you know that would flare up, but I was, like, I would rather have the endometriosis because the last blood clot went all the way from here up to my groin and I was, like [*makes a pained expression*], and they had a surgeon look at it.

Other women in this group resisted treatments because they felt some pharmaceuticals were unnatural. Tania was one such woman. She refused to take any kind of pill and also resisted several foods as unnatural. Other women in this group were selective about what medications they would take. The medications they identified as acceptable depend on their experiences with different kinds of prescriptions and their individual health care needs. As we talked, Tania justified her choice to avoid medication,

I have high cholesterol and I didn't take the medication that they recommended because I don't like taking pills and medicines. I figure people probably had high cholesterol years ago. A long time ago they didn't have any pills to reduce it. They just had to adjust their diet, but they didn't know that they had high cholesterol and I didn't see it as a major illness, so I didn't take medication for it. I just know because of technology now, I just know about it and to adjust my diet.

Mistrust of pharmaceuticals was common among the women in this group and when the conversation combined prescription medications with doctors, doctor's ethics were questioned. Women believed that nearly all doctors overprescribed medicine and, in the words of one participant, acted like "pill dispensaries." In a discussion of mental health services Teri, a white, thirty-one year old director of a not-for-profit that focused on women's mental health needs, explained, "Even most psychiatrists now don't spend an hour even initially with a client, the ones that I've seen. I mean for our clients it's twenty minutes even on the first time." When asked why she continued,

They see what medications you've been on; what are the feelings; how would they change it; do you have any, you know, they do a lot of the paperwork to get the best idea of what's going on with you rather than the interview. But it's not billable at the same rate and they aren't ever going to counsel you. They just give you the meds and track you, you know, to make sure you have the right doses or whatever, but they don't counsel. There just isn't enough money in it.

Our conversation turned to a discussion of PCPs who prescribed mental health medication without referring patients to a mental health specialist. Teri said this was a common practice that really bothered her. She explained,

The worst thing, I mean just the worst thing. It should be illegal. We have women who have, a lot of it is chemical. It's hormonal, but we have a lot of poor women who have real reasons for

depression besides being post-partum. They're vulnerable, in vulnerable situations, and have been all their lives. You wouldn't believe it. The things some of them go through just because of who they are, where they were born. They're raped by different men. They're abused so much they think it's a normal part of a relationship. When they can, they go to the doctor. They say they're sad or don't feel right. The doctor writes them a prescription, "Here take these pills they'll make you feel better." Like pills can just fix everything. They need to see someone, to talk to somebody that can really help them. Someone who can empower them.

I asked if the clients with difficult lives received better treatment from psychiatrists. She answered,

They [psychiatrists] can refer them to a counselor or a nurse who can talk to them more. The psychiatrists will do that. They'll give them medication but then sometimes they'll refer them to someone with less education to talk to, too.

Women with managed bodies felt that doctors were bribed by pharmaceutical companies to offer medications over other treatments. Pharmaceuticals that advertised on television were the most suspect. Rebecca was very angry about it, "Oh man, the dinners. The places they take them to. What those pharmaceutical companies can do and their budget for advertising and stuff is despicable, absolutely despicable. And I'm glad that bubble has finally burst." I asked what she meant by the bubble bursting and she said,

There's been some stuff publicly on watching the pharmaceuticals and cutting back on their expenses. So now they're doing more for the doctors, but it goes further down than that cause the doctors, if they prescribe say 75 percent of their patients that are on cholesterol lowering medication are given Lipitor, well Lipitor will help them with whatever they want. "Gee would you like to be a speaker at our conference in Grand Cayman. Oh you can be on a panel of about ten people." But it's the fact that this is what the companies are doing to reward the doctors for prescribing their meds. It's probably been in the last two months there's been an article in the Star about the business of the cost of drugs.

On October 5, 2008, the Kansas City Star printed a story about unethical relationships between pharmaceutical companies, doctors, and medical students. They reported that the government, medical schools, and pharmaceutical companies would begin to enforce stricter regulations against conflicts of interest. Regulations specifically targeted free gifts such as knickknack items (e.g., pens, pads, and stethoscope lights), resort trips, and restaurant meals. The story also said that members of Congress wanted legislation that required drug companies to report how much money they paid individual doctors. Laws for such reports already existed in some states but not in Kansas or Missouri (Bavley 2008). Only a

few months before the study began, the *New York Times* published an article about similar practices. Based on their research in Minnesota from 2000 to 2005, psychiatrists collected more money from drug companies than doctors in any other medical specialty (Harris, Carey, and Roberts 2007). While the study was not peer reviewed, psychiatric and medical professional organizations acknowledge such conflicts of interest existed with high prevalence (Fava 2007, Brennan et al. 2006)

There was reluctance to take some medications but eagerness to take others. Women with managed bodies thought that with the right medical assistance, they could feel strong, healthy, and good for the rest of their lives, regardless of outside factors such as aging or the onset of chronic disease. Many of these women resisted the idea that aging should affect their bodies at all beyond a few minor, easily fixed complaints until they were well into their seventies or, for one of the women in her seventies, their eighties. Unlike the majority of the women with cultivated bodies, women in this group had chronic conditions. That they should feel good forever was a message that was repeated frequently at the health events where I met some of them. The only time I observed them openly question their own doctor was when that doctor did not agree with them.

Like Ruth, Rudy was white, in her fifties, and an accountant. She did not want to be recorded but agreed to talk over coffee a couple of times at a center where she volunteered to help adults improve their literacy. Her ex-husband was dyslexic and a poor reader, so she felt a connection to the people who came in. She told me that she recently switched doctors because she did not like the one she had but was happier with her new provider. Her decision to switch came about when her earlier provider was unable to diagnose a digestive problem that occurred when she ate wheat-based products. The doctor stopped trying after he determined the problem was not detrimental to her long-term health. She angrily said that he told her the problem was age related or a natural slowing of her digestive track. His solution was to avoid the foods that bothered her. Rudy said his diagnosis and solution irritated and frustrated her. Although she admitted that her new doctor did no additional testing, she did change the diagnosis from aging to an allergy and recommended adding a digestive enzyme to Rudy's diet. Rudy could purchase the enzyme through her new doctor or at a local nutrition store.

Although the first doctor was more thorough, testing Rudy for multiple autoimmune disorders that might explain her trouble as well as have serious health ramifications, Rudy preferred the new doctor because she legitimated Rudy and offered her a solution for her problem. In Rudy's mind, her body was no longer breaking down because it was growing older. Allergies happened to everyone at every age. Rudy lacked any biological training and did not know the difference between an allergy or intolerance or that if she had an allergy a dietary supplement would not stop her immune system from reacting when she ate offending foods. That she thought she might be able to continue to eat the foods she loved was simply a bonus as she did not know for sure if the recommended enzyme would work because she had yet to try it. She said that she was planning to when she "got around to it."

Rudy also demanded that her doctor prescribe her medications when she thought they would benefit her because of what she saw about them in television advertisements. She was diabetic but did not think the disease was serious because it was type II diabetes. She explained,

Well it's not like the real diabetes, you know, the one you get when you're a kid. It's just, well you know, just like it's just caused by being heavy. You don't have to take insulin. At least, I don't have to take it now, not after I figured out how I felt with different aspects of my blood sugar. You know if I started to feel sick or whatever. And there are other medications that are easier to take than insulin that they have for it. Right now I have pills that help. I can't remember what, you know, they have ads for them on the TV all the time.

Rudy explained to me on multiple occasions that she struggled with her weight since childhood, but she gave up on actual weight loss when she accepted it was impossible for her, about five years after the birth of her second child. Acceptance of overweight was common among women in this group who were over fifty. This struggle, and subsequent acceptance of her appearance, was such a strong part of her identity that it came up in some way in nearly every part of her life story. It was part of her narratives about: dating, marriage, the birth of her children, and her divorce. She explained that while her parents were not overweight, her siblings were, which showed that her excess weight was genetic and thus outside of her control. She confirmed this through stories of repeated weight loss attempts, attempts that spanned more than thirty years.

Rudy was diagnosed with diabetes by her first doctor and said she was well educated about the disease. Her information came from the doctor, when she listened to him at the appointment where he diagnosed her, an appointment that lasted about twenty minutes. She also read the two pamphlets that he gave to her and did some research on her own on the Internet. She believed that her continued interest in health-related articles in women's magazines and discussions found on afternoon and prime time talk shows made her an authority on what was and was not good for her body. She really liked Dr. Oz, a cardiothoracic surgeon, professor of surgery at Columbia University, and television personality affiliated with Oprah Winfrey. When his name came up, she asked if I had read his book or seen his show on the Lifetime network. When I asked if she had seen a nutritionist, she looked at me incredulously and said she had taken several nutrition courses.

Rudy did not trust pharmaceutical companies but simultaneously was proud of herself because she paid close attention to the medication commercials she saw on television. They were educational and, in the words of speakers at health-related events, a woman had to be her own health advocate. Rudy thought it was impossible for doctors to keep track of all of the new medicines on the market. In addition, some pharmaceutical companies incentivized doctors to use their medications. Because of these two things, it was up to each individual to stay informed about what was available to treat their conditions and to request the items they thought would work well for them. She provided a recent example when she asked her new doctor about a diabetes drug. When I queried her about the commercial, it seemed she was talking about the drug Januvia (i.e., *Sitagliptin*), a medication advertised to increase a body's insulin production while it simultaneously reduced their sugar production. Rudy said,

I wondered why she hadn't mentioned it before because the commercials, they said it was for people who were having trouble getting their blood sugar under control and I really was. So I just asked her when I was there having my, you know, my three month, she was seeing me every three months then, my three month checkup and she was like, "Oh yeah, you know, that might really work for you." So she went ahead and wrote me a prescription and it works really well. I mean, I don't check my blood sugar that often anymore, but I can tell by the way I feel that I don't have the problems I used to. And she never would have thought about it if I hadn't seen an ad and asked her for it.

When I asked, Rudy was unaware of any potential side effects associated with Januvia but was unconcerned. She thought she would feel the side effects if there were any and would know that she needed to discontinue the drug. Known short-term side effects for Januvia included gastrointestinal distress; long-term side effects were unknown do to the short duration of existing studies (VanDeKoppel, Choe, and Sweet 2008). However, Avandia, another diabetes drug on the market for more than a decade was in the news because of associated side effects that increased takers risk of heart disease and because of the possibility that drug makers knew about this increased risk and did not report it.

While at a clinic in Kansas City, I informally spoke to two medical providers over lunch. Our conversation turned to patients who asked for prescription drugs in appointments. The providers said it happened a lot and they often gave in to patient's demands because it was easier than trying to fight with them or because they feared the patient would go to a different doctor if they did not give them the drug they wanted. They did not like that their patients asked for these drugs and felt the drugs a patient wanted were often not in their best interest. "I put you on drug A because drug A is what you should be on. It is cheaper and has a longer track record in terms of safety than drug B. But I know, you saw a commercial and it gave you the same education as a medical degree," one said in a moment of frustrated candor. "I would love to sit and talk about lifestyle modification. Eat this, not that. Get outside and move your body, but I don't have time and they don't want to hear it. A magic pill they see on TV that lowers cholesterol and lets them eat bacon, that's what they want. Yeah, I gave them the prescription. Maybe I shouldn't," the other admitted.

Women with cultivated bodies were health care customers and changed their doctors if they were unhappy with how basic services were provided such as how long they had to wait in the waiting room. Women with managed bodies changed their doctors if they did not like a diagnosis or felt that their doctor was not appropriately dedicated to their health care needs. At the same time, many feared losing a specific doctor because they felt their doctor was better than most other providers. This included Rudy, who felt that her new doctor was especially good and was afraid that other physicians were more like the doctor she left. Women were afraid they would lose their doctor because he or she would leave their

insurance company's network of providers. Only four of the women in this group never had a problem with such a change. Teri was deeply frustrated,

Our doctors have changed so often because they pay, they reimburse at such a low rate. Our doctors just say forget it I don't want to be on your panels anymore. I just feel like I'm constantly changing doctors and there is not continuity of care. It's just a very frustrating thing. I just need to remember my last. I think it was in May. I went in for the pap, April or May. I went in for a pap smear. You know my yearly and stuff. I just don't remember the wait being very long. She was probably with me for ten or fifteen minutes. She was very quick but always, she was always willing to answer questions, but she fired [*insurer's name*]. So that was the last time that I saw my primary care doctor.

Abby, a white, forty-five year old retail chain store bookkeeper said that she liked her primary care physician so much that when her previous insurer lost his contract, she began to pay out of pocket to see him. She explained,

I've been seeing the same doctor since 1994. And I followed him through his various locations. Now he is in South [*town*], Southwest [*town*]. He's moved to lower his patient load and to be closer to his family. There was one year when [*ex-husband's*] company didn't accept him as a provider. I just went for my yearly, which of course they would have covered, and then only if I really, really needed to. I'm not going to discontinue my doctor again.

Because women with managed bodies were afraid to lose their doctors, they were willing to put up with more from them. Most reported longer wait times than the fifteen minutes in reception. Waits for women with managed bodies were usually twenty to thirty minutes, sometimes longer. Although not the only one to report such a wait, Dana, a white, thirty-two year old driver, was the only woman who complained about it.

You only get so many days off and when they're gone they're gone. You wait in the doctor's office for like forty-five minutes to see the doctor for five and it kills an hour and half with driving. I have to be up all night, third shift. I get sleepy and if I haven't had any sleep that day it's impossible.

Instead of complain, women discussed strategies to limit wait times such as arriving five minutes or less before an appointment or making their appointments for first thing in the morning. Ruth explained, "I try to get the first morning appointment, so I think that helps." Sometimes strategies contradicted each other, "Oh if you wait until right before an appointment then the nurse might think you're late, they make you wait longer when you're late," Rebecca told me when she asked what I did to speed up my appointments.

Women in this group estimated they spent an average of ten minutes with their doctor once in exam. Some never saw the actual doctor, only a physician's assistant or nurse practitioner. The longest amount of time women ever thought they spent with a provider was twenty minutes. Dana guessed she spent around five minutes with her physician, the shortest amount of time reported. Her short exams caused her problems, specifically in terms of her diabetes. Her doctor ran tests but did not tell her the diagnosis until she specifically asked.

I think that's when I went back to her I said well I'm having this problem and my feet problem and you know all these doctors are asking me, 'Are you diabetic, how's your sugars,' and then she said, 'well yeah you're diabetic.' And she even ordered me a deal to prick my finger before she said I was diabetic. So I'm like she's giving me all this stuff, but she hasn't diagnosed me with anything.

Women trusted their doctors to order the right tests for them and tell them if the results were problematic, but they also thought that the responsibility to make sure each appointment met their expectations was theirs. This meant they needed to bring things up and ask questions. All exams included a brief exam and question and answer period. Abby said, "As far as time spent with the doctor, as much as I need. As long as I have questions or bring things up, the doctor spends the time with me to address things."

Although they would not leave their doctor because of it, women consistently complained about the amount of time they had to wait for their appointment. This was not just for a routine appointment, like it was for women with cultivated bodies. It was also for appointments to meet their immediate care needs. Women never thought waits for acute care were over five days, but when they were sick even five days seemed like a long time. Unable to manipulate the system like the women with cultivated bodies, they took over-the-counter medication and suffered. None reported they went to the emergency room or used acute care clinics when they had to wait.

Attitudes about Access

Overall, women with managed bodies felt the same about health care reform as women with cultivated bodies. The one noticeable difference was that even if they went for periods without insurance, these women were less sympathetic toward people who did not have health insurance than women with

cultivated bodies who had gone without insurance. Managed bodied women were afraid they would lose the access to care they had if the system change. They seemed unaware that women with cultivated bodies had better access, but they were aware there were people who received less care than they did. The women in this group whose opinions differed were those who had experienced a medical crisis while uninsured or who had children who were uninsured. These women were like Ellen in that they did not blame the uninsured for the problems with the US health care system or hold the uninsured responsible for an inability to access care. Instead these women blamed a combination of insurance companies, employers, and what they called US culture, a culture too entrepreneurial to provide universal health care.

When I lived in South Georgia everyone talked about the United States being such a wonderful place to live, but we have so many people who aren't covered and it seems like a lot of employers now are sort of aiming to get out of providing people with benefits including insurance. I think there should be something better, but I don't know what would work here because people just don't want to help each other out. I mean it's like if employers don't want to pay for the people that work for them then why would anybody else want to pay for people they don't even know with their taxes. Things just don't work that way here. Even if something did happen so there was a program for everybody, I don't think it would work very well if the government was in charge of it. I mean, look what they did with No Child Left Behind. It's a fiasco.

System Solutions

Four of the women with managed bodies were afraid of government-run health care because, as the above quote also indicates, they felt that the US government was corrupt and ineffective. They believed systems in other countries were good, but these systems could not be replicated in the US. Teri, who recently decided to go back to school for her PhD, expressed this the most succinctly when she said,

I do think that in the United States, with the culture that we have here that it would be very difficult to have universal health insurance because every time Congress passes a law, like No Child Left Behind, the reason that I left teaching, there's so many strings attached to it that it's impossible to give good care. I would think it would be impossible to give good care.

We're moving to Canada. That's our family's long-term plan. Shhh, I won't tell if you won't tell. We can't all be in Canada, but I'm just so stupid at learning languages that it isn't possible for me to move to Europe. That was one of my reasons for getting the Ph.D. when I presented it to Tom [her husband]. It will be easier to immigrate anywhere.

Ruth, who simultaneously complained that her insurance company had too much control over what doctor she saw, how long she saw him, and whether she could see a specialist, feared government-

run health care because she believed such a system would limit choice. She was honest when she told me that she based this fear on something she saw on television.

It seems to me it wouldn't be as good as what we have now. It kind of scares me because I watched something. I don't remember what show it was on, but I saw something fairly recently or got it on line maybe about a case where Canada, I know Canada has that government controlled, and the guy needed some kind of surgery, and he wasn't able to get it, and he had cancer. He had to come to the United States to have the treatment he needed because they basically denied it for him because, if I understand it, if they get that type of program where everybody is covered, you don't have your choice of anything. I mean it's just this is what you get and you don't have a choice. That is your choice. You don't have a choice. Whether that's right or not, I don't know.

Health Relativity

The greatest amount of variation in health-related lifestyle habits was among women with managed bodies. However, there was one trait that they all shared. Every woman with a managed body purchased products that were meant to make her healthier without the added investment of time or effort. Women with cultivated bodies knew that time and effort were required for cultivation and add them, even if the time and effort added are not their own. Women with managed bodies wanted to cultivate their bodies, but they had little free time and were tired at the end of the day.

Health relativity happens when people base health decisions on a limited number of choices that are similar in nature. An example is *Eat This, Not That*, a book series, which shows people how to choose the healthiest items from a selection of less-than-healthy options. Some see such health information as helpful, but health relativity makes unhealthy foods seem okay because they are better than another even unhealthier alternative. They legitimate bad foods and turn social discussions about food from what is available to what is most acceptable. Often, there are no healthy alternatives. When there are healthy options among convenience foods, these often lack the added sugar, salt, and fat that make these foods more palatable. Women who had diets that favored these foods questioned whether healthy foods could really taste good. Limited experience with fresh foods, often seen as bland or bitter because they were only ever eaten raw, helped to consolidate beliefs that healthy tasted bad.

Health relativity is a form of hegemony that supports the notion that food equals processed food, a notion women with managed bodies rarely questioned. Health relativity is easier than trying to

understand how the body uses micronutrients or the relationships among carbohydrates, proteins, and fats, so that, like the foods it legitimates, it takes little time or effort. Once accepted, health relativity also helps to substantiate the belief that people bring disease on themselves because they could have made healthier selections. It blinds people to the fact that in some areas food choices are limited such as an area of Wyandotte County that opened its first, and subsequently only, grocery store in thirty years while this research was conducted. Food relativity hides the fact that a choice between baked potato chips and fried potato chips is not really a choice.

Health relativity was not unique to women with managed bodies, but they actively embraced it where as other women tended to grudgingly accept it and sometimes even rejected it outright. Women with managed bodies liked health relativity because it made them feel in control. They felt like they were cultivating their bodies when they bought products that appeared healthy based on limited criteria. When they developed a potentially related health condition, they went to the doctor and bought more medical products in the hopes that these could fix them. Even if they could not find a medication or procedure that eliminated their new disease, they hoped the doctor would validate that they did all they could for their health and that their disease was not their fault. Women often feared that it was because, “perfect behavior was not possible all the time.” Women splurged and sometimes chose high-fat ice cream or a non-diet soda because it made them feel better emotionally. Health relativity thus lead them to blame themselves and see indiscretions, which were once choices that made them feel even more in control, as moments of weakness and lost control.

Although women with managed bodies paid more for less health care than women with cultivated bodies, women with managed bodies accepted the supremacy of the US health care system. Aware that this system distributed resources based on how much one paid for them, they feared an alternative that would take away their buying power. The access they had to health care also gave them a sense of control, but they were weary of doctors in general and resentful of the control that medical professionals had over their lives. This led them to mistrust doctors in general. Reliant on their own doctor for access to care, they imagined that their doctor was the one doctor that was above reproach.

Chapter 7 --The Neglected Body

In an interview with Bill Moyer July 10, 2009, former Cigna executive Wendell Potter explained why earlier that same year he felt compelled to go before Congress and testify about problems he identified with the US health insurance industry. Potter told Moyer that his testimony was prompted by witnessing the suffering of people who did not have access to adequate health care, suffering that he linked to the US health insurance industry.

It was being held at a Wise County Fairground. I took my camera. I took some pictures. It was a very cloudy, misty day, it was raining that day, and I walked through the fairground gates. And I didn't know what to expect. I just assumed that it would be, you know, like a health-- booths set up and people just getting their blood pressure checked and things like that. But what I saw were doctors who were set up to provide care in animal stalls. Or they'd erected tents, to care for people. I mean, there was no privacy. In some cases—and I've got some pictures of people being treated on gurneys, on rain-soaked pavement. And I saw people lined up, standing in line or sitting in these long, long lines, waiting to get care. People drove from South Carolina and Georgia and Kentucky, Tennessee—all over the region, because they knew that this was being done. A lot of them heard about it from word of mouth. There could have been people and probably were people that I had grown up with. They could have been people who grew up at the house down the road, in the house down the road from me.

When Moyer asked what he did after the event, Potter said that initially he did nothing because the extreme disparity between his life and the lives of those at this event left him in shock. He could not believe that such poverty existed in the US. Potter defended his lack of knowledge by explaining that his wealth and position isolated him. He provided an example of the social distance between an executive like himself and lower status Americans,

I had been in the industry and I'd risen up in the ranks. And I had a great job. And I had a terrific office in a high-rise building in Philadelphia. I was insulated. I didn't really see what was going on. I saw the data. I knew that 47 million people were uninsured, but I didn't put faces with that number.

Just a few weeks later though, I was back in Philadelphia and I would often fly on a corporate aircraft to go to meetings.

And I just thought that was a great way to travel. It is a great way to travel. You're sitting in a luxurious corporate jet, leather seats, very spacious. And I was served my lunch by a flight attendant who brought my lunch on a gold-rimmed plate. And she

handed me gold-plated silverware to eat it with. And then I remembered the people that I had seen in Wise County. Undoubtedly, they had no idea that this went on at the corporate levels of health insurance companies.

Introduction

Women with cultivated bodies used health resources to make their form as close to the American ideal as possible. Women with managed bodies mimicked women with cultivated bodies but without the same access to resources they could not quite achieve the same results. Women with neglected bodies once belonged in the other two groups but could not maintain these other two types of bodies. Women with neglected bodies retained habits from their former lives, but their limited access to health care and deteriorating physical condition affected them deeply. As they slipped down the class ladder and realized they were not, and perhaps never really were in control, they began to question the American system and whether it was really the best way for society to distribute resources.

Ilene

“I go to the doctor maybe twice a year and have lab tests maybe twice a year and my doctor’s been really kind to me and he gives me most of my pills,” Ilene explained as we sat in a smoky bar and grill eating an order of beer-batter onion rings that were decadently sprinkled with parmesan cheese. She was an obese woman with thin, shoulder length bleach blond hair that was pulled away from her light blue eyes with a black headband. Barely 60, she had bad knees that made it difficult for her to stand for long periods or walk more than a few feet at a time. Her clothes were loose cotton, made for comfort instead of style, and bought off the rack at a discount department store like Wal-Mart. The clothes added at least ten pounds to her already large body and years to her age. She offered a bitter smile as she continued, “None-the-less I’m still able to, I still spend enough on health insurance to get an IRS deduction but not enough for it to equal out.”

Ilene was a divorced mother of two who spent her working life in the front and not the back office. “I did sales, office management, answered the phones, personal secretary, pretty much everything,” she explained as she described the company where she worked for more than eighteen years.

She left five years ago when she could no longer handle what she described as the tirades of an abusive boss. She told me, “My kids were grown, married, starting to have kids of their own.” Now she paid her bills with money that she earned as a contract worker at a local box office. She said it was a fun job, “the closest you’ll ever get to getting paid to have a social life.” While fun, it did not provide her any benefits. For her health insurance, Ilene was left to the individual market where she paid \$500 a month for a policy that she said had a \$5,000 deductible and did not cover any of her prescriptions. She also told me that this insurance never paid a claim because she had never met its deductible.

A diabetic with severe back and knee pain, high cholesterol, and high blood pressure, Ilene, like many women her age, had pre-existing health conditions. She visited her doctor about twice a year to have an A1C, or blood sugar test. She also went when she had something that scared her, like this past summer when she said she broke out in a painful rash all over her arms and back. Although he was unable to help with her rash, she considered her doctor a good one because he gave her free sample medications to cover what would otherwise cost her over \$400 a month in prescriptions. She said that sometimes she was tempted to give up her insurance and use the premium money to pay for her medications. When I asked why she did not, she said, “I guess I like to think I’m respectable if I have insurance. My kids would freak out if I didn’t have it.”

Although she went to her doctor for the care required for her diabetes, to receive her medicine, and if she had a particularly painful or scary acute need that she felt was worth the additional debt of an office visit and associated testing, she did not go to the doctor for other things that she believed required a doctor’s care. She knew she needed to lose weight but, instead of dropping pounds, had only gained them for several years. Over the past few months, she put on a lot of weight very quickly. She wanted to go to a doctor for help with weight loss. She also wanted additional testing on her knees. She explained, “I’m getting to the point where I can hardly walk and I don’t know what to do about it. I know weight is a problem but my knees were first and I’m on pain pills and I need to get an MRI, but I can’t afford it.”

Ilene keeps her insurance because she would be embarrassed to be without it. At the same time, she thought health care was a human right and that everyone should have access to it. She blamed the

insurance company's greed, not only for limiting access to care but also for what she observed as a decline in basic health care services. "Well right now the insurance companies are ruining medicine and they're running the show. Let's get them out of the picture. It will take a dip down, but it can't go much further down than it already is. I mean I was in the hospital in like 1980. I mean the room was filthy then and that was [*hospital name*]. I know how bad it is. At least then people like me could get seen."

Ilene felt that she was very well informed about what increased people's risk for CVD and what she should do to keep her body healthy. When she was younger, she and her ex-husband lived in California for a while with her in-laws who were vegans (i.e., a person who uses no animal products). She pronounces it so that it rhymed with began. She said, "I did it mainly to keep piece in the family, but I liked it. But I kind of backed off of being a vegan after a year, but it was the healthiest time in my life. It was right before my older daughter was born. I loved it. I mean the food was, tasted so much, good and the weight just melted off. I didn't have to do anything. It just melted off." She considered the vegan lifestyle the ultimate in good health and extols its virtues as she devours a twelve ounce sirloin and side of sour cream mashed potatoes. The broccoli that came with her meal sat on a small side plate between us because she asked if I wanted it as she ordered, telling our waitress that she did not want this vegetable placed on her plate.

As she described a healthy diet, she said that dairy was especially bad and that its consumption was the primary reason Americans were obese. She explained, "Dairy's terrible. I mean I love it, I mean I love butter, I love cheese. Eggs don't bother me, I can do without eggs but cheese, ah cheese. But you know there is so much dairy in so many things and sugar is evil. It is just evil. I think sugar is addictive. I think sugar is the worst addiction on the planet, worse than any drug, worse than anything because it's just, well, you know, it is subsidized by the government." She said that natural, unrefined sugars were safe but expensive. She also told me to avoid artificial sweeteners, "My son-in-law works for Splenda, like don't get me started. I'm like, 'Do you know that they are saying that your product causes cancer.' He's like, 'no it doesn't.' I'm like, 'there's a study they could do but guess what. It takes twenty or thirty years.'"

Ilene was unable to do even the most basic kinds of physical activity. She also did not have the money to seek assistance. She said that she would like to exercise more, and she used to take much better care of her body, but, “There were some things going on that were just not nice, that were not happening right. I had to deal with them, things with my kids that I had to deal with. Well, then you think, ‘I’ll get back to doing it,’ but it’s not as easy as you think when you get older. Every day I think, ‘This will be the day you get up and try to touch your toes and do some exercises,’ but I don’t because I can barely walk to the bathroom and barely walk and you know if I walk from here to there I have to sit and rest for a minute. It is what it is, you know. And then you, just because you’re sedentary you gain weight because you’re sedentary.”

I asked if she thought that being sedentary was the only thing that increased her weight. She laughed and said it was the main thing but, of course, diet was also important. She told me, “If I could fault my doctor for one thing it’s like I’ve been asking him for four years to give me a diet I could use but you know. It’s like I’m diabetic, but I learned that I could eat sugar to a certain extent. I would find that when I was testing my blood sugar it would go, if I ate bread at night like for a snack my sugar would be higher the next morning then it would be if I ate M&Ms. So I was, like, hello, I think I’ll eat the M&Ms.”

I asked her where her health information came from, if not her doctor. She said, “Based on my experience. I mean I’ve read a lot of books on health and I know a lot of things that are healthy, so I know when I’m eating foods that are and aren’t healthy. It’s choices. So I mean, I mean when I drove home from Illinois five hours and I was falling asleep in the car and I had the window open, so I wasn’t surprised when I caught a cold after that even though I had the heat on, but the cold air so that I knew that was not going to sit right. But that’s how I decide what’s healthy. You know I know. So that’s how I know things are healthy, from my own experience and reading and a gut feeling.”

Neglected Bodies

Ilene’s sentiments were similar to those of other women with neglected bodies. She said she hated her coverage because it never paid for anything, but she was afraid to go without it because of the cost of care and the stigma that was associated with being uninsured. There were thirteen women in this

group, including three women who were on Medicaid (Table 8). Seven had individual policies and four of these seven were enrolled in the Kansas High Risk Pool (KHIA), which charged them high monthly premiums, had high deductibles, and did not cover most prescriptions. These four women’s premiums ranged from \$500 to \$1,024 a month. None spoke of copayments or coinsurance, but their deductibles prevented them from going to the doctor. For approved providers, deductibles ranged from \$2,000 to \$5,000. If they did visit their doctor, their high deductibles precluded the insurance company from ever paying a claim. If they had a copayment or coinsurance, they may not have realized it.

Table 8 – Demographic Information for Women with Neglected Bodies

Income Level	Age	Married	# in Household	Occupation	Education	Race
< 5,000	28	Yes	5	Clothing Store Clerk	< High School	White
< 5,000	46	No	6	SSI	High School	Black
10,001 - 20,000	51	No	1	SSI	Some College	Black
10,001 - 20,000	47	No	2	Sales Person	4 year degree	White
20,001 - 40,000	59	No	1	Services Coordinator	4 year degree	Latino
20,001 - 40,000	60	No	1	Box Office	4 year degree	White
20,001 - 40,000	62	No	1	Administrative Assistant	Some College	White
40,001 - 60,000	60	Yes	2	Childcare Provider	High School	Black
40,001 - 60,000	21	Yes	3	Receptionist	High School	White
40,000 - 60,000	34	No	2	Pediatric Nurse Practitioner	Graduate School	White
60,001 - 80,000	49	No	1	Registered Nurse	Some Grad School	Asian
80,001 - 100,000	64	Yes	2	Job Coach	4 year degree	White
80,001 - 100,000	55	Yes	2	Book Keeper	Some College	White

Two of the remaining three women had access to a group plan. One obtained coverage through her employer. On paper this woman’s policy looked like that of women with managed bodies, but in the six years that she had it, the insurer never paid a single claim. The insurer always denied her because her provider was out of network, even when she chose a provider from the company’s Website. She once appealed the rejection of a claim. The second time around they denied her because the health problem she went for was a preexisting condition. She wanted different coverage but could not afford to buy a policy on her own.

The other woman with a group policy had it because the policy was a part of her retirement package. The policy was good and affordable when she worked but once she retired the premiums rose and the coverage diminished. She felt the premium, now over \$300 a month, was still something she

could afford with her \$40,000 to \$60,000 annual household income divided between only her and her husband, but the coverage only paid for prescriptions and hospitalizations. It did not cover standard or preventive care. She sighed over her dinner at a local bar and grill and said,

Well you don't want to because it seems like such a waste when you never use the insurance, all that money every month but at my age, well I'm not getting any younger. Let's just put it that way. And who can afford to stay at the hospital. Medicare is going to feel like a raise.

People were often forced to the individual market because they only worked part-time or were contract workers but some simply worked for very a small business or owned their own small business. This meant people who self-insured had a wide range of incomes, reflected among these women. Annual household incomes began in the \$10,000 to \$20,000 range and ended in the \$80,000 to \$100,000 range. One woman was married to a dentist. Another was a nurse practitioner who split her time between two practices, which made her a part-time employee even though she often worked more than forty hours a week. One woman who was self-employed in sales explained that with the downturn in the economy she paid more in premiums than she brought home each month and relied on a trust for the difference and to cover household expenses.

Eight of the thirteen women were white. Three were black, one Asian, and one Latina. The oldest was sixty-four years old. The youngest was twenty-eight. Excluding the four from the high-risk-pool, annual household income categories ranged from \$20,000 to \$30,000 and \$80,000 to \$100,000. Of all thirteen women, five had a four year college degree. One completed graduate school. Four were married. One of the thirteen had dental insurance. None had vision coverage. Women in this group had several preexisting health conditions such as diabetes, depression, CVD, gastroesophageal reflux disease (GERDS), high cholesterol, and high blood pressure.

These women struggled when they had to see their medical provider. Most avoided appointments unless the visit was absolutely essential. After they went, they struggled to pay the associated bills, particularly if there were lab fees. One used a safety-net provider. The rest assumed these were only for the uninsured. They also thought that safety-net clinics were for the indigent and thus provided substandard care. All were grateful to have some kind of health insurance coverage because it gave them

access to the health care system. They were afraid that without insurance they would be turned away from care providers including hospitals and urgent care facilities. For these women, being uninsured was unfathomable.

Bodily Neglect

The majority of women in this group were overweight or obese. Of the three who were not, two were health care providers and one reported the highest income range that was reported for this group. The nutrition and exercise habits of women in this group were a combination of those found among women with other types of bodies, particularly those with managed bodies and forgotten bodies. All of the women with neglected bodies worked. Most had limited budgets. Like women with managed bodies, these women shopped right after payday and then went to the store intermittently to replenish used-up or spoiled items. Women with neglected bodies prefer easy to fix, previously prepared, frozen foods, but not all of them had enough money to afford them. Poorer women with neglected bodies also relied heavily on simple, inexpensive convenience foods like boxed macaroni and cheese and fast-food.

Women in this category agreed with the women in the previous two chapters that the things found in processed foods were bad. They were particularly critical of additives like preservatives and trans-fats, but only half indicated they had heard of high fructose corn syrup. Four of the women with neglected bodies preferred organics. One of the two women with the highest incomes explained that she purchased organic fruits, vegetables, dairy products, and meat regularly. Two other women purchased a few organic items. Ilene wanted to purchase organics but could not afford them. All three of the latter women included processed foods that advertised they were made from organic products as organics. For example, one of the women said she preferred Newman's Own Organic Pop Corn.

Those with neglected bodies were not overly critical of carbohydrates, although several told me a person must watch their carbohydrate intake. When I asked what they meant, they included the same foods as women with managed bodies, which were processed grains. Three of the women added sugar to the list. One laughed and said, "Well sugar of course. Everybody knows that refined sugar is a bad carb."

Women with neglected bodies were more likely to indicate they indulged in foods that were not good for them over the course of our conversations. Some brought up their bad food habits frequently as if trying to get me to admit I liked the same kinds of foods, so we could conspire together. One talks about Hardee's for nearly five minutes one day before I explained there was no Hardee's in Lawrence. Later, she took me to Hardee's and we bonded over cheeseburgers with extra bacon. She was the first to do this, but I ate a lot of fast-food and local greasy spoon fare with women who had neglected and forgotten bodies. As long as I did it, too, it seemed okay for these women to admit they ate things that were deep fat fried, high in fat, and high in sugar. Sometimes it was our only option. Three of the women were interviewed in Kansas City, Kansas, and there were no other kinds of restaurants around. With one exception, women with neglected bodies always told me how unhealthy the foods were while we ate them. One woman, who took me to a local hamburger stand, listed off all of the known risks for CVD as she salted her double bacon cheeseburger.

Only two of the women in this group belonged to gyms. One with a gym membership was also one of the most affluent from this group. The other was a pediatric nurse practitioner. Both indicated that they exercised regularly. The pediatric nurse talked about exercise frequently over the weeks that we interacted and in such a way that it appeared to be an important part of her life. At one of our first meetings, she asked if I played racquet ball. When I said that I did not, she asked if I wanted to learn. I later found out that she played amateur racquet ball tournaments and placed in the last tournament she was in. For the other woman, going to the gym was an important social activity where she could catch up with her girlfriends. Other women with neglected bodies wished they exercised more, but regular exercise was too difficult with their schedules, energy levels, level of discipline, budget, or health concerns.

Health Care Hangers On

All of the women with neglected bodies indicated that they once had health insurance similar to the insurance of women with managed or cultivated bodies. They were no longer able to obtain the same kind of coverage because they either no longer worked for a company that provided benefits or because

they had a group policy that did not do what it promised. These women had medical debt. They only visited a doctor when they absolutely had to, although the definition of ‘had to’ varied from woman to woman. They also feared a visit to the ER because of the cost and said they rarely had preventive screenings. Some skipped treatments or failed to take prescribed medications because they could not afford them.

Because these women’s experiences with health care were so different from those of women with cultivated and managed bodies, the HMO/PPO distinction was not relevant for them. Women in this group did not generally differentiate between HMOs or PPOs when we talked. All but one discussed the difficulties with access to providers through a network. One told me that for a higher fee she could see someone outside her provider’s plan.

Ten of the thirteen of women in this group had at least one serious chronic illness. At least three had more than one. Four avoided preventive diagnostic tests because they were afraid that such a test might show something was wrong with them they could not afford to treat. Three had policies that would not pay for preventive health care. One avoided any kind of diagnostic test because she hoped to change insurers and was afraid of a new preexisting condition that would make that impossible. One, the second youngest of the group, was allowed up to two diagnostic tests per year and usually used them to have her yearly well woman exam and general physical. Those who feared a new diagnosis ranged in age from forty-nine to sixty-four years old. The financial costs of diagnostic tests made them undesirable, but women indicated they could afford some screenings if they chose. Based on their income, the low cost of basic tests, and the availability of many of these tests at events like health fairs, this was likely true. Other screenings cost more. For example, a bone density scan was around \$250, which was probably out of reach for those with the lowest incomes in this group, especially in light of what they paid each month for their premiums. Marcia was a sixty-four year old job coach who trained and worked as a dental hygienist before she found what she called more fulfilling work. She told me, “Cholesterol, mammogram, bone density, I want to have them all, but what happens if something is wrong? I’ve got

that \$5,000 deductible. When I get Medicare I'll get them done and go from there. I'm just holding my breath waiting for Medicare.”

Kristy was unable to afford preventive tests. A fifty-five year old bookkeeper, she lost her job with a large firm and, with it, the associated benefits. She worked in her husband's small landscaping business. Kristy had a history of congenital heart disease. She had several related surgeries and was uninsurable on the individual market. Because of this, she ended up in the Kansas high-risk pool. She told me that she wanted preventive tests, but the cost of care for even her acute health needs was often out of reach. She could not justify paying for preventive tests when she had acute needs. She talked about saving the money for a preventive appointment in the future, but then indicated she also needed to save up what she owed for past care. She was embarrassed to go to the doctor's office while in debt to it. She was unable to convince her husband to let her ask for charity assistance because he refused to let his family take a handout. After she explained her situation and I asked when she thought she might see the doctor again she referenced a nondescript point in the future,

Right now I've been having a terrible time with sore throats and trying to get rid of them and it's just that time of year with dampness and the mold and that kind of thing. I need to refill all my prescriptions, but it is that kind of thing where it is almost too expensive right now, so I'm trying the over-the-counter stuff so I can see if I can get it to work. I'm putting off that yearly visit because of all the financial burden we're under right now. It is something I need to save up for because my mother died from breast cancer, so. It is just cost being so high and being embarrassed about owing money.

You know a couple of them, the payments I've been trying to make, they threatened to turn me into a collection agency unless I pay it all off when they wanted it, in three payments. I can't pay that kind of money off in three payments, just no way. You know, when you've got a \$23,000 bill on you, you can't pay it in three payments. That's all there is to it. So [*hospital name*] finally sent me something on the financial situation and my husband won't let me fill it out. So you know I'm knocking my head up against a wall with him.

I think he's embarrassed, but I don't think he realizes how bad it is going to be on our credit and the financial system. I don't think he understands that. I'm the one sitting down and writing all the bills and everything right now and he just doesn't understand that. He says, “Well they'll accept two payments of fifty dollars a month. They have to.” I said, “No they don't have to. They're telling me they're not going to. They said they would turn me over to collections and that's what they've done.”

Kristy told me that over the past few years her weight crept up, which could cause serious complications for her heart. She was unable to access a nutritionist through the high-risk pool. Because

her husband obtained a policy before he had a preexisting condition, he was able to afford a better health insurance plan. A year before our interview he had a major heart attack and had to have bypass surgery. As part of his treatment, his plan covered a nutritionist. He refused to go. At his doctor's request, her husband's insurer said she could go instead.

I talked to them about what foods to cut back on and what good foods to get on. And he doesn't want to do some of it. He wants to do a little of it, but I'm like okay, but you cut back here and you, I try the whole thing for me and I have that Cheerios for me every morning and if I have a snack, Cheerios. I think between the Cheerios and the exercise has made a big difference and trying to get that positive attitude.

Angel is a fifty-nine year old services coordinator for persons with disabilities at a not-for-profit agency that once offered health benefits but, due to rising premium costs, could no longer afford to provide insurance for its employees. She had been on the individual market for about a year with a policy that had an extremely high deductible. Injured in a serious car accident years before, she had some mild issues with her left arm and foot. When she bought the policy, they made her sign a waiver for anything related to the previous accident. She did not know such things occurred before she purchased the plan and said, "It shouldn't be allowed. I got the insurance in case I ever had anything really serious come up for me and something that serious is more than likely going to be related to the accident. I mean that's just the odds." In the process of trying to find better coverage, she shook her head when I asked her whether or not she sought preventive exams. "No way; they find out I have a heart problem or there is something wrong with my eyes or God only knows what and I'll never get insurance."

Kristen, a thirty-four year old, white nurse had a plan to cover her major medical expenses. She was the woman with the plan that also paid for two preventive exams a year and is the racquet ball player. She said that she usually used one exam for a well-woman visit and one for a general physical. This past year she said she used both for well-woman exams because there was a problem with her first set of results. She did not think they would cover the second exam because it was a second exam for the same thing.

I had to have two well-woman exams in a year and I thought oh they're not going to cover the second one. I know they aren't going to help me out with any of that. Let me just put aside

some money because I know I'm probably going to have to spend x amount for this exam and it turned out they ended up providing more than I thought they would.

She was the only woman in this group to say something nice about her health insurance. She also explained that at her age she was healthy and did not need to go to the doctor, so there was no real need for a more inclusive policy. She admitted that she did not think she could afford one but hoped that by the time she was old enough to need something better, she would have group insurance again. She was actively looking for employment with a health care provider that would give her a full forty hours a week instead of the twenty hours she had at two clinics.

Kristen was lucky because she was healthy, but most of the women in this group were not as fortunate. They not only needed the standard preventive care recommended for women their age, but those with pre-existing conditions often required regular visits with specialists to monitor specific systems as well. All of the women in this situation said these exams were important, but not all follow their exam schedules as well as Ilene said she did with her A1C appointments. Of course, Ilene's doctor would not provide her medication if she did not go, so she had an additional incentive to show up for these exams. Most said they tried to go and reported the most common strategy used to cut down on costs was to reduce their total number of appointments. For example, if a woman was required to go every six months, she goes once a year. Women also triaged their health care needs.

Women with the higher incomes were more likely to go for acute health care needs as well as for appointments related to any chronic conditions they had than women in this group with lower incomes. Women with lower incomes said they tried to skip care on things such as urinary tract and sinus infections. Instead they waited in discomfort for days in the hopes that whatever was wrong with them would go away. For example, Janelle was a sixty-two year old, white office worker I found at the only truly free clinic in the area. She thought she had an upper respiratory infection and hoped the doctors would write her a prescription for antibiotics. She could not afford to go to her primary care physician and, because she was at a free clinic, was initially reluctant to admit she had insurance. She said she was grateful to this clinic, which asked no questions about a patient's financial status. Even though the

process for treatment was somewhat lengthy and uncomfortable, she knew she would eventually receive care. We sat in an empty conference room. Her voice was very quiet as she said,

It wouldn't be a lot. I'm not sure exactly, maybe \$100 for the visit and \$20 or \$25 for the culture. Antibiotics are really cheap. They're like ten, you know, I think it was ten dollars the last time I needed them. But I'm on a fixed income, semi-retired. I only work part-time and that, that's a lot of groceries really.

When able to go, women with neglected bodies had doctor's visits comparable to those with managed bodies. However, women with neglected bodies were even more reluctant to complain about their providers. The biggest problem that the women in this group faced was their inability to afford health care. They also told me that any doctor was preferable to no doctor because they believed their doctor was the key to the entire health care system. Their doctors provided free medication, offered reduced rates or deferred payment plans, and wrote referrals that allowed them access to other doctors with different specialties. Their doctors would not see them if they did not have health insurance, so they sacrificed for their health insurance. It gave them access to medicine. Women in this group said people without health insurance had no doctor and no access. Ilene explained,

I'm almost to the point where I'm going to come to the decision where I drop the risk-pool, but I'm not going to lose my house over it [health care cost]. You know if I end up in the hospital somebody is going to pay for it. They're not going to kick me out. I mean I won't get class A service, but I wouldn't get class A service anyway.

As the above quote demonstrates, women in this group were also afraid that if something happened and they found a hospital that would take them, the cost would be so high they would lose everything they owned to pay for it. Although many already had medical debt in the thousands of dollars, they feared debt in the hundreds of thousands of dollars. Women did not go to the emergency room because their high premiums and deductibles made it impossible. No matter how sick they were, they would wait for a regular appointment before they went to the emergency room. "If I go to the hospital, it's \$5,000 right there. Pop \$5,000. That's my deductible," Marcia explained.

Attitudes about Access

Women with the worst coverage were conflicted about who to blame for their inability to access care and for the health care crisis. Like women with cultivated and managed bodies, they saw that, with

the exception of the completely helpless, everyone was responsible for themselves. Good people did not take handouts. They pulled themselves up by their bootstraps. Besides insurance granting them access to the health care system, this belief was another reason that these women worked so hard to maintain their coverage at such great personal cost. Over time, they began to question their beliefs and blame the government for failing to control insurers.

I've just been begging, you know. I mean why do I worry about what the president can do? He's not going to change insurance. Nobody's going to be able to do anything with insurance in the time that they've got. And I've been waiting since Bush ran four years ago, since he ran four years before that because I've been doing this individual self-employed thing for eight, for probably at least six years and it's never getting any better.

They also feel socially abandoned in a culture where worth was based on wealth. As she talked, the woman from above added, "And with people, if you don't have the money the doctors and the hospitals are gonna take a look and say well so what you're alive. Well, so what I'm alive. I might as well be dead I don't have any money. I don't have any way to do anything." For many, feeling socially abandoned went beyond their inability to access good health insurance. Women with neglected bodies were born to high social positions. One woman was the daughter of a dentist. Another was the daughter of an engineer. They went to college, married well, and did what they were told they were supposed to do to maintain a good quality of life for themselves and their children. Then, they became sick, divorced, lost their jobs, or, in the case of one woman, survived Hurricane Katrina. They fell down the class ladder. Something most of the women with neglected bodies blamed on what they now identify as unfair social institutions. Ilene explained,

I used to say many are called but few are chosen. I think single moms are the new saints like in India, you know, they have the holy men that wander around, like they get married and they raise their families and then when their done with that it's time for their spiritual ride, so they put their yellow garments on and wander around and beg. Well in America we have the single moms who have to do the begging. You'd be amazed at how many women will stay in an abusive relationship or a bad relationship rather than go out on their own because of how tough it is. I've seen what they'll go through, but it's better if they leave. I'm not a feminist, but most of the women that I meet that are like that end up out of their relationships.

System Solutions

When asked how they thought the American health care system should be fixed, these women had one response. Not all of them looked me in the eye and said it as unequivocally as Ilene did when she said, “Socialist, I mean socialized medicine,” but not all had fallen as far down the class ladder, either. A couple still earned high incomes or were married to men who earned high incomes. While the reality of the health insurance market made them question their earlier beliefs about health care, they were not quite ready to throw out their whole worldview. Still, they were ready for something a little more socialized.

As she talked about insurance, Marcia said,

I’m going to tell you what. I don’t know. We had this discussion with some friends the other night, with some friends, and he was saying to everyone at the table, “Do you think you’re entitled.” And part of me says, “No, I’m not entitled to that. If I worked I should provide health insurance, I should provide for myself.” But on the other hand then, I think wouldn’t it be wonderful if everybody just got it, if everybody was, kind of like socialized medicine. And I hate saying that, but it is difficult for people.

Release as Control

In consumer-based societies, markets require that people engage in regular cycles of control and release behaviors. Markets need control to enlist the hours of work needed for production. They need periods of release so people will indulge and purchase the items that are produced (Bordo 1993: 199-201, Reischer and Koo 2004: 301). While messages that encourage these cycles of control and release affect everyone, mass marketing, the deprivation caused by wealth disparity, and TV images that show the poor what they are missing create deviations in traditional patterns of control release. The women with neglected bodies once had cultivated and managed bodies. They felt their control slipping away. They reacted to varying degrees by engaging in behaviors they identified as bad but felt good. These women used their bodies to express displeasure at how society treated them. The majority of women who openly smoked cigarettes were women with neglected bodies, followed by women with forgotten ones.

Women with neglected bodies were angry at society. They played by the rules and society let them down. Some were trying not to play by the rules anymore. Others were not as concerned with the rules as they once were, particularly younger women who assumed they would raise their social position

again. Instead of embracing the fact that the system failed them and engaging in discourse against it, they rebelled using its rules. In so doing, they validated the system to those outside their position. Women with cultivated and managed bodies did not look at Ilene and see someone who was once like them but went through a bad divorce and then raised two children on her own with limited support. They did not see the bright, articulate woman who wished she could spend more time with her granddaughter. They saw a fat, lazy, bitter woman who refused to do anything to help herself.

Chapter 8 --The Forgotten Body

Introduction

Women with cultivated and managed bodies used health resources to try and attain the cultural ideal of the perfect body. Although not always able to achieve this form with the resources available to them, these women were always able to access medical care when they needed it. Women with neglected bodies were able to seek care when they felt they absolutely must but were often left in medical debt and were afraid to seek care for things they did not identify as life threatening. Women with forgotten bodies had very limited access to health care. All but the very youngest had disabling or potentially disabling health conditions, but only those with severe chronic conditions had what they considered a regular medical provider. All recounted times when they needed care but were unable to access it. Women in this group were aware of messages about the ideal body but found this body so far out of their reach that they rarely tried to do anything to attain it.

Sharon

“You know, I just couldn’t ask for a better team of people. The doctors, the sisters because I’ve gone down on them [fainted] when I’ve been there and you know everybody’s been super.” Sharon told me about the safety-net clinic where she received most of her health care as she readjusted her walker against the table in the large hotel diner where we had brunch. She was short, obese, and had limp brown hair and small green eyes. Several of her front teeth were black with decay and one was missing. Her clothes were worn but clean. Her movements were stiff and belonged to a woman much older than her fifty-nine years. “They keep a close eye on my eyes, my feet. I have a problem with my one toenail on the right foot. It wants to constantly break. My left leg, I have a, I got bit by a recluse spider. And this has been two years. At first I went to [*hospital name*] and all I kept hearing at the emergency room was we need to admit you but you don’t have insurance. We need to admit you but you don’t have insurance.”

Sharon lost her insurance two years before when she lost her government disability due to some legal troubles in another state. Since that time, she was refused health care repeatedly, primarily by

emergency rooms. Sharon cleared up her legal problems, but in Kansas, doctors changed her primary disability diagnosis from multiple sclerosis to fibromyalgia, which was not considered a disabling health condition. She did not get her benefits back. When we talked, Sharon had a new application on appeal. She had other health conditions that might qualify her for disability, such as type II diabetes and related neuropathy, kidney failure, congestive heart failure, depression, back problems, and liver damage. Medications for one condition were usually contraindicated by another. She explained, “We’re between a hard rock and a hard spot.”

Sharon was diagnosed with diabetes in 1998. When she was on disability, she had the condition under control. The doctor put her on Metformin but offered her no information about the disease. After ten years of heavy medication use, the Metformin and diabetes had severely damaged her kidneys. “I would write down, you know, my numbers and stuff. He would just look at that and want to increase my Metformin. I didn’t know anything about A1C,” she explained. The doctors at the safety-net clinic took her off the Metformin immediately after they tested her kidneys and put her in contact with a nurse who specialized in diabetes education for the indigent. Sharon saw the nurse at least once a week. The nurse not only helped Sharon with lifestyle modification but gave her all of her diabetes testing supplies. This was a big deal for Sharon because a box of 100 generic brand blood testing strips cost her around \$50 at a pharmacy and \$40 at Wal-Mart when she could get there. She did not drive and had to rely on others for transportation. She went through at least three strips a day. Sometimes the cost of strips was higher than her grocery budget. When she told me this she laughed a little and said, “Eating comes first, you know.”

Sharon was divorced and had two grown children who lived in other states. Her daughter was on disability for bipolar disorder, a condition Sharon blamed on her daughter’s ex-husband because he was physically and emotionally abusive. Her son had had an intellectual disability from birth and lived in a group home. Neither was in a position to help Sharon. Before she went on disability, Sharon worked as a medical assistant and as a home health-aid. Both were physically demanding jobs. She had no real retirement savings but collected a small stipend from her ex-husband’s government pension. Otherwise,

she relied on an older sister, also on disability, and her father, who recently had open-heart surgery, to take care of her.

Sharon accessed health care through the Catholic charities network. She saw volunteers who spent a lot of time with her and offered what medical help they could with limited, mostly donated supplies. Although this care was not enough to change her health trajectory, she could not express enough gratitude. “The Sisters of *[name]* and *[Catholic clinic]* paid for it. They have been so super. I have, almost a \$6,000 bill for *[Catholic hospital]* that they wrote off before that. The only thing that they haven’t written off is the three ambulance bills *[through a private company]*. And they’ve now turned those over to collections. I mean they were so nasty about that. I asked them if they could, if there was any way of getting a grant or reducing it. And *[they said]* ‘Well we can submit a hardship case and try to reduce it a little bit.’ They reduced it \$100.”

When I ask if she had an opinion about how health care was provisioned in the US, she shook her head at me and said that it was not right. She thought people who were sick ought to get care, period. She also said that she had never really thought about the political side of it. She told me that people like her did not count much in politics but continued that she did not understand how people could call themselves Christian as they turned away from people who were in need. “It just isn’t right. It sure isn’t what Jesus says in my Bible, but maybe they have a different copy than I got. I know for sure that you aren’t worth nothing without money. It isn’t as bad here as it was where I used to live either, but people are exactly how much they got in the bank. I worked hard all my life, took care of everybody the same whether they had money or not. I never sat around waiting for a handout and now I’m stuck, and because I’m stuck, I don’t count. I don’t mind it for me so much anymore. I’m where I’m at and I’ve come to terms, but I worry about my kids and grandkids.”

Her health knowledge improved when she began to see the diabetes nurse. The nurse offered a series of classes that she required people take to receive free diabetes supplies. Sharon was a peer mentor in the classes and because of the education the nurse provided, read a lot of labels and looked for how many carbs, particularly sugar carbs, were in foods. She also tried to avoid fats and stick with things that

were lower in sodium. She did not seem clear on why she did these things, but she trusted the nurse who told her to do them and taught her how, and knew that they were important for her because of her diabetes and related health problems. Sharon purchased predominantly processed foods that had long shelf lives. She went to the store with a list of items that she wanted and then compared the nutrition information to select the healthiest item. She had the carb content of several of the foods that she bought memorized and told me these counts. Sometimes she also knew the carb counts of the brands closest competition. She said, “And if you get the Special K you’re only getting one carb [*diabetes exchange*] or nineteen grams of carbs, which is actually one carb and, you know, it’s just a whole lot more healthier for you. And they do have a generic of them now, which is a bit cheaper and it is just the same amount of carbs.”

Sharon thought natural foods were better, but natural was something that was written on a box label. It did not translate into “foods closer to the earth” like it did for some of the women with cultivated bodies. Sharon explained, “I look for the natural but then I compare to see, ‘cause sometimes when it says natural if you look on down it’s hidden, that word sugar is hidden down in there. So I watch to see how much sugar is hidden in it. And sometimes the word natural, there’s more carbs in natural than there is in regular. You know, I just really, that word carb plays a big role ‘cause my carbs turn to sugar.”

Sharon did not exercise. She was not physically capable.

Forgotten Bodies

Sharon was unusual among the uninsured women I spoke to because she did not work. Only three of these twelve women were unemployed (Table 9). Two of the unemployed women volunteered. One at a clothes store where she received a small, under-the-table commission for items she sold. The other was a volunteer at the Women’s Center. She was not paid but considered her work her tithe to the church since she could not afford to give money. Four of the twelve women with forgotten bodies had applied for federal disability benefits. All were turned down, three because they worked too many hours and were disqualified before their health was ever considered. Two who had not applied for disability had illnesses on Social Security’s list of disability-qualifying conditions but had not considered an application. Five of the six women with potentially disabling condition were over forty, and the severity

of their conditions would increase with age. Younger women who had not applied for Social Security disability also reported health conditions such as diabetes or back injuries that would worsen as they aged and could eventually lead to a disability application. For a couple of these women, such a trajectory was likely without medical intervention.

Table 9 – Demographic Information for Women with Forgotten Bodies*

Income Level	Age	Married	# in Household	Occupation	Education	Race
< 5,000	42	No	4	Student/Volunteer	Some College	Native American
10,001 - 20,000	24	No	4	Receptionist	High School	Latino
10,001 - 20,000	60	No	1	Substitute Teacher	Graduate School	White
10,001 - 20,000	52	No	2	Assisted Living	High School	White
10,001 - 20,000	46	Yes	3	Home Maker	< High School	Latino
10,001 - 20,000	20	No	5.5	Billing Clerk/Waitress	High School	White
20,001 - 40,000	58	No	3	None/Volunteer	Tech. Certificate	White
20,001 - 40,000	35	Yes	4	Accounts Receivable	High School	White
40,001 - 60,000	38	No	5	Hair Stylist	Trade School	White
40,001 - 60,000	41	No	3	Demo Associate	High School	White

* Two women refused to fill out a demographic questionnaire

Women without health insurance fell into two groups, those with and those without regular health care providers. Six of the women said they lacked a regular provider. All but five were under forty-years old, but they still reported a range of health problems from migraines to back pain and anxiety. The other six had regular providers. All of those with regular providers had a chronic health condition that required monitoring. All of the women in this group sought care either from safety-net providers or the emergency room. Those with a medical home found it at a safety-net clinic. Two of the women with such a provider also saw a specialist arranged through their regular provider. One saw a doctor who volunteered his time. The other had her bills paid by her extended family. All of the women in this group reported unmet health care needs. Almost all of them also reported a time they went to the emergency room for help and were turned away.

Eight of the twelve women were white. Two were Latina; one was Black; and one was Native American, who was raised in a mixed Latino/Ukrainian household. The oldest woman was sixty years old; the youngest was twenty. Annual household incomes began under \$5,000 and went up to \$60,000.

One woman had a graduate degree, one a bachelor's degree, one was a student, and two graduated from trade school. Only one had not finished high school. Three were married. An additional three lived with their partners. Half had dependent children.

None of the women with forgotten bodies had dental or vision coverage. Most needed dental services. Except when they were asked, none mentioned vision coverage. Glasses were something they bought off the rack at local discount department stores like Wal-Mart.

Forgetting the Body

All but two of the women with forgotten bodies were overweight or obese. The two who were not were in their twenties. Generally, weight increased with age so that the most obese were the oldest. In terms of what they ate, women in this group were limited by their available money, time, and food preparation knowledge. They had small grocery budgets and shopped only right after payday because once their bills were paid there was no money left. For most, this limited grocery shopping to once or twice a month. Because their trips to the store were infrequent, women bought inexpensive staples with long shelf lives and stocked up on these staples when they went on sale. These women rarely purchased fresh produce because they said it spoiled and was too expensive, but preparation time and complexity also played a part.

With limited time to split between work and family, women in this group relied on foods that were quick and easy to prepare. They knew how to microwave, fry, bake, boil, and simmer. Most learned to cook from their mothers or from food package directions. They rarely used cookbooks or recipes, although they did sometimes use the recipes that were suggested on the back of prepackaged foods. When I asked, women in this group told me they rarely if ever bought cookbooks because these were luxuries they could not afford. Some of the women had difficulty reading recipes, especially if the recipes had unfamiliar cooking techniques or ingredients. Unless they went out of their way to go to the library, these women lacked access to technologies that other women said they used to look up these things. Almost all of the women with forgotten bodies owned a computer, but most did not have the

Internet because they could not afford the monthly bill or because their computer was infected with viruses and not useable, the case with Sharon.

For women with forgotten bodies, natural foods were fresh, frozen, and canned fruits and vegetables, foods with whole wheat, whole grain, or natural written on their label, and foods that were cooked in a homemade way. They relied on inexpensive, pre-made foods such as cereal, Pop-Tarts, and, pasta and, if made with at least some fresh ingredients, saw them as acceptable. The only foods entirely rejected were those seen as entirely chemical, such as artificial sweeteners, which caused a host of ills from diarrhea to brain cancer. When I asked, these women did not know what high fructose corn syrup or hydrogenated oils were, although they knew they were bad, and did say they preferred items that were trans-fat free. When they read food labels, they stuck to the front of the package and tried to choose the healthiest brand based on what the box said. As Sharon explained, "I always choose the healthy Pop-Tarts," meaning the Pop-Tarts with fiber in them. Foods that took longer, such as homemade macaroni and cheese, were more natural and better, but women rarely had time or energy for these foods.

Most of these women did not care for vegetables, with a few barely tolerable exceptions that almost always began with canned green beans and expanded to include corn, peas, and carrots. During a discussion about food one woman told me, "Most people here don't know what to do with fresh green beans. That's why they don't go to City Market. They don't know you can cook the fresh to taste like canned, maybe even better." Women tried to hide the taste of vegetables in other foods, and took for granted this was the way they were eaten if eaten at all. They assumed that most people did not like vegetables and that people who said they did were lying to sound healthier. Fruit was also not mentioned favorably very often unless in reference to baked desserts. Women tolerated fruit cocktail, bananas, and sometimes apples. An exception was when one woman explained, "I spend all that money for a little tiny thing of like strawberries and then they're gone in like two hours and then what?" Women also ate the fruit available at Keeler Women's Center. Women with forgotten bodies did not take vitamins due to their expense.

Women with forgotten bodies could not afford gym memberships, although several said that they wished they could afford to join these facilities. The gym they talked about the most often was the YMCA. Three of the women who I interviewed were met at a nutrition class that provided women with a six month family membership to the YMCA. YMCA rates were based on income and the women who discussed prices told me quotes that varied a great deal. Women also had a difficult time obtaining a membership because they were required to either create an automatic monthly payment plan through a credit card or checking account or to pay several months of their membership in advance. The receptionist at the YMCA said six months, but two interviewed women said three. Even at three months, these women were unable to come up with that much cash.

Women in this group talked about a desire to increase physical activity by walking around their neighborhoods. All of the women with chronic health conditions were limited in what they could do by their health. They were also limited in how much time they had and how much energy they had at the end of the day. However, their single biggest complaint in terms of trying to increase their physical activity related to the weather. In the summer it was too hot and in the winter too cold to go outside. They did not consider in-door exercise when they talked about physical activity. When I asked two of them about it specifically, they said there was not enough room inside their homes to really work-out.

Access Denied

Uninsured women were not health care customers. They did not have managed or even neglected bodies. Doctors did not provide them with control or open the door so they could access treatment. These women saw whatever health care provider would see them, when that person would see them, and were grateful for any attention they received. These women waited the longest for their appointments and sometimes spent weeks trying to see someone because high patient volume and limited resources caused long wait times at safety-net clinics. Some clinics required people to call to schedule their appointment at a specific time on a specific day because they were so inundated with calls they would have spent all of their time answering the phone and turning people away if they let people simply call in whenever they needed an appointment. On the specific day and at the specific time, so many people called that the

women said they would spend the entire hour dialing and listening to a busy signal, a ringing phone, or waiting on hold terrified their call would be dropped and they would be forced to call in again.

These women also spent the longest amount of time in reception waiting to see their health care provider, often more than an hour. The women's wait time depended on how many patients were scheduled before them and how much time providers spent with each patient. They did not complain. Instead they expressed gratitude that there were providers who would see them at all for the reduced rates they paid. This does not mean complaints were not observed in clinics. I saw several patients express discontent at the amount of time they had to spend in reception while at safety-net clinics. However, the women who I formally interviewed explained that the amount of time they spent in the front office was equal to the amount of time they spent in the back and were okay with that exchange. As Hope, a white, forty-one year old retail worker explained,

Sometimes I have to wait an hour for him to get in there because I don't have insurance, but I spend maybe forty-five minutes or sometimes more with him directly. I'm just guessing. We talk. He tells me that, well he really hasn't said I need to lose weight, but I know I have to lose weight. He hints at it, tells me to exercise, to walk. It's just that when you stand all day. I'm just exhausted. And then at night it's been so hot.

Uninsured women unanimously reported the longest amount of time spent directly with their health care providers. Sometimes their exams were only fifteen or twenty minutes. This was most often reported for acute illnesses that required simple treatments like antibiotics, but even for these visits the providers often took the time to search drug store formularies to find the lowest price for their prescription. Some of the women's appointments were also much longer. With less access to technological tests and treatments than providers who saw insured patients, providers for the uninsured spent a lot of time discussing symptoms and advising women about behavioral changes that might help their problem. In 2006 I shadowed a physician at one of the safety-net clinics women used.

I spent the day with a doctor originally from Mexico who volunteered at the clinic once a week. The day I shadowed him, he saw a Latina woman in her early fifties who was probably diabetic but could not afford the lab work needed to test for the condition. The doctor said he would try to make arrangements to have the test done, paid for by a Catholic charity, but it would take a couple of weeks to

setup. Without the test, the doctor spent an hour talking to the woman about her symptoms and advising her about her diet. As he spoke, he held her feet and gently ran his hands along them and her lower legs. This relaxed her, made her listen more attentively, and helped the circulation in these extremities. After the visit was over she said she knew that she was not cured and that she needed to follow his directions, but she also said that she felt that he treated her and there was less sickness in her body. She felt better.

One woman explained,

They're just there to take care of me where some of the doctor's offices, which is really crazy because I have been in the situation where I went to a doctor when I had insurance and they treated me like a number, but when I go to the clinic they treat me like they really care and these are people who volunteer their time, so they really want to help. They're not there for the money but the cause.

Women with forgotten bodies had longer appointments with providers at safety-net clinics but also had a much harder time receiving attention at other health care facilities. Nearly all of the women without insurance talked about being turned away from an emergency room. For all but one, the emergency room was their provider of last resort, so they only went when they were in dire need. These women said that they did not use emergency rooms regularly because they were afraid to accrue medical debt. They were also embarrassed they had no health insurance. Some assumed they would be turned away. Before she was homeless, one woman spent several months moving from one friend or relative's home to another. During that time, she worked odd jobs and had no health insurance. She relied on the emergency room for primary care, but after a time even it grew out of reach.

[Hospital] suing me now for \$1,800 for when I was so skinny. I didn't have no iron and they had to give me two blood transfusions back in 2002. And then you get scared to go to the doctor because you can't afford it. You don't want to get sued no more. Take your income tax. Take your state taxes every year. Sometimes you, I got to the point where I quit going to the doctor for the [tumor] that he told me was as big as a silver dollar.

While women with cultivated bodies believed uninsured women overused emergency room services, uninsured women only went when absolutely necessary. Each uninsured woman defined necessity a little differently, but in general it was when pain was so severe it interfered with their ability to work, a fear that whatever was wrong would cause permanent damage to their body if left untreated, or someone called paramedics for them before they could ask the person not to make the call. Cathy, a

white, thirty-five year old, collections agent told me about a time when she sought care because of pain.

Not only was she initially turned away, but she was also left in debt.

I had an injury. The doctor couldn't point out what it was, but I had a compound fracture and I have stenosis of the spine. I don't know what that is, so don't ask me please. I just know it is a narrowing of the canal. Apparently I have some discs that collapsed and pinched a nerve and I got to the point where I could not use my arm. The pain was unbearable and then it got to the point that it was more than pain. It was numbness and weakness. I'd pick up my fork 'cause I am right handed and it would just drop and I couldn't even tell at first that I'd dropped it. So I had to find somebody to help me 'cause once again I couldn't work. I couldn't eat. I couldn't sleep. I mean it affected every single aspect of my life and I was living on pain pills, which it got to the point where the pain pills weren't, I mean, it was either you know take six to eight instead of your one or two and again in another couple of hours you're taking another five or something. I mean you're just eating them like crazy, which wasn't helping either. So I had to find somebody to help me.

I went through a lot of problems and I'm fighting with *[name]* hospital right now because I went there once, to the ER. Saw a doctor. He told me to get an MRI, you know, that kind of stuff. I went back a couple of weeks later because I was out of pain pills. I still hadn't been fixed. Nobody was seeing me. I needed help. Everybody said go to *[name]* state hospital they have to help you. So I'm sitting in the ER, a returning patient, and the charge nurse decides that I'm seeking pain pills and leaves me sitting in her waiting room for seven hours. I saw people walk in there going (*coughs softly*), "I need to see somebody." "Oh come on back." So I'm getting very angry so I go up there and I'm like, "This is crap I need to be seen." "Oh well we have all these traumas in front of you." And I'm like, "I'm sitting in your waiting room. No you don't." Getting very angry. So then they charge me for an ER visit, so I'm fighting with them telling them, "Okay first of all after I left your hospital I went to *[another hospital]* and the doctor saw me and called the neurosurgeon. I had surgery four days later. That's how bad my situation was, so you're billing me. You want more money. I'm sorry you didn't think it was necessary to see me. I don't think it is necessary to pay you."

Inability to move past a gatekeeper because the person believed they were there to obtain pain medication was common, but three other women were like Cathy and immediately went to a different emergency room after they were turned away from the first and received treatment at the second. All three began at the same hospital. Most of the women, regardless of their group, believed this hospital was run by the state and would see anyone. They did not realize it changed to a for-profit hospital over nine years ago. Lilly was also unaware of its change to for-profit status, but she noted a change in how patients were treated.

[Hospital] has changed. You know you could be sick and go to *[hospital]* and they would see you no matter what. Now that lady told me, when I was bleeding, that I had to go back to *[hospital]* and I didn't have any money to see the doctor. The lady told me I can't see you because you don't have any insurance. They don't understand that when a person tells you that

and rejects you it is a hurtful thing. I haven't been back to *[hospital]* since. So I know how that goes, so it's been a different world and things like that.

Lilly was told by the hospital's staff that they would not see her without health insurance. Hospital workers were not usually so forthcoming. Instead, workers left women waiting until they went away on their own or confronted whoever was on duty as Cathy did. While most of the people I talked to thought that this emergency room would see uninsured patients because of its supposed state status, many of the insured women I talked with in the area also told me that hospitals were only required to see someone if the threat of their death is imminent. Women who reported such urgent care situations were more likely to say that doctors saw them when they went to the emergency room, but the care they received was limited. Sharon had such a situation and went to the same emergency room as Cathy. She was seen, stabilized, and then refused additional treatment because she lacked health insurance.

At first I went to *[hospital]* and all I kept hearing at the emergency room was, "We need to admit you, but you don't have insurance. We need to admit you, but you don't have insurance." I heard that for four hours, the whole time I was in that emergency room that night while they was pumping IVs with antibiotics into me and then they sent me home with a bottle of antibiotics because I didn't have insurance. Then I hear well they can't do that. They can't treat you that way. Well, they did. I've gotten the same treatment from *[another hospital]*.

Then in March of this year I was going up the stairs up to, we lived in a different house, and I was going up the stairs to my bedroom and I was taking my laundry up and I was using the laundry as my walker and one step at a time and I started to feel like I was going to black out, so I was turning around so I could sit down and I blacked out anyway and I went straight back and went down the stairs and this is the wall and my head went like this against the wall.

She used her hand to show me how the back of her head smacked into a wall and her neck was bent perpendicular to her body. Sharon's sister was terrified Sharon was seriously hurt and called an ambulance. They rushed Sharon to a hospital but not the closest one, which was the one where so many women reported they were refused care. Instead the ambulance workers drove her to a charity hospital that was an additional twenty minutes away.

My neck was sprained, sprained my wrist again, wrenched my back. He *[the doctor]* told me I absolutely had to stay on the walker and absolutely no more stairs. And I had a concussion. And I should be in the hospital for at least forty-eight hours but because I didn't have insurance they didn't hospitalize me and they're not supposed to be able to do that, but I don't have insurance. My sister went off. She says, "You know I have heard that so many times." And there's been times my blood sugar's been four and 500 that I should be in the hospital, but why bother when they are not going to do anything? You know all you hear is, "You don't have insurance."

The Emergency Medical Treatment and Active Labor Act (EMTALA) sets out the rules hospitals are required to follow when treating patients who do not have health insurance and cannot afford to pay for care. The law states that emergency rooms must examine a person and, if a critical medical condition is found, stabilize him or her. Once stable enough to transfer to another hospital, whether on his or her own or by ambulance, the emergency room is free to discharge the person. Since 2003, hospital workers were allowed to inquire about patients' ability to pay, although they could not request payment before an exam (Black 2006: 7). In 2008, the maximum penalty for failing to meet EMTALA regulations was \$50,000 per incident for hospitals with more than 100 beds and \$25,000 per incident for hospitals with less than 100 beds. A hospital found not in compliance could also lose its contract with the Center for Medicare and Medicaid Services (CMS) (Medlaw.com 2008: on-line).

Area emergency rooms referred women who could not pay to safety-net clinics. Safety-net clinics referred women with hard-to-treat conditions back to emergency room because the clinics simply did not have the facilities to help. Thus the sickest women with the worst health conditions become ping-pong balls that were bounced back and forth between providers who either could not or would not help them.

Only one uninsured woman, Sally a white, thirty-eight year old hair stylist, reported a good experience at the emergency room. She was forced to go on three occasions because she was having chest pains and thought she was having a heart attack. Each time Sally was diagnosed with something different, but she was always seen immediately. Her visits were to a large urban hospital in Missouri that she often used as a primary care provider because she could not afford a regular doctor. This hospital differed from others in the area because it also had several specialty clinics, as well as a general one, that saw patients for nonemergency needs. As we talked, it became clear that Sally did not differentiate between the emergency room and the clinic and, for her nonemergency needs, went to their clinic.

Uninsured women rarely received preventive care. For those under thirty years old, the idea of spending money to see a doctor to test for something that could cause a disease at some unforeseeable

time in the future was unrealistic. They could not afford to go to the doctor for immediate care needs so spending money on future health was crazy. When I ask if she sought preventive care, Helena, a twenty-four year old, Latina receptionist, said no. I asked if the mother of two had her well-woman exams and she said,

Not if I don't have to I won't. I mean the last time I had it was a year ago [*when she was pregnant*], but I don't see myself going every year. It doesn't bother me because I don't prefer to put my legs up in no stirrups, so if I don't need to go. I feel that I don't need, I mean every single well-woman exam that I've had always came out normal, so I don't feel that I need to go every year.

When possible, they did go for prenatal care. This required enrollment in Medicaid, which they reported was a difficult process. Beth was an example of the difficulties women faced as they attempted to obtain government coverage. After her miscarriage, Beth went to a woman's clinic near her home for follow up care. She was still on Medicaid. They did an initial pelvic and asked her to come back for a follow-up exam in six months, afraid she would need additional treatment. At our interview she told me that her Medicaid coverage ended and she could not afford the appointment. "I was supposed to make a short-term follow up at about six months or so, which I'm about do for and called him. I don't have my Medicaid anymore 'cause it was temporary, for while I was pregnant. They [*the doctor's office*] are way too expensive for me." I asked if she thought she would go somewhere else, a safety-net clinic perhaps, and have the exam. "Sometime I'm sure. I'll get it done sometime."

Uninsured women over thirty and without chronic conditions also lacked preventive care. This was not because they did not want it but because decisions on how to spend money were based on immediate needs. Cathy explained,

So I have to, me -- myself, I have to make a decision do I put gas in my car or do I go to the doctor? Do I put food on the table or do I go to the doctor? Well, everything comes before the doctor. Unless it's just, you know, like how I ended up at [*safety-net clinic*], interfering with my job. You know I had to make a choice and so I had to go to the doctor.

I asked if anything besides cost prevented her from seeking preventive care and she said,

No, not really, just the cost. The cost of it and some doctors you know when you tell them that you are self-pay they say, "You know, okay we'll discount it by so much." But most of the offices aren't really. You know to me \$60 to walk in the door to me, I'm sorry that's not a discount. Especially for me when I have insurance I was only going to pay you a \$20 copay

anyway. Which I understand you're getting paid from the insurance you know, but you know I would think it would be less. I'm a poor person, you know.

When I asked about this in reference to specific conditions, Cathy lamented her inability to receive services and admitted that not knowing about her health concerned her,

When I had insurance the high cholesterol yes. It wasn't, he said I was just two points over. I haven't been back since obviously. I have changed, not completely, but I'm hoping that with what I have done on my own I have brought myself back down or I'm level or you know that it doesn't go up. Actually it does [*cause her concern*]. It does all the time. Because I know high cholesterol makes clogged arteries makes the heart go bad.

Cathy was unique for her category. Without insurance she could not access a nutritionist on her own but was able to see one with her obese daughter who was on Medicaid. The appointments were supposed to focus on the daughter, but the nutritionist recognized it was not possible to change the child's habits without changing the parent's and also spent a great deal of time talking about Cathy's diet. Cathy had more knowledge about what she should eat than other women in this group, but she still did not have the ability to eat the way she should.

You know how there is WIC for women and children, it would be nice if there was some kind of program or some kind of store like Aldies or something where you could go and get your healthier foods because I love whole foods, but I can't shop there [it is too far away]. I mean I can't. So that would be wonderful if there were some kind of program because I think that many-many people besides me would so benefit and they would do it. You know, they would do it.

Uninsured women over forty without chronic conditions resisted diagnostic procedures because they were afraid of the results. Those with serious health conditions were much more likely to receive appropriate preventive care because their primary care providers were more aware of what assistance programs were available and made the arrangements to see that they had it. The care itself was often sporadic because it was based on transitory charity programs, research studies, and grant funded projects. These women said they wanted it because they were afraid of secondary conditions that would exacerbate what was already wrong with them. These women told me there was a lot of stress associated with receiving their results, which were rarely benign. Sharon used preventive care services when they were available to her but was upset when she was unable to access treatment after she received her results.

[Safety-net clinic] pays for it and they found, last women's exam, I had had a problem with discharge from the breast. Dr. *[name]* did some tests. She expressed some of the discharge and they sent it off and it come back with cancer cells so she sent me to Dr. *[name]*. He's over by *[name]* hospital. He is a sweetheart. He's really sweet. The Sisters of *[name]* and *[safety-net clinic]* paid for that and I had to go in for breast biopsies on both breasts. They cut a lot of tissue out and I had pre-cancer cells there. I'd just as soon they took them off now than wait, but all they can do now because I don't have the insurance, all they can do now is wait. If the discharge gets dark again then I have to go back in for more breast biopsies.

Sharon was sure that if she had insurance at the time, she would have received the surgery.

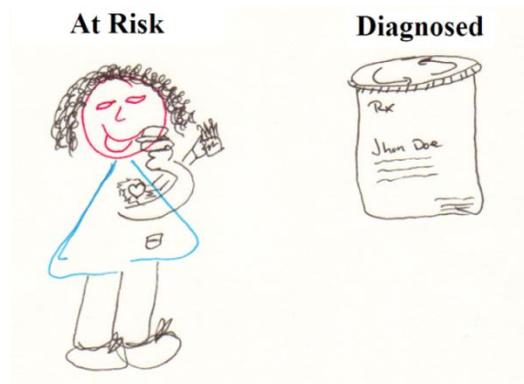
Without insurance, there was no way for her to afford what she was told was an \$8,000 operation. She waited for the discharge to change color again and for the cells to show cancer. She hoped when they did, and she was certain they would, the Sisters would still help her access treatment.

Uninsured women often believed there were pills or treatments that could solve all or most of their health problems but, because they could not afford them, they could not access them. These women never mentioned providers who overprescribed, but their providers were aware that they could not afford a lot of medication. This sometimes placed the providers who treated them in a bind. When I asked whether patients asked for medications they could not afford at the safety-net clinic where she worked, one nurse told me,

That is such a problem because I know *[other nurse's name]* the adult provider sees these patients all the time. They come in and they have their high cholesterol, they have their high blood pressure, they have high lipids. They think, "Oh I can take a pill and it will magically disappear," and they don't change anything in their lifestyle.

When I asked her to draw a picture of someone at risk for and someone diagnosed with CVD, Helena vividly showed that pills cured this disease (Figure 10). With on again/off again Medicaid coverage, Helena had not had coverage for a year. She complained of health problems but avoided safety-net clinics out of embarrassment. She was also overweight, had a family history of diabetes, and knew little about nutrition except that fast-food was bad. As she drew the picture in Figure 10, she asked if she could draw a prescription bottle for someone diagnosed and said, "If anything you've stopped eating the hamburgers and the fries and put some pills in your body now."

Figure 10
A Person “At Risk” and Diagnosed with CVD



Safety-net clinics had people on staff to try and sign their patients up for pharmacy assistance programs when their medications were expensive and needed frequent refills. Program acceptance was always a gamble. Some also had long application forms that had to be filled out monthly. Individuals were approved one month only to be declined the next. Unlike women with insurance, uninsured women rarely received samples from their providers. Workers at safety-net clinics said they wanted to offer their patients samples but did not have them to give. Kristen is angry about the unfairness of this,

There is a little girl that has asthma. She's Hispanic. They don't have any insurance and they can't afford her inhalers. So I was scrambling around trying to find something that I could help her with cause it's really dangerous to not treat your asthma. And I was finally able to find some kind of coupon at another clinic that I work at for a free inhaler. And I was able to give her a free inhaler because of that, but it's really interesting to me. I also work in a private practice in [suburb name] where it's all insured. They don't do any Medicaid. They don't do any uninsured and they have a closet full of samples, of medication samples for patients that really don't even need them. And then you have a place like here, where patients really, really need these medications. And I don't know why there is such a disparity in that.

After a moment she independently suggested that the reason safety-net clinics received no samples was because company representatives wanted to send them to people who would buy the medication after they tried it. "I don't know if it's just the drug representatives, you know, want to give medication to people who can afford to get it again." The last time that I was at the safety-net clinic where she worked, I saw a flyer in the break room that showed the clinic had invited a pharmaceutical representative to come for lunch, provided by the clinic. Everyone was required to attend.

Attitudes about Access

Women with forgotten bodies were either so caught up in their daily struggles that they did not have time to think about who was responsible for the difficulties they had accessing health care or blamed the government. The anger they felt toward the government was different than that of the women in Chapter 7. Women with forgotten bodies viewed the government as an extension of society, a tool meant to provide a safety-net for those in need. One woman explained,

I know this is kind of farfetched, but I see all the money that we're spending on war and once that even the veterans when they come back they don't get the proper healthcare either. You know, but they're over there and then it makes me wonder about their families and I just think that our society, I mean you look at all the different other countries, for instance you got Canada, or like my Dad when he went to Ireland, he fell down into the bathroom and he needed seven stitches and he had to go to the hospital and they only charged him a dollar a stitch and a lot of the people are covered there and he thought that was really great and I just think that our government could do more.

While she looked toward the federal government for assistance, Sally directed her anger toward the state. When I asked her about health care she said, "I think it's terrible. I think that, put it this way, Matt Blunt has messed up a lot of Missouri people as far as being able to get Medicaid or anything like that. He's really hurt the disabled. He's hurt children. He is an ass; he is."

System Solutions

Women with forgotten bodies wanted government run health care. Several were trying desperately to access it through government disability programs. These women were less likely to call such programs socialized medicine but simply referred to them as government care or as health care in other countries. All were aware that the US was the only Western nation that did not provide universal care. They talked about the good things they heard about programs abroad, programs they heard about from on-line friends or from friends and family who had traveled abroad. Lisa, a fifty-two year old former high school janitor who quit work to take care of her mother after her mother had a stroke said, "I play Backgammon on the computer from all over the world and that was what the people from Norway were telling me, that they get vacation and they were like two weeks, what and then I have a friend on

there and he's a computer genius from London and sometimes he will call and we'll talk about the differences in health care and it just doesn't make sense for one of the strongest countries."

Structural Violence

Health inequality is a form of structural violence or violence inflicted on people due to unfair social institutions. In societies that are extremely unequal, a culture of indifference prevails that deflects attention away from the ill and is perpetuated and expressed in the rationalities that are used to manage disease. "This culture of inequality facilitates a pathogenic biosocial spiral of socioeconomic exclusion and deteriorating health" (Nguyen and Peschard 2003: 448). Such a spiral is documented in the US. Statistically it is seen in a disability gradient that runs across the socioeconomic spectrum where the poor are more likely to become disabled (Minkler, Fuller-Thompson, and Guralnik 2006). Ethnographically it has also been shown through the stories of people locked into their social place by cycles of illness and marginal unemployment (Sered and Fernandopulle 2006).

Although many analyses have explored this among people excluded from the system, structural violence is not only experienced by people at the bottom. It requires the ideological support of those at the top who embody it as well (Rylko-Bauer and Farmer 2002: 493). Women at the top cultivated their bodies to exhibit higher social position. Women in the middle tried to mimic women at the top and in so doing legitimated the idea that people could control their health. As women began to slip down the spectrum they grew angry at the system that was beginning to exclude them. Instead of speaking out against it, they embraced bad behaviors associated with poor health and perpetuated the system even more. Finally, women at the bottom were left to do the best they could with their health with the few resources available to them on the fringes and no time or energy to complain. These women did not try to cultivate their bodies. Sometimes they said they wished they could lose weight but usually added it was not possible. The only thing they had that set them ahead of the women with cultivated, managed, and neglected bodies was that when they finally were able to find care, the people who administered it did so because they wanted to help and emotionally invested themselves in the women.

Chapter 9 --Desire and Deviation

Introduction

Women who cultivated their bodies cultivated to exercise control. The strict diets they followed and their disciplined workout regimens were ways to cope with their daily lives (Nichter 2000: 149). These women said they were in control and drew images to reflect it. Women with managed bodies bought things to help them control their lives and exercised control in how they selected products. Their control was not as pervasive as women with cultivated bodies and sometimes they complained that they were not given enough, but generally they felt like they were in charge of their lives. Women with neglected bodies felt their control slipping away and were scared. They rebelled by engaging in what they identified as poor health behaviors, which for them was a kind of choice and made them feel in control again. Women with forgotten bodies told me repeatedly that they were out of control. They cried. Some were dying because they had been denied the health care that they needed. They looked to society to offer them control but were often left without it.

The word control is thrown around a lot in the social sciences and public health. It was the dominant theme in women's interviews. Looking at how women used this word showed that for them control was about the future. It was reserve capital, the symbolic potential for upward mobility. That upward mobility is the most important aspect of American ideology makes control more salient, but even with ideology removed women sought control because with it they knew that they and their children would be okay. This chapter explores what it meant to be okay and not okay in terms of repression and social solidarity through the experiences of four women.

Not Looking at this Right

It was late afternoon in early December. The sun was just beginning to set, creating long shadows that fell heavily across the large mahogany table in Stacy's formal dining room. She sipped from a can of diet soda and told me about recent events in her life. A carpet saleswoman in her late forties, Stacy was hit hard by the economic downturn because her income was dependent on commission. A bad economy meant decreased sales, which meant that for the past few months she had paid more in

premiums for her and her eight year old son's health insurance than she earned. The difference between them, as well as the money she and her son lived on, came from a trust her father set up before he died. As she wiped away tears, she told me that the money from his trust was nearly gone. Besides recently being used to supplement her income, she said she also spent money from the trust to pay for her college education and for her beautiful home in an upscale suburb. She explained that she only had around \$60,000 left. She hoped to use the money to partner with a friend and open a liquor store, banking that such a business would still make money even during hard economic times. She then talked about how much she spent on her health insurance and how hard it was to keep it.

I pay \$1,024 every month. It's hard to think if I can even make the payment every month. I've had to actually sell stocks to afford health insurance. You know they hear you're in a high-risk pool and, you know, you're struggling to make ends meet right now and then they're going to cancel you and you have no place else to go for insurance. You're just SOL [sorry out of luck]. Then you get to, you know, just trying to find the money because I just had surgery. Didn't know my insurance had been cancelled. My son, he was born with cardiomyopathy and he has to have a heart echo every year and has to do major things at Children's Mercy and has major surgeries just about every year for the last seven years until this year. And it's like with how much medical care cost, I may as well write it going bankrupt.

Because of the economic downturn, Stacy's social position was tenuous, though she was not yet in active free fall down the class ladder. Stacy was born into an upper-middle class family of physicians. It surprised her that she could not maintain her social position with the combination of her inheritance and education. She understood the precariousness of her situation and offered insight into how her political and social views changed as her circumstances deteriorated. Although initially a fiscal conservative opposed to increased taxes and government health care, Stacy was at a crossroads. The rumors she heard about bad government care in other countries sounded better than the care she had in the US with her expensive insurance. Unable to reject her worldview in its entirety, she struggled to explain her new beliefs using the frame of her old ones.

Something has got to be done. Just to live, I'm sitting here thinking right now I need to sell my house. I really, you know, having to sell your house, needing to sell your house to be able to afford healthcare. Oh, it doesn't matter if you don't have any place to live but just pay your healthcare. You know it's not good and in a way, I'm the furthest thing away from a socialist but a lot of the way it's handled in Europe and in Canada it may not, if the government was

going to pay for it and they said this and that I might look at going to some of those doctors, but I don't see anybody doing anything for me and why do I have to let them [the insurance company] choose who I go to when I have to pay them \$12,000 a year.

Stacy identified inflation and the depressed economy as the reason for her diminished social status. She said that the recent economic events were extreme and brought a lot of media attention to a problem that, among normal people like her, had existed for years. She explained that it took a long time for her to deplete her assets to their current level. She then listed off a string of terrible events that recently occurred in her life and included the loss of a job with the promise of better benefits, the death of her brother, and a serious physical injury that limited her ability to lift product samples. It was clear from her haggard appearance and the disarray of her carefully decorated home that all of these things took a serious toll on her psyche.

Stacy was a single mother. Her son's father was "in the picture, but he isn't." She received little social or familial support and knew that if she was unable to make it there was no one for her or her son to fall back on. Her fear for her son was palpable as she wiped away tears. Because she began towards the top of the social spectrum and was slowly slipping down, Stacy could see how the system hurt all of the people in it. When able, she said that she utilized a number of types of care similar to the procedures and treatments that were used by the women who cultivated their bodies. In one moment, she questioned whether or not body cultivation was really necessary. The next, she longed for the resources to engage in cultivation attempts. She was also used to being at the front of the line for health resources and having to wait for or even forego care was a shock. Stacy railed against her doctor for failing to treat her like a customer one minute and questioned the legitimacy of a system that determined people's inherent value based on their fiscal worth the next.

When we stepped outside so Stacy could smoke a cigarette, a habit from her teen years that she said she gave up until recently, this tall relatively thin woman quietly admitted that she had lap band surgery to try and reduce her weight two years before. The surgery was a failure because she could not afford to complete the procedure. Because she was thin, I was surprised. I asked her why she felt it

necessary to go to such an extreme. She said, “I’ve watched my weight all my life. I mean I’ve fought my weight all my life. I’ve always been aware, been made aware. It’s continually, it’s brought up continually around me.”

Stacy’s admission that she had “been made aware” of her weight all of her life suggested that her need to cultivate her body was a social value inscribed throughout her childhood and into her adolescent years. When I insisted that Stacy was too thin to need surgical intervention, she laughed and said that she needed help with the fifteen pounds she gained while pregnant and could not lose even after eight years. Our conversation was an example of fat talk, or “informal dialogue in which individuals express body dissatisfaction” (Britton et al. 2006: 247). For women, fat talk is a ritualized behavior that is learned at least as early as adolescence and that serves several social purposes from displaying modesty to showing one’s comprehension and acceptance of cultural norms (ibid., Nichter 2000). Fat talk is not indicative of behavior (Nichter 2000: 47).

Among adolescent girls, fat talk is also a sign of distress. It is a way for them to tell their friends that they feel out of control in an ambiguous way. Ambiguity is necessary as the determination of exactly what is bothersome is sometimes difficult. What is bothersome is often embarrassing, which is why girls do not want to mention it directly. For example, a girl in a locker room might say she is fat because she is embarrassed to show her body (Nichter 2000: 47). It would be equally embarrassing to point out that she is showing her body. A girl about to eat something that is unhealthy with a friend will say she is fat in order to acknowledge and apologize for her indulgence. Girls are able to read one another and contextual cues to interpret the meaning of each other’s fat talk, so they can utter appropriate, affirmative statements and mitigate the initial speaker’s distress (ibid: 48).

The rapid succession of negative events in Stacy’s life, her disclosure of them, and the fact that our conversation occurred while we stood on her porch surrounded by Halloween decorations in the fading December light so she could smoke a cigarette, suggested Stacy’s statement was meant to convey that she felt out of control. That she actually said so earlier and would say so again in a few minutes helped confirm my assumption. Stacy did not think the use of lap band surgery was excessive, because it

was an important aid to help her reestablish control. Among some adult women dieting is not simply a means for losing weight. It is a mechanism for imposing control over daily activities and in so doing a sense of control over life (Nichter 2000: 149). The use of surgical intervention, particularly a lap band which, after placement, requires a person follow a regimented diet that limits not only how much she can eat but what she can eat, when she can eat, and how long she has to chew, is a way for Stacy to gain control over part of her life and her body with the assistance of a surgical technique and, she hoped, a surgeon. Stacy wanted a healer who would help her. It did not work out the way she hoped,

I had the [lap band] surgery done on Friday. My throat closed on Saturday, and I couldn't get anybody at [doctor's office] to return my calls. And I would never ever pass them on to anybody because nobody called me Saturday to check and see how I was. I tried to call on Saturday to tell them I was having a problem and I paged and paged and paged. Nobody ever called me back. I finally got the doctor's number at home and called him at home. He bitched me out for calling him at home. I went to [hospital name] on Sunday, sat in their waiting room for over three hours, threw up in the hall by the cafeteria because there was nowhere to go there were so many people waiting there. I threw up into a grocery bag lying on the floor. They finally said we can't have you out here doing this, so we're going to put you in here. I was like thank you very much now that I've been throwing up for two hours. I was hospitalized. I was released on Thursday. I was stuffed in a corner room with a lady on dialysis. I had no light. It was a very depressing place.

Stacy finished her cigarette and we headed back inside. She stopped before an oil painting in her formal hallway. It showed a simplified image of the desert at sunset. It was her favorite picture and it brought her peace. If she had the money, she would move west because the desert gave her a sense of calm. We sat back in the dining room. She told me about all of the healthy things she used to do and her friends still did that she wished she could afford. Things ranged from designer diets to expensive vitamin regimens. Stacy explained that she knew losing weight would not completely eliminate the need for other health related behaviors but aside from smoking, which she promised to quit when her life was calmer, excess weight was the worst thing for a person's health. She thought the lap band would help her take care of her weight.

Stacy was one of my final and most pivotal interviews. Without her, I am not certain I would have understood women from the cultivated group. Stacey was a lot like Jenny except that Jenny made over \$300,000 a year and Stacy made between \$10,000 and \$20,000. Jenny was also alone in the world

with the exception of her children. Jenny's sons were her joy but were dependent on her for survival. Like the father of Stacy's son, Jenny's ex-husband was not dependable. Jenny added that besides not helping financially, he was passive aggressive and added to her stress. Jenny's sons provided her with love but did not mitigate her need for control. Instead, they accentuated it because she had to take care of them. As we talked, Jenny explained that there were worse sins than being fat. She told me a story about a woman who started a Fortune 500 company, profiled in one of her magazines. The woman sold the company and went to live at a spa for four years because, the magazine said, she deserved it. The article mentioned that the woman had a minor child. Jenny said, "I don't like to be judgmental, but who abandons their child for four years to live at a spa?" Jenny felt her most important job was to raise her children with every possible financial advantage. There was no one to fall back on if she was not successful. She felt stressed and out of control. She dissipated those feelings by accepting social messages about how she should look and using products and services to exercise control over her body. As we talked she told me that since her sons were older and beginning to prepare for college, she was planning to quit her high-stress job.

Even with her reduced wealth, Stacy tried to exercise some control over the food that came into her house. As with many of the women with lesser incomes, she focused on how foods impacted her child over herself. She avoided processed foods, particularly anything with hydrogenated oils, high fructose corn syrup, or other added sugars. She said her son ate fresh fruits, vegetables, and lean proteins. Like women with managed bodies, she sometimes bought processed foods because they were easier on her budget and her time, but there was a more complex process that went into her deciding which processed foods were okay. She explained, "It kind of depends on what it is. I'm going to go by a Lunchable and it's processed, but I look at it as being meat and cheese and that's healthier, you know. It's not a fried food. You know, definitely Spam is processed, but it also has protein in it and that maybe what somebody can afford. You know it all again goes on what you can afford to live."

As she told me about the risks for CVD, she listed all of the usual suspects such as being overweight and high cholesterol and then started to talk about her son. He was born with a heart problem

that led to his having multiple open heart surgeries. His first surgery took place when he was an infant. She told me that sometimes she wondered what she did while she was pregnant to cause the defect showing that although she was able to recognize behavior was limited by income, she still blamed people, and herself, for their poor health outcomes. She explained that even though the doctors repeatedly assured her that his problem was genetic and not related to the uterine environment, she still could not help herself from wondering if there was something she did wrong to “bring the disease on him.”

Our conversation turned again to medical treatments and medication commercials. I asked what she thought of the ads for medicines that she saw on TV, thinking that like the other women I talked to who lived in her neighborhood she would tell me that ads were a resource. I was surprised when she said, “I think they are confusing. I don’t think they are right to be saying, “Ask your doctor.” I mean I ask them and they’re like, ‘Well, Stacy you’re doing Lipitor for this-this-this and this.’” But they don’t, I think they are very confusing and I think a lot of times people can’t get that medication, or it’s too expensive for them to get and they can’t afford it. And so they think they’ve got some medication that is going to help them and then they can’t get it and can’t afford it and go into a major depression.” I asked if this had happened to her. She did not answer for a while, studying the top of her diet Coke can. When she finally spoke, she questioned the entire premise behind body cultivation.

I think it is a very, like you know, you know how people talk about cancer, well, you know, people only lived in the Little House on the Prairie, they only lived to be a certain age. Maybe our bodies really only were meant to live so long. Maybe all this additional medicine that we give people and medication and direction, maybe we’re not supposed to. I mean what really is God’s plan? And I’m not a hugely religious person. I’m more spiritual than I am religious, but I mean what if we don’t have the answers.

Not all of the women moving down the social spectrum waivered back and forth between questioning body cultivation one moment and completely buying into it the next.

As Bad as I Want to Be

“She wants me to come in for blood work and stuff to do a write up, but I did not go because what if she found something wrong? I’m not gonna. I can’t deal with it because of no insurance, so I’d rather not know.” She stared at me from across the 1950s-style chrome and white Formica table and

talked about her last appointment with a nurse practitioner at a nearby safety-net clinic. We were in a tiny greasy spoon on the outskirts of Kansas City, Kansas. They only accepted cash and all of the food on the menu was prepared on a single fry-grill at the front of the restaurant. Catherine turned her attention to her plain, white coffee mug, adding three packets of sugar and two plastic thimbles of cream. She was a heavy set woman in her late fifties with long, wavy blond hair streaked with gray and white. She talked fast but in a warm way that quickly put me at ease. Her lined, freckled face spoke of years in the sun, or what she called that California lifestyle, without protection. “Does it worry me that something might be wrong with me? No, it doesn’t worry me. It just doesn’t. I don’t know why.”

Born and raised in Kansas City, Catherine did not talk very much about her early life. She talked about her work as a teacher at an inner city school in Los Angeles (LA) and the time she spent in college earning her master’s degree in education. She told me about the trips she took all over the world with her students at a private high school before she decided to go back for her master’s. Semi-retired, Catherine moved back to Kansas City because she had no one in LA and wanted to be closer to her siblings and their children after she “burned out” in the LA school system. By selling her LA home when house prices were at an all-time high, Catherine was able to buy a nice house in an upscale suburb for cash and sock away what seemed like a large sum for her retirement. After a year it became clear the money would not last her the rest of her life. To help stretch it out, she worked as a substitute teacher and was embarrassed to admit she earned only \$13,000 the previous year. She added in a quiet tone that her job offered no benefits. When I asked why she did not take a full-time teaching position in Kansas City, she explained that she could not find a job due to her age. “They see you as temporary,” she said. The turn of events frustrated her. She said repeatedly throughout the interview that this was not her. “I have a successful life,” she said over and over again.

Catherine had not had health insurance for nearly two years. When she taught school in LA, she had Kaiser or “very good health insurance.” Catherine “heard a lot of negative things about Kaiser,” but she liked it. “They were testing me all the time. You know let’s check this and let’s check that.” She also “didn’t pay for anything, doctor’s appointments or anything.” Not having insurance left her, “totally

freaked out.” She was too young for Medicare and ineligible for Medicaid. I asked if she sought individual insurance on the private market. Catherine answered, “It’s too expensive and I’m cheap.” Her voice quivered when she said it. For a woman her age in perfect health, available policies had an average deductible of \$2,280 and average monthly premium of \$280. That made the annual cost \$3,360, or 26 percent of her annual income, before she ever saw a doctor. She would also have to pay for all of her health care until she met the deductible. It was likely her insurance would also be more expensive since Catherine was not in perfect health. She had high blood pressure and depression, which could significantly raise her premium. These conditions might even have precluded her from qualifying for individual insurance. When she looked into individual insurance herself, it was not just the price but also the physical examinations that companies required that deterred her. She explained, “Well once I get a job and get insurance, if I have a preexisting condition, I already have two you know, I don’t want any more.”

Catherine was in a safety-net clinic to obtain a new prescription for her blood pressure medicine when we met. Later during her interview, she talked about her appointment. She appreciated that the nurse practitioner looked up and found a place where Catherine could buy her prescription for \$4. She also liked that when the nurse found out Catherine had not had blood work in a couple of years, the nurse pressed her to come back for a workup. Catherine did not plan to return for a second visit because she did not want to know if there was something else wrong with her. She emphasized that she would have the work done if she had insurance and added, “I did my yearly checkups every year. I had my cholesterol checked. It was always under 200 but who knows now.”

Catherine thought that everyone had the right to health insurance they could afford but, beyond that, was not particularly cognizant of current health care debates. When I asked if health care was an issue she would vote on in the upcoming election, she said that she had no plans to vote. She thought it was a meaningless activity. Catherine worried about emergencies. She worried about the high price of care and the possibility that she could lose her house if something serious happened to her, but the easiest solution was to avoid thinking about it and to avoid care. I asked if there was ever a time when she was

faced with a health emergency and had to go to the doctor. One had not come up recently but, years ago when she also lacked health insurance while in graduate school, she ended up in the hospital.

I had ulcers so bad. I was in ungodly pain for two or three years or something you know, but it was like...I didn't go to college until I was forty-one and I just didn't want. I didn't have insurance at the time and I didn't want to go. I didn't want to take the time, so pain doesn't. Pain is pain. So eventually I got to the point where I was humongous and I hadn't excreted anything for weeks and I went to the doctor. I went to the hospital. They were going to put a tube down my throat to see what was going on and I woke up and they said, "Well, you're staying in the hospital. We could not get the tube past your throat. You're full of food." What happened, I had had ulcers so many years that there was one on each side of the opening of my stomach and over the years they had healed and scar tissue...had flamed up and healed and scar tissue. They grew, the scar tissue grew together and no food was leaving my, there was no exit to my stomach, and so they had a...I had to sit in the hospital for four weeks with a tube in my nose draining out the food and then four weeks later they could operate on me because they really couldn't know what was going on until they could operate. And so they had to take out half my stomach but that's what happens...and I don't go to the doctor.

Catherine understood good nutrition and how to live a physically active life. She was trained by the LA school system in a program meant to improve student health. Like nearly all of the interviewed women, Catherine categorized disease risks into things a person could control and ones that they could not. Of controllable risks, exercise and food had the most influence over CVD. Exercise was "good for your bones and your muscles and that's what keeps your body moving." Catherine said that she walked "every day so that I can keep my bones and, you know, my body, so I walk every day." After she said it she stopped and played with her fork for a minute. Then she said, "Well, not really. I haven't walked lately, but I've been working in my yard. If I had the money, I would belong to a health club and go work out cause I used to do that." She belonged to a gym in California where she worked out at least three but more often four times a week. She also ate a healthy diet. Now, she purposefully engaged in what she called "the worst" health behaviors. She identifies fast-food as the worst food and then added that it was her primary source of sustenance. She ate it every day, usually twice. The rest of her food came from a dollar store. "These are choices we make in what foods we buy," she said, emphasizing her choice to eat poorly. "If I had an apple or potato chips sitting there, I'd eat the potato chips." She added,

When I had health insurance I went [to the doctor] every year. You know I got all the required checkups every year. I went to work out. I ate fruits and vegetables like mangos. I really like mangos. I did the whole ball of wax. I just won't do it now. If I get health

insurance I'll get back on the routine, you know. I'd get yearly checkups. I'd do the whole thing.

Catherine was a mature, intelligent woman, something she liked to point out, but her words were the words of an adolescent trying to alert the adults around her to a need for support. That she repeatedly told me about her self-destructive behaviors in a provocative, even lurid way suggested she wanted someone to reach out to her with concern. When I asked her to draw someone at risk for CVD, she drew Figure 11 and said, "That would be me. This is me." She also talked about a time she went to an expensive private physician in the area who was an old family friend. She hoped he would help her with her high blood pressure but during their appointment, he never said anything about it or her weight. Instead, he told her that she looked "like a healthy specimen" and billed her for a double appointment because they spent so much time chatting about their shared past. Catherine's voice was bitter as she recounted the story, but her attempt to find care from someone that she knew was suggestive.

Figure 11
Catherine



Catherine was classified as a woman with a forgotten body, but she was not unlike women with neglected bodies in that she wanted attention for bad behaviors. She felt alone and socially abandoned. She did not like Kansas City because she was not as close to her family as she thought she was in California. Her nieces and nephews grew to teenagers while she was gone and did not have time for her. Her friends were over a thousand miles away. She was in a deep depression, "I'm so depressed here that I hardly get out of the house. I have depression really bad so, just here, I can't hardly function." She explained that it was because of her depression that she made poor health choices. "I think my depression

influences it a lot because I don't care about myself, my well-being, my health. It's just too much effort to take care of myself."

Catherine always followed such statements with one that expressed guilt over the effect her death would have on her sister. She felt that it was ironic that her sister, who was eight years younger, was obsessed with her health even though Catherine did not "give it the time of day." Her sister had excellent health insurance and "a billion things wrong with her. She's allergic to her blood. She has a blood disease. She has migraines. She has all kinds of things wrong with her. She goes to the doctor all the time." Her sister was devoted to converting Catherine to a more health-conscious lifestyle but had so far failed to affect her. "I think it's funny and she just, it irritates the shit out of her that I'm like I am. It just irritates her to death and I get tired of hearing her health stuff and it's really bizarre."

When I asked Catherine if her younger sister supported her, she said no and was critical of her sister's demands on her time and energy. Catherine explained, "She's a lot younger than I am and when our mom died she kind of put me in that place, in that role. I wanted to be there for her, but it's always about her. Everything is always about her." Catherine bristled at her sister's demands but then felt guilty and imagined what would happen if her poor health behaviors caught up to her and she died. She did not want to cause her younger sister pain but needed support herself and was unable to be her sister's sole emotional caretaker. Catherine explained,

You know what happens, happens. You know you've got to die of something, but I'm eight years older than her and I would feel really bad if I croaked on her because she was devastated when my mom died. She was way devastated and she's not over it yet when my brother died seven years ago. She's not married. We're single and we're all we have. I feel bad about that. I feel real bad about that, that I don't take care of myself because of her.

Catherine wanted someone to see and care about her. She needed to know that she mattered. She showed that she was angry about the way her family and society treated her and tried to obtain attention through self-described bad behaviors.

Remembered

Lisa did not fall down the ladder in the same way that Catherine did. Lisa started out further down and never climbed any higher. She also never engaged in the good health behaviors that Catherine

described from her life in California. Lisa was fifty-two years old and dying from liver failure. Diagnosed with hepatitis C, she thought she contracted the disease while working as a janitor at a local public school. There was no way to be sure, which made any kind of financial assistance with the condition, or restitution for it, impossible. Laid off from the school, Lisa was now a live-in caretaker for her mother who had several strokes and needed constant assistance. Lisa was paid by the state but had no access to benefits. She applied for disability but was turned down because she worked too many hours. I asked if she appealed. She answered no but planned to reduce the hours she reported. This would mean a pay cut but since she lived with her mother would not mean less work.

Besides hepatitis, Lisa was also obese, had a thyroid problem, type II diabetes, and high cholesterol. She was only able to receive treatment for her thyroid condition because of the poor condition of her liver. She also has corneal dystrophy, a condition where lipids or cholesterol accumulated on the cornea of her eye. Treated with drops or surgery, full recovery was normal but, depending on the type of dystrophy, transplantation was sometimes required. Lisa needed surgery to scrape her corneas and may have required a transplant as well. It was sometimes painful when the excess cells were scraped off of her cornea by her eyelid, but her primary concern was that she might go blind. She already had a hard time driving and counted on others to give her rides. The nurse practitioner who acted as her primary care giver through the safety-net clinic where we meet referred her to the hospital for tests and to a number of specialists for her conditions. Lisa could not afford them.

I need Medicaid. Just like today, these are my eye drops and this is \$60 and I've had to be on those since the diagnosis, well the end of May and my procedure is not until August 8 and you know at four times a day it doesn't last long. And I'm on two eye gels. They've put me on thyroid medicine, and I'm on something they gave me some for depression too.

Lisa's body was in bad shape. She described herself as a person who did not think she had to grow up until she was forty years old. When she was younger, she drank, smoked, and ate bad foods. She believed that her body was paying for it. She knew she needed thousands of dollars' worth of care and recently spent a lot of money on her health, so much that it seemed unreal. I asked how she paid for the care. She did not. Her family paid. Lisa was married once for a few years, but it did not work out.

She never had children, but she had four brothers. They worried that if her medical bills were left unpaid she would not receive the care she needed, so they paid for her treatments with their credit cards. She paid them back a little each week to help with the cost but knew it was not enough to scratch the surface.

Lisa felt indebted to her family for more than just the money for her treatment. They also spent a lot of time with her and helped her with the day-to-day tasks that were a struggle. She was especially close to a sister-in-law who drove her around. As we talked, Lisa explained that her primary care nurse told her to do several things to help improve her health. The things she was supposed to do were major lifestyle changes that people often took years to implement. She did them all within a couple of months. Lisa was not naïve enough to think they would change her health trajectory. She knew that, in Sharon's words, they were between a rock and a hard place, but she planned to live long enough to pay her family back.

Before she saw the nurse, Lisa ate "fast food and then fried food and a lot of, lot of potatoes and things like that. Like have a hamburger, fry it, and fried chicken and sausages and breakfast." When she tried to lose weight before, it never worked.

Well when I was younger I was always I kind of weighed around 125-130, but then when I turned thirty-five I just started gaining and gaining and then I tried every kind of program there is, but I'll be good for a couple weeks and then I just can't get a program to stick to it. And then in the last couple years I just feel like I'm hungry all the time and I don't know if that has to do with these other issues or it's just part of depression or what it is.

After she talked to the nurse, Lisa changed her diet. She needed to lose the extra weight that contributed to her diabetes. As she described her new diet, she showed me her kitchen. The food matched her words. It was full of whole wheat and whole grain breads and crackers, fresh and frozen fruits and vegetables, and lean cuts of fish, chicken, and turkey.

I've started eating breakfast. I eat oatmeal with skim milk and I eat some whole wheat toast and then for lunch I have some tuna or chicken or turkey and then some cottage cheese and some fruit with that. Maybe a little snack in between with some fruit or maybe some sugar free or low fat yogurt and then for supper eat some either...I like chicken breast. I cut it up in these big chunks and spray a skillet with Pam and then spray a little Parkay on their and it gets quite a bit of flavor. And then cottage cheese and I have mixed vegetables like broccoli and cauliflower and things like that.

Her sister-in-law drove her to the store and helped her pick out her groceries. Lisa also exercised more. Family members came over and walked with her around her neighborhood. She really enjoyed walking but, because of her deteriorating vision, could not go out alone. The support of her family, in paying her medical bills, driving her places, and walking her around the neighborhood, contributed to Lisa's overall wellbeing. Since her succession of diagnoses, her mental health improved dramatically. Her family, better diet, and increased physical activity may not have been the only contributors. Like most of the women with forgotten bodies, Lisa had depression and took medication provided by a pharmacy assistance program. It was possible that some of her change in attitude was due to this diagnosis and resultant prescription but that was not the case with Roberta.

Part of a Community

Roberta was a forty-two year old part-time college student and volunteer receptionist at a women's community center. She grew up in the heart of Kansas City, Kansas, and lived there all her life. A Native American, she was adopted as an infant by elderly parents who immigrated to the US from Mexico (her father) and Yugoslavia (her mother). Her mother died when she was fifteen-years-old and her father, left in extreme despair, disappeared from her life for several years. Roberta went through a series of short, bad relationships with older men until she found herself pregnant at fifteen. She married the father of her child, but the marriage lasted just long enough for her to have the baby and become pregnant again. To support her two children, Roberta worked a number of low-skill, dead-end jobs. After the children were in elementary school, she married again and had two more back-to-back babies. Her second husband stayed only a little longer than the first. Although he could not handle domestic life, he helped out financially when able and, as their youngest child prepared to graduate from high school, they remained friends.

Rebecca criticized people who quit work in order to access benefits from the state. Roberta explained a time when she had to make such a choice, but it was not as straightforward as Rebecca imagined. Roberta recalled,

I was a mechanic at [company], but their insurance was so high and it didn't even cover dentistry. And I couldn't get on a program for my kids, you know for the Healthwave or whatever they have because I was making \$14 an hour. And the problem with it, I had four kids and even though, it looks different on paper from what it really is in reality. You know because you have to pay rent and utilities and clothes and food and for four kids and the two were right after each other so I had two in diapers and two on formula. It was really hard. I had a hard time getting all those bills paid and everything.

Roberta quit so her children could go on Healthwave and would be able to go to the doctor. She also looked for a better job that had accessible benefits, which she eventually found. Throughout the course of our conversations, Rebecca repeatedly emphasized the importance of children but always in such a way as to imply that people on government benefits did not care about their kids as much as people who worked. Rebecca's logic did not correspond to Roberta's life.

Roberta had a difficult life but retained an open mind and heart as well as optimism about her future. During one of our conversations, she confessed that she was not always so upbeat. Two years before we met, she was more than a hundred pounds overweight, depressed, and having a hard time just leaving her house. She did not have health insurance and could not remember the last time she did. When I asked, she said it was sometime in the 1990s, perhaps 1992. She also said that when she was depressed, she thought she could not afford to go to a doctor in her community. As a Native American, Roberta had free access to the clinics offered by the Bureau of Indian Affairs, but the closest one was nearly an hour away. She did not have a car or the money required to pay someone to drive her. Her health was very bad. Without intervention, she believed she would have died. She explained,

I just recently, when I came to the Women's Center they gave me the address and phone number to the clinic, but before that I was really, really sick because I had the thyroid that I wasn't taking care of and so my hair was falling out and I was like gaining weight rapidly and I got to the point that I couldn't even breath because this swells up and I got a goiter. I guess I was diabetic and didn't know, so when I did go to the clinic they told me it was a good thing I did go when I did because if I would have waited I probably wouldn't have been able to live through because not to many people realize how dangerous thyroid is. A friend, she was telling me that a friend of her mother went into a coma from having thyroid, hyper-thyroid. Since I've been there I was about 200 pounds and on my way to the death bed. That was about two years ago. And I've been, you know, the doctor tells me to exercise and everything. We did yoga classes here, me and my daughter. My doctor is giving me advice telling me the things that I need to do to be healthy.

Roberta turned her life around because of the Sisters at the women's center where we met. It was the Sisters who helped her find a local clinic that saw her for a reduced rate of \$15 a visit based on her income. The Sisters also gave her information for a program that provided her with eye glasses and, once when she needed it, with emergency financial assistance. They also helped her apply for a scholarship to a local Catholic community college where she began classes for a degree in early childhood education and signed her up for the center's classes on nutrition and physical education. More importantly, they not only told her they wanted her to come back, they gave her bus passes so she could.

When I came here I was a mess. I kid you not. I was a mess, but they helped me, straightened me out and made me feel like I belonged and I look forward to coming here now. I look forward to getting up in the morning. And that's what did it. I mean you have to have someone who, I mean my kids care about me, but they're getting older now. They don't need me as much anymore. You have to feel like, that's what's important, you have to, you have to look forward to your days, not just, not just, and it was like they thought I was important when I didn't think I was important.

One of Roberta's experiences at the clinic highlighted why the support of the Sisters, and not just the health care that they were able to help her access, was important. Nearly all of the women I spoke with in the neglected and forgotten groups who could access some form of health care provider had a diagnosis of depression and a prescription for anti-depressants. Often their anti-depressants were the only medication that they could access. When Roberta arrived at the safety-net clinic, she was immediately diagnosed with depression, given a prescription for anti-depressants, and assistance filling out the paperwork for a program offered by a big pharmaceutical company to supply low-income individuals with medication. Initially she took advantage of the program but found the medicine had terrible side effects. When she learned it was also addictive, she refused to take it again.

Roberta asked her doctor what to do about her depression. Her doctor said she needed to exercise more and eat better. The doctor helped her develop a plan, but she added that she was already working on that through the classes at the center. She laughed a little and said that she really just needed people to care about her like the Sisters care about all of the women who came in. When I asked Roberta if she thought the medical care made a difference in her behavior, she explained that it probably did but also said that she still needed more medical care than the archdiocese clinic was able to offer, "I still need x-

rays on an x-ray on my back because I was in a car accident. Well there's a lot of services that [*clinic name*] isn't able to carry." She planned to go to Tribal Health Services when she had the money for the car ride. She also worried a little because she felt dependent on the prescription for her thyroid and thought that Wal-Mart would someday end its \$4 prescription drug plan.

I asked her if there was anything else she needed, and she was hesitant because she did not want to sound like she was complaining. Finally she admitted that she needed access to dental care and she was missing a number of her back teeth. She looked sad as she said that when she lost some of the teeth the dentist told her they were salvageable through root canal, but she could not afford the \$500 procedure nor did she have the money for the crown required at follow-up. Having each tooth pulled cost her \$20. She had the \$20. Subsequently she had trouble with a number of foods, particularly fresh fruits and vegetables that were crunchy. She also had terrible summer allergies. In the late summer months it was not uncommon to see her with puffy, red, watery eyes. She took over the counter medication but was unsure which was best, especially with her other health conditions. She could not afford to go to the doctor for something so basic. Roberta also showed me a scar that ran from the tip of her left thumb nail to its cuticle. The base of the cut reopened and a little bit of puss oozed out. She could not afford to go to the emergency room for stitches when it happened and, because of that, it never healed properly.

Roberta made an effort to improve her life and herself because she had hope. She saw a better future for herself, a life that she wanted to be in. More than that, Roberta belonged to something and someone greater than herself. Although there was no outward expectation for Roberta to repay them, the Sisters sacrificed their time and emotional energy for her just as she sacrificed her time and emotional energy for the futures of her children. She was now part of their family, or community, and as such had a certain obligation not to waste what they gave up for her. I met several other women at the center who recounted similar stories of feeling adrift until they found the Sisters who made them feel whole again. The Sisters were not always successful, but when someone cared about them, women were more likely to care about themselves.

Women want a Healer

Interviewed women were disconnected. They were separated from each other, from their families, and from the rest of society. In their disconnected state, those that could tried to fall back on their health care providers who they thought should connect with them and heal them body and soul. While women often talked about their health in terms of control and their metaphors centered on ideas of body cultivation, they did not outwardly say they wanted to cultivate their bodies when they sought care. They said they wanted someone to make them feel better when they were sick, make sure they did not become ill when they were well, and someone who helped them fight off the deterioration that came with time and, when they had it or were at risk for it, chronic disease. All of the interviewed women had a clear picture of their perfect health care provider and generally this person was always the same.

I never saw *Marcus Welby, M.D.*, a television show on ABC from September 23, 1969 to July 29, 1976. I did not know it existed until three women over the age of fifty mentioned it to me as they talked about the kind of doctor they wanted. While other women did not reference the show directly, when they described their ideal provider they described its title character. Dr. Welby was different even from the other television physicians of his day. Turow (2009) reported that, while other medical dramas focused on acute care needs, Welby dealt with patients who had long-term health problems. He had a holistic approach that helped him heal people psychologically as well as physically. *Marcus Welby, M.D.* was the most popular show on television for several years and numerous fans wrote the lead actor for personal advice, but the show also generated some controversy. Feminists worried that Welby controlled his female patients too much; and doctors felt the fictional physician made them look bad because it raised patient's expectations too high.

It is likely that many of the women I spoke with either no longer had a direct recollection of this show or, for those who were born after 1976, simply never saw it. But the idea of Dr. Welby lodged itself into popular consciousness. Callahan and Berrios (2005: 16-24) explained that many people believe most general practitioners in the 1950s were a version of this wise, caring, patient-centered doctor. The fact

that historical records show that the character was more fiction than fact, even then, is irrelevant. Dr. Welby became the iconic version of a good doctor.

When women described their perfect provider, it was always a doctor. When asked, they said a nurse practitioner or physician's assistant was an acceptable replacement if they received the care they wanted and the person worked closely with a physician. What they wanted was someone who would spend time with them. They wanted at least fifteen minutes, but thirty minutes was better. Women wanted someone to sit with them, talk to them, and find out what they thought was wrong with them before their exam began. They also wanted a provider that remembered their name and, when appropriate, the names of their children. They wanted someone who knew who they were and why they sought care in the past. Teri said, "I want a doctor I feel comfortable being naked in front of. Is that too much to ask?" Even Jenny who was hyperfocused on controlling her own care, wanted a doctor who knew something about her.

I would love to have a physician who knows everything about me and is very comfortable with the fact that I go and get what I need from wherever I need it. I mean I'm the one who coordinates everything for me right now, which I will continue to do, but I feel a little disjointed like there isn't a doctor who knows anything about me. I mean my history and stuff like that.

When I began my research I thought that a woman's relationship with her health care provider would be the most influential factor in determining her health behaviors. I assumed that women with good insurance would have access to good doctors who spent long periods of time with their patients telling them what to eat, how often to exercise, and in general supporting their patients in these efforts. I did not anticipate that women with the best health insurance treated their providers like cosmetologists, jumping from one specialty to another to access the treatments that they thought worked best for them or that women in the group below primarily used their health care providers as sources of personal validation and accepted even mediocre treatment as long as the doctor told them what they wanted to hear and wrote appropriate prescriptions. I never dreamed that the women with the closest relationships to their providers were women without insurance who had chronic diseases and who, aside from their aforementioned providers, had little access to treatment. Women's behaviors were associated with

relationships, but they were associated with all of women's relationships. It was people's relationships with family, friends, and society that gave them control.

Health Reform

It is not clear how the Patient Protection and Affordable Care Act (PPACA) passed in March of 2010 will affect the US health care system. Much of the law remains unimplemented and several politicians want it repealed. The law relies heavily on Health Insurance Exchanges, or market-based entities meant to sell health insurance. Exchanges will be developed, implemented in 2014, and run by states or the federal government. They are based on a model created by earlier health reform efforts in Massachusetts and create markets where people can select and purchase a health insurance policy from a list of available options that are easily comparable in terms of quality, access, and premiums. Policies will be rated at different levels (e.g., bronze, silver, gold), the minimum requirements of which are federally mandated but otherwise left to states to determine. States may also choose to partner with other states and create multi-state or regional exchanges (Kingsdale and Bertko 2010). Not everyone will use insurance exchanges; they are for people who cannot access health insurance through an employer. People who do not earn enough money (less than 400% of poverty level), will also receive subsidies from the government to help offset the costs of premiums. Once exchanges are in place, everyone in the US will be required to have insurance or will have to pay a fine (PPACA 2010).

In addition to insurance exchanges, the law stipulates a number of regulatory changes and benefits such as the following:

- As of September 28, 2010, health insurers can no longer deny coverage for a child younger than nineteen because of a pre-existing health condition. As of 2014 this protection will be extended to everyone so that no one will ever be denied coverage again due to medical history.
- As of September 2010, insurers are prohibited from placing limits on what can be spent on the majority of benefits people receive. Limits will be eliminated entirely in 2014.
- Once exchanges are established, insurers will have a limit on how much they can require people to pay out-of-pocket on expenses such as copayments, coinsurance, and deductibles.

- As of September 2010, insurers are required to cover many preventive services without charging a copayment, coinsurance, or deductible.
- Individuals are allowed to stay on their parent's insurance plan until they are twenty-six years old.
- States are allowed to begin Medicaid expansion using federal dollars to include a number of people currently not insured. States will be required to expand Medicaid to cover additional individuals in 2014.

Having health insurance is not the same as having access to care. While the health reform law looks like it will go a long way toward guaranteeing people health insurance, it remains unclear whether it will guarantee they have care. As implementation of this new legislation moves forward, every effort must be made to ensure that health insurance translates into adequate health care. The law also does not address the differentiation in access among women with cultivated, managed, and neglected bodies. How will the government ensure equity in care among different kinds of health insurance policies? There are many people who have neglected and forgotten bodies because of the broken system that was in place for so long. These are people who have often gone for years without health care. Like Sharon and Ilene, these individuals have multiple chronic health conditions that will require extensive and expensive treatment. The law is supposed to create huge savings for future generations by offering preventive care that will keep people's health from deteriorating, but how will the backlog of poor health from the current system affect the law's implementation and the cost of future exchanges?

Chapter 10 –Destruction of the Social Reproduction of Health

Among US adults, health behaviors cluster. Those who engage in one poor health behavior, such as smoking, are more likely to engage in others such as eating fast-food. There is even a dose-response relationship: people who smoke more ate more fast-food (Carroll et al. 2006). Although this relationship is shown quantitatively, little research addresses why this is the case. This research helps shed light on the relationship by showing that health behaviors are part of the social reproduction of health.

The Social Reproduction of Health

Two ways exist to think about the social reproduction of health. In the first, the cultural institutions that create and support the existence and structure of classes are perpetuated and transmitted across generations (Janzen 1992). Chapters 5 through 9 explore how health resources, specifically types of food and medical care, were disproportionately distributed among fifty-five women in Kansas City, with those in the highest social positions receiving the most resources. Among these women, those who had better access worked for corporations or the federal government (or had husbands who did), had higher incomes, more advanced education, and were more often married. Chapter 5 discussed how these women turned their access into symbolic capital (i.e., physical and reserve capital) using resources to maintain and alter their internal health and physical appearance so that their bodies more closely matched the American iconic female form: young and thin.

Susan Bordo (1993) suggested that women want an iconic body because it signifies higher social position. More importantly, she said this body indicates the potential for upward mobility, the most important aspect of American ideology. Chapter 4 explores women's association between the iconic body and personal control and how the body is an important indicator of a person's ability to self-manage. Without this ability, a person cannot manage others, which is required for advances at the workplace and will improve social position. Chapter 4 also discussed how the fat or out-of-control body was seen as uneducated and unattractive, qualities that also negated women's potential for social improvement. Statistics on trends in annual income showed the majority of Americans were losing ground in terms of

their social position (Perrucci and Wysong: 2008). This could make symbols that represented the potential for upward mobility especially important.

While Chapter 5 showed that women of higher social position used excess resources to cultivate their bodies, Chapters 6 through 9 explored how the unequal distribution of health resources was a form of structural violence, as interviewed women in lower social positions were unable to access the resources they needed to remain healthy. Access to resources followed an inverse gradient with body deterioration: fewer resources meant poorer health.

Chapter 6 discussed the daily habits and experiences of women able to access enough resources to manage their bodies through most of their lives but, as they aged, their bodies deteriorated and developed chronic diseases, such as type II diabetes. Women with managed bodies desired the iconic body. Unable to access the same level of resources as women who cultivated their bodies, women with managed bodies bought products they hoped would help them. They simultaneously expressed a deep cynicism about products, cynicism born after years of trying products that failed. The products remained important to women because purchasing them made women with managed bodies feel they were choosing what was best for them. Eventually women with managed bodies gave up and accepted their bodies for what they were. They continued to rely on doctors to tell them they did all they could to stay healthy. The primary resource women with cultivated bodies could access that women with managed bodies could not was time, something marketers emphasized to sell products.

In 1978 Marshall Sahlins used US food patterns to show that people use cultural knowledge and past experience to make decisions; cultural knowledge that comes out of one's social class (Sahlins 1978: 211). While Sahlins found that higher-class women preferred processed foods over whole ones, my research actually mirrors his conclusions. When Sahlins did his research, processed foods were more expensive than whole foods. Several events over the next four decades led to the reciprocal relationship between food and class. In the late 1970s there was a push by public health to understand chronic disease, industrial agriculture became the norm, the natural foods movement began to emphasize that labor-intensive foods made better tasting food, and the association between impossible-to-achieve body

ideals and ideologies that emphasized self-surveillance became more prominent (Guthman 2003: 53). Throughout this period, increased wealth disparity also created more need for women's labor outside the home. This change caused a shift in food patterns and led to a devaluation of processed food items that made it easier for women to work a full day at the office and then come home and put in another day for their families. Being able to stay home and make home cooked meals became a way to show social status (Kawachi and Kennedy 2006: 116-120; Douglas 1984: 12-13).

Consumer-based societies require that people engage in regular cycles of control and release to enlist the hours of work needed for production and periods of release needed so people will purchase the items that are produced (Bordo 1993: 199-201; Reischer and Koo 2004: 301). Messages that encourage these cycles affect everyone but mass marketing, the deprivation caused by wealth disparity, and TV images that show the poor what they are missing create deviations in traditional patterns. That a majority of production now happens overseas might also influence modern patterns, but more research on this is needed. Women with neglected bodies felt their ability to maintain control slipping away and sometimes reacted by making a choice to engage in behaviors that they identified as bad but felt good. Women who did this were those who were particularly angry at society or who were beginning to question their past beliefs that supported it. Because they could not access resources, their bodies were also breaking down.

Women with forgotten bodies did the best they could with the few resources available to them. Nearly all of their foods were processed. These women did not have the money to buy more expensive foods or the time or energy to fix them. They also lacked the time and energy to complain. The only thing they had that set them ahead of other women was that when they finally were able to find medical care, the people who administered it did so because they wanted to help and emotionally invested themselves in these women. As helpful as that emotional investment was, it did little when a woman's body was so deteriorated that she was near death.

Women learned their health habits from their parents and their desire to cultivate their bodies, as well as how they did it, largely from their mothers. Media messages also contributed to women's cultivation desires and knowledge. These parental and media influences meant that body types had the

potential to be perpetuated across generations, which would make health socially reproduced. It appears that education could affect how women thought about health, food, and exercise but did little to affect their habits.

So What about Canada?

A study released by the journal *Health Affairs* (2010) reports that over the past decade the US ranking for life expectancy fell from 24th in the world to 49th (Muenning and Glied 2010; CIA Factbook 2010). The study investigated why the US now has a life expectancy that is worse than some developing nations and found that instead of the reasons most often reported by the popular media, such as population diversity, smoking, and obesity, the problem is the US health care system. The authors say the best way to improve life expectancy and reduce health care costs is to provide treatment to prevent long-term chronic diseases that arise in midlife. The authors also identify a lack of coordinated care and the system's emphasis on specialty care as problems that must be addressed (Muennig and Glied 2010).

Canada was brought up frequently by respondents and is often criticized by Americans for its health care system. At 9th in the world, Canada ranks far ahead of the US for life expectancy at birth (CIA Factbook 2010). Canadians spend far less on health care, with savings primarily coming from the costs of administration. In 1999 Canadians spent \$752 less per person on administrative fees than Americans (Woolhandler et al. 2003: 768, 772-773), an amount that has likely grown. Prior to the implementation of Medicare for all in Canada, Canadian and US health care spending levels were parallel. After thirty years of universal coverage, Canada spent 50 percent less than the US, while providing quality care for everyone (McBane 2010: 3). Canada does not deny people care because they cannot afford to pay for it. When someone receives care is based on medical need and, following that, their place in line when their need is first identified. The Canadian system is not perfect. No system is, but it is far from the inefficient, ineffectual monstrosity that the insurance industry claims. Jenny may not have liked the Canadian health care system because she would be unable to access care prior to others in need with her excellent insurance and ability to manipulate the system but Ilene, who desperately needed

an MRI and was unlikely to receive one, might not have thought that the two weeks average wait for such a service in Canada was such a long time.

Breakdown of the Social Reproduction of Health

The second way to think about the social reproduction of health is its impact on the continuation of society as a whole. In the US, the economic drive for profit breaks down social systems. Food sellers almost exclusively advertise processed foods with added sugars, salt, and fat because these are cheaper and they can charge more for them. The sellers then market foods to women, saying they are healthy. In addition, insurance companies charge people for a product that they often fail to deliver as they try to raise their profit margins. Inability to access consistent, quality health care leaves physical marks on people's bodies (Scheper-Hughes and Lock 1987: 7-8, 25-28), as do low quality processed foods (Nestle 2007). Poor health becomes a physical manifestation of lower status. Rylko-Bauer and Farmer (2002) suggested that the market-driven forces behind the US health care system were attempting to redefine the relationship between the state and society and, in so doing, were unstitching the social fabric.

When I began my research, I asked whether women's cultural construction of CVD risk varied based on their access to health care as that care was mediated by their health insurance or a lack of it. My research had three elements: (1) to assess the CVD information that was circulating in the area and how that information was influenced by public health and health related industries; (2) to explore how women's knowledge of CVD and cardiovascular risks were influenced by circulating information and from women's own experiences; and (3) to record how women's knowledge affected their actions and interactions. When I began, I thought that a woman's relationship with her health care provider would be the most influential factor in determining her health behaviors. I assumed that women with good insurance would have access to good doctors who spent long periods of time with them, supporting their efforts to maintain good health. I never anticipated that the women with the best health insurance would jump from one provider to another using health care as a kind of beauty aid, or that the women in the group below them would use their health care providers as sources of personal validation. I never thought that the women with the closest relationships to their providers would be women without insurance who

had chronic diseases and who, aside from their providers, had little access to treatment. I also never thought that the most important determinant in terms of health-related behaviors would be women's types of connections to other human beings.

In *Food for Life: the Spirituality and Ethics of Eating*, L. Shannon Jung (2004: 62) observed that in the US, "The values that dominate the food system are designed to promote a level of consumption and greed that will produce the greatest amount of profit and market share." He explored how a system that created false demand to maximize corporate profit could shift social focus away from hungry people toward what is in business corporations' fiscal best interest. This shift in values affected everyone's desires and ability to reason due to constant social and media pressure. It changed how people thought and acted. Specifically, Jung (2004: 66) said, people have "abrogated responsibility for each other and, at the most tangible level, responsibility for caring for each other physically and materially."

There were parallels between Jung's (2004) view of the US food system and its health care system. Jung considered how people could consume more food than they needed while they simultaneously distanced themselves from the needs of people who were hungry, what he called an abrogation of responsibility. In terms of health care, there is a similar abrogation of responsibility, exacerbated by the insurance industry, which alters the nature of the social contract so it is no longer between individuals and society. The social effect of this shift can only be understood when explored at the level of individual experience: Jenny's overuse of health care and Ilene and Sharon's inability to access it. Jung pointed out that within a society, the abrogation of responsibility for others leads to mistrust because people who do not take care of others do not trust others to take care of them. The inability to trust others creates anxiety, which blossoms into a preoccupation with taking care of oneself. In terms of health care and related resources like food, this preoccupation is encouraged through risk messages, which further divide people, deepen their anxiety, and convince them they can protect themselves if they purchase the right products or behave in certain ways (O'Malley 2000: 478-480; Douglas 1992: 28; Althaus 2005: 575).

Jung (2004) said that deep levels of anxiety that center on the need to take care of the self can lead to a sense of entitlement as a person consumes more than their fair share. This sense of entitlement further disconnects a person from others and from herself. For those who travel this path, Jung suggested that some will feel hubris and aggrandize their own worth, while others will feel despair due to social disconnect. It seemed that women with cultivated and managed bodies exhibited hubris, as they sought out new and different treatments, and disconnect, as they expressed stress and fear. They looked to their doctors to provide the lost connection but were often disappointed. Only women who reconnected with others improved their health without falling into the trap of body cultivation.

Data from around the world show that the more equal a society is, the better its health outcomes. This fact has led some researchers to conclude that the most unequal societies are unhealthy (Nguyen and Peschard 2003: 450, Kawachi and Kennedy 2002). It was what one interviewed woman decided as we talked and she compared her experiences in the US with those in Botswana where she lived as a journalist several years before we met. “They took care of each other,” she explained. “When one person in the village was ill, it was a reflection on the whole village. All of the old men would come, from all of the outside areas too. They would have a big party and a ceremony. We would have to leave before the ceremony. They didn’t let outsiders watch, but they would figure out what the people in the village did and everybody worked together to fix it and make the person better. Not like here. Here nobody cares about what happens to people. That’s what it is. It’s like our whole society is sick.”

Conclusion

People in the US want to believe that health care is provided by employers and is something they can receive as a perk, but instead they pay huge amounts of money for it hidden by the way the system is administered. In the end, everyone in society is hurt, but very few people benefit. Health reform might help but that remains unclear. Among the fifty-five women who were interviewed, health care resources were administered in such a way that some women overused care while others had little or no access to it. The system hurt those at the bottom and left visible marks on their bodies. It also hurt those at the top who overused care in ways that were potentially unhealthy and emotionally untenable. The system

seemed to provide little benefit to those interviewed but was perpetuated among them by an ideology that equated worth with the potential to earn more wealth.

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Insurance Cues

- Tell me about your health insurance (e.g. good or bad, cover or not cover)?
- Can you tell me about an experience you had with your insurance company that stands out to you?
- What do you think about the issue of health insurance in America today?
- Was there ever a time you did not have health insurance?
- Tell me the kinds of things you go to the doctor for.
- Tell me about your last trip to the doctor, what was it like, what happened?
- Was there ever a time when you did not have health insurance?
- Tell me about it, what was it like? Did you ever need medical care in that period?
- Is there a particular event or experience that you remember from that period?
- Was there ever a time you needed to go to the doctor, but didn't go because of the cost (loved one; another reason)?

CVD Cues

- How do you decide what is healthy?
- Tell me what comes to your mind when I say cardiovascular disease?
- Draw a picture of a person at risk for CVD and describe them to me.
- Why are you drawing that?
- Next to that person, draw a picture of a person with CVD...why are you drawing that?
- How would the person in each picture differ if they were the opposite sex?
- Is there someone you know that had an experience with this disease? What was that like for you?
- Tell me all the things that increase people's risk for CVD (and rank them).
- Why did you list each one (go through)?
- Tell me all the things that decrease someone's risk (and rank them).
- Why did you list each one (go through)?
- Does the recent smoking ban in KC affect you? Tell me what you think about it.
- Were you (or a loved one) ever a smoker? What happened?
- Have you (or a loved one) ever been diagnosed with high cholesterol or high blood pressure? What was that like?
- Tell me about the things you do that you think increase your risk. What do you do to decrease it?
- Is there someone who increases your risk? Tell me about them?
- Where does your CVD knowledge come from?
- Has a medical professional ever talked to you about CVD? Can you tell me what that was like?

Appendix 1 (Page 2 of 2)

General Medical Questions

- Tell me about the medication commercials you've seen on television?
- Have you ever seen a commercial and wondered if you might have the condition it talked about?
- Tell me about this experience, did you go to the doctor, what happened?