AT RISK IN AMERICA
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The first edition of Lu Ann Aday’s *At Risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States* was published in early 1993. Why should you read and own this second edition, published some eight years later? The intervening years have been “good years” for the general welfare of the country according to key economic indicators: increasing per capita income, gross national product, and stock market value, with generally low unemployment and interest rates. You need Aday’s new edition to find out if the vulnerable populations of the United States have shared in this increasing largess of the nation—particularly as it applies to health and health care.

You will find that in some ways, for some vulnerable groups, there has been improvement—but in far too many instances there has been stagnation or decline in health indices for vulnerable populations. Even in instances where conditions have not deteriorated, the status of vulnerable populations is often worse than what might be considered acceptable and feasibly obtained according to external norms and guidelines, such as those provided in *Healthy People 2000* (Public Health Service, 1990). Aday points out that social systems promote, in varying degrees, individual rights and the common good. Perhaps, vulnerable populations in the United States would fare better if the system placed relatively more emphasis on the common good.

This new edition of *At Risk in America* provides extensive descriptions and analyses of trends during the 1990s, elaborates and extends Aday’s theoretical framework of vulnerability, provides a systematic assessment of research needed to advance our understanding of the vulnerable and the health problems they face, and outlines a policy and plan of action to address these problems.
Aday’s concept of vulnerability is a sociological one: “[B]oth the origins and remedies of vulnerability are rooted in the bonds of human communities . . . [T]o be vulnerable to others is to be in a position of being hurt or ignored as well as helped by them . . . [A]s members of human communities we are all potentially vulnerable.” Populations are vulnerable that have low social status and limited social or human capital. Key vulnerable populations Aday explores in detail include: high-risk mothers and infants, the chronically ill and disabled, those with HIV/AIDS, the mentally ill and disabled, alcohol and substance abusers, the suicide and homicide prone, abusing families, the homeless, and immigrants and refugees. For all these groups she provides a careful assessment of the extent of their vulnerability, the adequacy of the programs that serve them, and the accessibility, quality, and costs of the care they receive.

This second edition of Aday’s comprehensive analysis of vulnerable populations deserves to be on your bookshelf. It is a must for policymakers, health care practitioners, teachers, researchers, and students concerned about the people she describes. It will help us all to think about the nature of the problems of vulnerable populations; it provides a comprehensive source of relevant, up-to-date data and references and carefully considered suggestions for improving the condition of vulnerable populations.

January 2001

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Policy developments early in the twentieth century led to the expansion of the U.S. health care system and to improved access for many of the traditionally medically and socioeconomically disadvantaged segments of the U.S. population. However, progress has not been without its price. A corresponding acceleration in the rate of expenditures for medical care has accompanied these changes. Public and private providers and third-party payers responded by encouraging initiatives to cut back on the resources spent on health care and to develop innovative organizational models for the cost-effective practice of medicine.

These changes have had a profound impact on slowing or reversing many of the favorable trends of improved access for groups for whom the doors of the health care system were historically more likely to be closed, such as the poor, minorities, the uninsured, and those without a usual medical provider. Further, the increasing visibility of sociomedical morbidities, such as HIV/AIDS, drug and alcohol addiction, family violence, and homelessness, among others, have highlighted categories of individuals with needs, who are particularly vulnerable to restrictive social, economic, and health policies. The solutions to addressing the needs of these diverse groups have been fragmented and categorical—resulting in many particularly at-risk individuals slipping through the cracks of the existing health and social service systems.

The research in this area is often categorical and fragmented, not systematically related to other bodies of information, and fails to identify issues that cut across different professional or service delivery domains. No source has pulled together, in a systematic fashion, the array of information and identified the cross-cutting policy and research issues for the seemingly growing numbers of the vulnerable.
At Risk in America provides this needed integration and synthesis. It presents (1) a framework for identifying and studying vulnerable populations, (2) data on the needs of these populations and on the trends and correlates in the growth of these populations over time, (3) issues regarding the access, cost, and quality of their care, (4) policies and programs that have been developed to address their needs, and (5) research and policy initiatives that could be undertaken to ameliorate vulnerability.

This second edition of the book updates the data and sources presented in Chapters Two through Nine and Resources A and B of the first edition, as well as any corollary conclusions regarding the status of the primary groups that are the focus of the book: high-risk mothers and infants, chronically ill and disabled, persons living with HIV/AIDS, mentally ill and disabled, alcohol or substance abusers, suicide or homicide prone, abusing families, homeless persons, and immigrants and refugees. Other groups may well be identified to be of concern. The framework introduced here, however, is intended to provide a guide for identifying relevant needs and likely programs to address them for these and other groups, focusing particularly on the social determinants of health and illness.

The remaining chapters focus on refining and updating the conceptual framework (Chapter One), research needs (Chapter Ten), and policy implications (Chapter Eleven) introduced in the first edition, based on the latest theoretical, empirical, and policy developments in this area.

Since the publication of the first edition, there has been an increasing interest in the social determinants of health and the design and implementation of new methodologies for tracing aggregate or societal influences on individuals’ health and well-being. The accelerating transformation of the health care system to a managed care–driven environment, and the corresponding challenges to redefine the role of public health, have led to a re-examination of the medical and nonmedical remedies for improving the health of populations. The second edition of At Risk in America reviews these recent and emerging trends and their implications for addressing the needs of the most vulnerable.

**Audience**

Public health, health care, social science, social work, and policy analysis professionals, academicians, and researchers will be interested in this book. At Risk in America can serve as a reference for legislative staff, policymakers, health professionals, program administrators and students, as well as provide a framework for guiding subsequent research and program development in this area.

This book can acquaint students with the literature in the field and provide a framework to use in identifying vulnerable groups and their specific and common problems. The book can be used as a text for public health, health administration, medical sociology, behavioral science, and social work students, as well as students in the health care professions in courses dealing with the operation and evaluation of the health care system.
At Risk in America can provide health and public health professionals with the background information they will need in developing or evaluating programs to address the needs of vulnerable groups in their own states or communities. The book can serve as a reference source for policymakers and their staffs who need a quick and timely review of the issues for selected target groups. And, finally, this book can also provide a vision of who the most vulnerable are likely to be in the future, what programs or policies can anticipate and address their needs, and what systemic solutions should be considered to address the deepening access, cost, and quality crises in the U.S. health care system.

Overview of the Contents

Each chapter in this book poses a question to explore with respect to the health and health care of vulnerable populations. Vulnerable populations are defined as being at risk of poor physical, psychological, or social health, based on the World Health Organization’s definition of health as a “state of complete physical, mental, and social well-being” (World Health Organization, 1948, p. 1). Selected groups are highlighted throughout the book to illustrate and examine the applicability of the framework for studying vulnerability developed here. The nine vulnerable population groups, based on the primacy of the different types of needs, that will be the primary focus of the book, are as follows: physical needs—high-risk mothers and infants, chronically ill and disabled, persons living with HIV/AIDS; psychological needs—mentally ill and disabled, alcohol or substance abusers, the suicide or homicide prone; social needs—abusing families, homeless persons, immigrants and refugees. The rationale for choosing these groups is discussed in Chapter One.

At Risk in America is organized to facilitate an overview of the cross-cutting issues across the array of groups examined, as well as to provide specific details on a particular group of interest. The first chapter describes the conceptual framework to guide the presentation of material to address the questions regarding the health and health care of vulnerable populations posed in each of the chapters that follow. The final chapter (Chapter Eleven) discusses the principles and parameters of a more community-oriented health policy to ameliorate vulnerability to poor physical, psychological, and social health.

Each of the other chapters (Two through Ten) is divided into three main sections: (1) an introduction to the main question that will be addressed in the chapter and the approach used to assemble and organize the evidence to answer it, (2) a synopsis of the cross-cutting issues identified across all of the vulnerable populations examined, and (3) a population-specific overview of the evidence for each group. In each of these chapters, summary tables are provided to highlight key findings.

Readers may elect to focus on the summary or overview sections of each chapter, or to examine the evidence for a specific question or group within or across chapters.
Chapter One asks who are the vulnerable. The framework for defining and studying vulnerable populations that serves as the basis for the perspective on vulnerability developed in subsequent chapters is presented.

Chapter Two asks how many are vulnerable. National estimates on the number and growth of vulnerable populations are summarized, and the extent to which there is an overlap in these groups is highlighted.

Chapter Three poses the question of who is most vulnerable. Data on demographic subgroups of each of the nine major vulnerable population groups are presented, focusing particularly on breakdowns by age, sex, race, income, and education.

Chapter Four asks why different groups are particularly vulnerable. This discussion provides an overview of the major political, cultural, social, and economic changes in the United States that have given rise to growth in the number and categories of vulnerable populations. The impact of the availability of resources resulting from differences in social status (prestige and power), social capital (social support), and human capital (jobs, schools, and housing) are examined in explaining the differential vulnerability of different subgroups of the population.

Chapter Five asks what programs there are to address the needs of vulnerable populations. Major programs and services are highlighted in the context of a continuum of preventive, treatment, and long-term care services.

Chapter Six asks who pays for care. The discussion focuses on the public and private third-party sources of financing that have been available to pay for the services provided.

Chapter Seven explores how good access to care is. Evidence of organizational and financial barriers to obtaining needed services is reviewed.

Chapter Eight asks how much care costs. A summary of what is known about the total and out-of-pocket costs of care and the cost benefit and cost-effectiveness of alternative program and care arrangements is provided. This chapter illuminates the personal and societal costs of providing care to vulnerable populations, and it considers the efficiency of alternative programs and policies to address the needs of these populations.

Chapter Nine reviews what is known about the quality of care. In this chapter, data are presented on structure, process, and outcome dimensions of the quality of care currently being provided to vulnerable populations, through the medical care, as well as other, service delivery sectors.

Chapter Ten raises the question of what still needs to be known about the health and health care of vulnerable populations. Descriptive, analytic, and evaluative research priorities are identified, and proposals for the type of information needed to make informed decisions, and how to obtain the required information, are presented.

Chapter Eleven asks what programs and policies are needed. This final chapter presents a community-oriented health policy paradigm, based on the perspective on vulnerability developed in previous chapters, as a basis for recommendations regarding how best to address the health and health care needs of vulnerable populations.
An extensive set of references as well as a resource describing the major national data sources on vulnerable populations and a second resource containing detailed source notes on the data tables in this book are provided.

The unique contribution *At Risk in America* makes is to synthesize existing information on the array of vulnerable populations that have emerged in recent years and present a framework for articulating coherent and integrated research and policy agendas to address their needs. The book identifies research in progress to reflect the most up-to-date information on these issues, documents the major sources to consult on the topic, and provides recommendations regarding what still needs to be known and done to address the health and health care needs of vulnerable populations in the United States.

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Lu Ann Aday
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L.A.A.
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AT RISK IN AMERICA
CHAPTER ONE

WHO ARE THE VULNERABLE?

Both the origins and remedies of vulnerability are rooted in the bonds of human communities. The parentheses that inscribe our lives (its beginnings and endings, as well as the passages within it) take form in the arms of those who care for us when we are most in need of physical help, spiritual solace, or warm companionship. Their presence supports and strengthens us, and the blessings of their caring seek to salve the wounds of body, mind, and spirit that accompany the odyssey of our lives.

To be vulnerable is to be susceptible to harm or neglect, that is, acts of commission or omission on the part of others that can wound. The word *vulnerable* is derived from the Latin verb *vulnerare* (to wound) and the noun *vulnus* (wound). To be vulnerable is to be in a position of being hurt or ignored, as well as helped, by others.

As members of human communities, we are all potentially vulnerable.

Framework for Studying Vulnerable Populations

Two different mother tongues—those of “individual rights” and the “common good”—have historically characterized American social and political discourse. The semantics of the first emphasize the meanings of autonomy, independence, and individual well-being, while the second highlights norms of reciprocity, interdependence, and the public good. Social critics have, however, observed that in contemporary American society, the first language of individualism has come to override the second mother tongue of community (Beauchamp, 1988; Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Putnam, 1993, 1995).
James Coleman (1990), in his book *Foundations of Social Theory*, points out that to formulate meaningful theories or explanations of social phenomenon, both the macro (collective) and the micro (individual) levels of observation and analysis and their interrelationships must be examined. Focusing on individual characteristics, attitudes, or behaviors (such as violence proneness) may fail to reveal the impact that larger social influences or trends (such as media violence) have on individuals. Correspondingly, theories regarding relationships between largely collective phenomena (such as the prevalence of media violence and rates of violent crime) that fail to illuminate the dynamics of these social forces for individuals fall short of developing fully meaningful explanations of the phenomena. The measurement of collective phenomena at the individual level of analysis (methodological individualism) also tends to bias the explanations of these phenomena toward individual motivations and actions.

The approach to studying the health and health care of vulnerable populations undertaken here examines the ethical, conceptual, and political contributions of the community (macro) and individual (micro) perspectives and their interrelationships in illuminating the concept of vulnerability. Vulnerable populations are at risk of poor physical, psychological, or social health. The discussion that follows explores a framework for understanding both the community- and individual-level correlates of vulnerability to poor physical, psychological, and social health. (See Figure 1.1.)

**Ethical Norms and Values**

The principal ethical norms and values for guiding decision making regarding the amelioration of risk underlying an individual perspective on the origins of poor physical, psychological, or social health are personal autonomy, independence, and associated individual rights. Good health is viewed to be primarily a function of personal lifestyle choices, and poor health outcomes result because individuals fail to assume adequate personal responsibility for their health and well-being.

A community perspective on the origins of health needs focuses on the differential risks that exist for different groups as a function of the availability of opportunities and resources for maximizing their health. Norms of reciprocity, trust, and social obligation acknowledge the webs of interdependence and mutual support and caring that are essential for minimizing the risks of poor physical, psychological, or social health. Poor health results because communities fail to invest in and assume responsibility for the collective well-being of their members (Aday, Begley, Lairson, & Slater, 1998; Evans, Barer, & Marmor, 1994).

**Concept: Health Status**

*Health* is defined by the World Health Organization (WHO) as a “state of complete physical, mental, and social well-being” (World Health Organization, 1948, p. 1). Correspondingly, health can be measured along a continuum of seriousness,
Who Are the Vulnerable?

with good health being at the positive end of the continuum, defined by indicators of good health or physical development, and death at the negative end, defined by population-specific mortality (death) rates. Needs are those departures from full physical, mental, and social health that people experience in the course of their lives.

A variety of indicators of the different WHO dimensions of health (physical, mental, and social) have been developed. Generally physical health has been characterized as “the physiologic and physical status of the body” and mental or psychological health as “the state of mind, including basic intellectual functions such as memory and feelings.” Physical and mental indicators tend to “end at the skin,” and indicators of social health extend beyond the individual to include both the quantity and quality of social contacts with other people (Ware, 1986, pp. 205–206).

The magnitude and seriousness of individual or community needs along each of these dimensions may differ depending on how they are defined and measured. Health needs, for example, can be based on clinicians’ judgments, patients’ perceptions, or observed or reported levels of functioning. Clinical or diagnostic