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INTRODUCTION: FAMILIES AND THEIR HEALTH



When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.

(Herophilus of Chalcedon 335 BC to 280 BC,
in Durant 1966:638)

THIS QUOTE FROM ANTIQUITY IS AS TRUE IN THE TWENTY-FIRST CENTURY as when first scribed, yet understanding the dimensions and determinants of health, particularly family health, has never been more challenging as our understanding of the complexity of illness increases. American families confront a paradox of their country spending more on health care than any other nation on the planet, yet on almost every measure of health status, such as infant mortality and adult longevity, the United States ranks below many developed countries. What can be done to remedy this inconsistency? A first step demands recognition that family health is multidimensional and impacted by the interactions of determinants. This book offers a plausible, pertinent approach to such recognition. The introduction provides working definitions as well as an interactive Family Health Determinants Model, which serves as a framework for the remaining chapters. Included in this chapter is an overview of the status of family health as well as a description of the theoretical

foundation in the evolving concept of family health and well-being. Case studies¹ are woven into this and following chapters so as to provide human context to this very dynamic process called family health.

Family Health: Definitions and Determinants

Scholars and practitioners from family and medical sciences, as well as many in the general public, recognize the crucial effect of family health and wellness² on overall family well-being and quality of life. Many of these scholars and practitioners agree that family health goes beyond absence of disease and dysfunction, and therefore accept a more multidimensional portrait of being healthy and well.³ In this book, the terms *health* and *wellness* will be used interchangeably to mean an ability to live life with vitality and meaning regardless of disease and disability.

Applying this multidimensional definition to family health broadens related concepts of family well-being and health-related quality of life. While defining well-being enjoys strong agreement as a “state of being healthy, happy, or prosperous” (Webster’s 1984:1310), health-related quality of life is less easily explained or measured. According to the Centers for Disease Control and Prevention (CDC), health-related quality of life is how individuals and or families “perceive physical and mental health over time” (Moriarty, Zack, and Kobau 2003:1). With advances in medical science and technology, the issue of health-related quality of life increasingly challenges patients, their families, health care providers, insurers, educators, along with those in government and business. Families increasingly struggle with questions of not only the availability, accessibility, quality, and cost of health care, but also of health-related quality of life issues of survivors and their families. “Is it worthwhile to keep a comatose person alive on a respirator? ... Traditional indicators like mortality rates and objective clinical parameters are no longer adequate for answering these questions” (Chen, Li, and Kochen 2005:1). Who decides when life is worth living? How to aid families physically, intellectually, emotionally, and socially with such life and death decisions and resulting ramifications? Such are questions increasingly facing families in the twenty-first century. Family health, therefore, is a dynamic process. In response, this book incorporates Perri Bomar’s definition of family health as “encompassing a family’s quality of life, the health of each member, family

¹ Names, locations, and other personal specifics are altered to protect confidentiality.

² Wellness expands the concept of health beyond uncontrolled factors (e.g., genes, age) to include health decisions made about how to live life (i.e., perceptions, attitudes, choices, actions).

³ Dimensions of health and wellness include: a physical, emotional, intellectual, spiritual, social, and interpersonal, plus environmental-planetary components (Insel, Paul M. and Walton T. Roth. 2008. *Core Concepts in Health Brief*. Boston, MA: McGraw-Hill).

interactions, spirituality, nutrition, coping, environment, recreation and routines, sleep, and sexuality” (2004:11).

Along with a multidimensional appreciation for family health, there are five determinants that significantly impact health. These interconnected determinants include biology (genetics), behavioral patterns, social-cultural circumstances, environmental exposures, and health care (policy and services). Figure 1.1 provides a model to aid in understanding the dynamic interactive nature of these determinants and their impacts on family health. This model is based on the *Healthy People 2010* concepts; Michael McGinnis, Pamela Williams-Russo, and James Knickman’s (2002) “determinants” of health; the work from the National Research Council and Institute of Medicine (2004); and David Kindig’s (2007) Expanded Population Health Model.

The Family Health Determinants Model illustrates some of the complexities involved in family health issues not only due to the interactions among determinants, but also in terms of health equity as revealed in the social-cultural circumstances determinant of Figure 1.1. Health disparities among individuals, families, groups, regions, and nations are glaringly evident in basic local, national, and global health

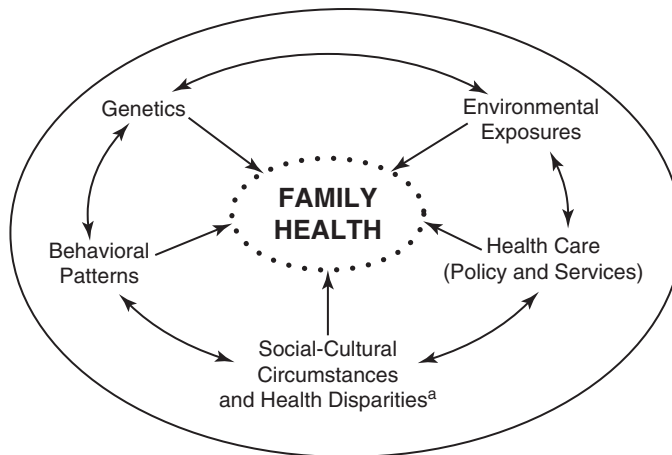


Figure 1.1 Family Health Determinants Model

^a*Health disparity* is a disproportionate burden or risk of disease, disability, ill health, or death in a particular population or subgroup. *Healthy People 2010*, a national health promotion and disease prevention initiative, placed major concern over health disparities on the basis of gender, race, ethnicity, education, socioeconomic status, disability, geographic location, and/or sexual orientation.

Sources: Compiled from the U.S. Department of Health and Human Services. 2000. “Determinants of Health.” *Healthy People 2010 Report*. p. 30. Retrieved May 3, 2008. (www.healthypeople.gov/Document/html/uih/uih_bw/uih_2.htm); and the National Research Council and Institute of Medicine. 2004. Pp. 28–44. *Children’s Health, The Nation’s Wealth*. Washington, DC: The National Academies Press.

findings (e.g., mortality, morbidity, incidence, or prevalence rates of a disease or illness). Dennis Raphael (2006) argues that such data avoids the causes for such disparities, which he identifies as “health inequalities.” Health disparities or health inequalities, therefore, are disproportionate burdens or risks of disease, disability, ill health, and/or death on a particular population or subgroup. *Healthy People 2010*, a national health promotion and disease prevention initiative, placed major concern over health disparities on the basis of gender, age, race, ethnicity, education, socioeconomic status, disability, geographic location, and sexual orientation.

The health of individual members and their families is determined by these determinants “acting not in isolation but by our experience where domains [determinants] interconnect” (McGinnis, et al. 2002:83). Genetic predispositions are influenced by behavioral patterns and/or environmental exposures. Families’ behavior patterns and environmental exposures are affected by their social-cultural circumstances and access to quality health care. “Our genetic predispositions affect the health care we need, and our social [cultural] circumstances [environmental exposure and behaviors] affect the health care we receive [or do not receive]” (McGinnis, et al. 2002:83). Families, medical and social scientists, as well as practitioners need to appreciate these dynamic interactions in the family health process. The following story about Tyra and her family provides an opportunity to identify these determinants and the impacts of interactions on this family’s health and well-being.

Case 1.1 Tyra: Influences on Family Health

As an energetic, 42-year-old, Tyra thought she was in good health. Well, perhaps she could lose a few pounds, but she was worried more about her husband Gabe’s high blood pressure and their twin daughters’ asthma than about her own health. She knew she should stop smoking, eat better, and get some exercise, but there never seemed to be enough time. Gabe and she both worked full-time at low paying jobs with neither position providing adequate health care coverage, so regular adult health checkups simply didn’t happen. Tyra knew she had high blood pressure and a family history of stroke, but again, like most adults, she thought of heart disease and stroke as male health issues. The air quality of the neighborhood they lived in exasperated their daughters’ asthma and caused the girls to stay inside rather than play outdoors. This environmental exposure added to the strain of the girls’ chronic illness, plus fears over losing the children’s Medicaid coverage heightened Tyra’s stress level to where she often couldn’t sleep through the night. The stress on both Gabe and Tyra also wounded their marriage and intimacy as they fought more and communicated less. Tyra, nor anyone else in her family, thought she might have a serious health condition, so when the event happened it was sudden and without warning. Tyra returned from work just as Gabe was leaving

for his job. She felt dizzy and a terrible headache pounded as she climbed the stairs to their drab apartment. Fumbling with her keys, panic gripped her as she realized her left side was numb. Falling like a rag doll, she hit the dirty floor dropping a bag of groceries and breaking a jar of spaghetti sauce she had picked up for dinner. Hearing breaking glass, Gabe raced into the hallway and found Tyra crumpled on the floor, unable to speak or move her left side. The next door neighbor peeked out into hallway and called 911 as Gabe carried Tyra into their apartment. Unfortunately for Tyra and her family, the hospital she was taken to did not have a primary stroke center so while they were able to save Tyra's life, they could not minimize the extent of damage caused by the stroke. After treatment in the intensive care unit, Tyra stayed in the hospital a few days before being discharged. Tyra was fortunate to have survived since each year twice as many women die from stroke than breast cancer. Yet, African Americans aged 20 to 44 years are 2.4 times as likely to have a stroke and twice as likely to die from a stroke than non-Hispanic whites (National Stroke Association 2008:1). Tyra lived, but suffered from severe stroke-related disabilities that forced her to quit her job and begin physical therapy in hopes of regaining her speech and improve movement of her left side. Her inadequate health insurance only covered a fraction of the cost of the needed physical therapy and provided no coverage for mental health needs. Family health, however, is more encompassing than physical illness and disability. While the physical trauma subsided, the psychological and social issues intensified as Tyra and her family struggled with the anxiety over the loss of income, adjustments to shifting household and parenting roles, Tyra's growing depression over her disability, plus trying to deal with the increasing stress of staggering medical bills.

All five determinants (see Figure 1.1) significantly impacted Tyra's family health and well-being. Consider Tyra's genetic predisposition to stroke and how that may have been impacted by her behavior patterns. Their daughters' asthma may have been influenced by inside (e.g., poor ventilation, secondhand smoke) and outside (e.g., air pollution) environmental exposures. Considering Tyra's and Gabe's family health histories of high blood pressure and stroke, they both should have had access to regular preventative health care, yet several social-cultural determinants (e.g., socioeconomic status, geographic location) served as barriers to the health care they needed. While this family had strengths, such as a loving relationship and some health coverage, the challenges posed by interactions among the five determinants negatively swayed the quality of this family's health and well-being. Chapters 2 to 6 will examine each of these five determinants with Chapter 4 focusing on the impacts of health disparities. Serving as a foundation for these later chapters, the following sections offer a glimpse at the status of family health in the United States

as well as a brief review of the theoretical foundation of this multidimensional, interactive process called family health. One of the first steps in understanding this dynamic process is measuring the health status of American families.

The Status of American Families' Health

Life expectancy and infant mortality are fundamental measures of health. In 2008, it was estimated that Americans experienced their highest life expectancy measure at 78.1 years. Yet, this increase lacked equity as sex and race disparity gaps grew with white females living over a decade longer than black males: white females (81 years), black females (76.9 years), white males (76 years), and black males (70 years) (National Center for Health Statistics 2008a:1). On a global scale, this increase in overall life expectancy (78.1 years) was still meager when compared with other developed nations. When compared with 30 most developed nations that comprise the Organization for Economic Co-operation and Development (OECD), American families fell near the bottom with 23 nations ranking higher in longer life expectancy at birth while 26 nations ranked lower in infant mortality rates (OECD 2007:3). The U.S. Census Bureau (2008) reports that even when compared to the larger world community of over 220 countries, 43 countries have a higher life expectancy and 41 countries have lower infant mortality rates than the United States. Table 1.1 presents data on infant mortality and life expectancy for 28 nations.

Specific causes of death and levels of chronic illness are additional measures of health. When compared with seven developed nations (i.e., Canada, France, Japan, Germany, Spain, Greece, and the United Kingdom), Americans had the highest mortality rates for ischemic heart disease;⁴ trachea, bronchitis, and lung cancer; and diabetes mellitus; as well as ranking higher than six of these seven nations in unintentional injuries, intentional injuries, and neuropsychiatric conditions⁵ (World Health Organization 2007). In the area of chronic disease, American families' health ratings likewise fell short when compared to 10 European countries. Americans experienced higher rates of heart disease, high blood pressure, high cholesterol, stroke, diabetes, chronic lung disease, arthritis, and cancer with the prevalence of obesity twice that seen in these European nations (Thorpe, Howard, and

⁴ Ischemia heart condition is when blood flow (i.e., oxygen) to the heart is restricted, also known as coronary heart disease [American Heart Association. 2008a. "Silent Ischemia and Ischemic Heart Disease." Retrieved March 9, 2008. (www.americanheart.org/presenter.jhtml?identifier=4720)].

⁵ Neuropsychiatry involves neurology and psychiatry and is commonly called *behavioral neurology*. A medical discipline focusing on dementia, epilepsy, head injury, attention deficit disorder, and so on. (Silver, Jonathan M. 2006. "Behavioral Neurology and Neuropsychiatry Is a Subspecialty." *Journal of Neuropsychiatry and Clinical Neurosciences* 18:146–148).

Table 1.1 Infant Mortality Rate and Life Expectancy for 28 Nations, 2009

Country	Infant Mortality Rate (Deaths per 1,000 Live Births)	Life Expectancy at Birth (Years)
Japan	3	82
Singapore	2	82
Hong Kong S.A.R.	3	82
France	3	81
Switzerland	4	81
Israel	4	81
Australia	5	82
Canada	5	81
Sweden	3	81
Iceland	3	81
New Zealand	5	80
Italy	6	80
Netherlands	5	79
Spain	4	80
Norway	4	80
Greece	5	80
Austria	4	79
Belgium	4	79
Germany	4	79
Finland	4	79
United Kingdom	5	79
South Korea	4	79
Ireland	5	78
United States	6	78
Mexico	18	76
Poland	7	76
China	20	73
Russia	11	66

Source: Adapted from the U.S. Census Bureau. 2009. "U.S. Census Bureau International Data Base (IDB)." Retrieved July 11, 2009. (www.census.gov/ipc/www/idb/informationGateway.php).

Galactionova 2007). When faced with such statistics, American families may become complacent rationalizing that the United States is more heterogeneous than countries such as Japan, Switzerland, or Iceland. Stark disparities in health status among American families certainly exist across gender, geographic, racial-ethnic, and socioeconomic status demographics (see Chapters 4 and 5). Yet, when the health status of only white Americans is compared with peers in other developed nations the results again find the health of American families falling short (Schroeder 2007). While some gains exist, for example, lower infant mortality rates, the nagging reality is that Americans spend more on health and health care than any other developed nation, yet experience lower measures of wellness. For example, the 2006 health care cost per capita in the United States was \$6,714 or more than twice the average (\$2,694) for the remaining 30 OECD nations (OECD 2008a:1). Alarming, American health spending is estimated to rise from approximately \$2.2 trillion in 2006 to over \$4 trillion by 2016 (Schoen et al. 2007a:ix). Ellen Nolte and Martin McKee (2008) raised additional alarm as the United States dropped further behind peer OECD nations in overall health care system performance. When compared with 17 countries (14 western European nations plus Canada, Australia, New Zealand, and Japan), on causes of deaths that occurred before 75 years of age that are considered “amenable”⁶ to health care, the United States’ ranking was unacceptably low. Between 1997 to 1998 and 2002 to 2003, a decrease in amenable mortality averaged 17 percent in all countries except the United States which had only a 4 percent reduction (Nolte and McKee 2008:59). Their findings suggest that if the American health care system had reduced its amenable death rate as the three top-performing nations, 101,000 fewer deaths would have occurred over this five-year period (2008:59).

These international comparisons reveal a gap between how much Americans spend and what they receive for their health care dollars that frustrates providers and consumers alike. Yet, American families have experienced some health improvements as reported by the United Health Foundation in their 18th annual report on the nation. These successes include reductions of infant mortality, infectious diseases (with the exception of sexually transmitted diseases among adolescents, see Chapter 4), prevalence of smoking, cardiovascular deaths, violent crime, children in poverty and occupational fatalities, plus increases in immunization coverage and prenatal care. These findings are welcome news. This same report includes other measures, however, that reflect a less positive side of American

⁶ Amenable deaths are those that systematic health care should have prevented, for example, “bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular diseases, and complications of surgical procedures.” (Nolte, Ellen and C. Martin McKee. 2008. “Measuring the Health of Nations: Updating an Earlier Analysis.” *Health Affairs* 27(1):58–71).

family health including a rapid increase in the prevalence of obesity, escalating rate of uninsured, increasing number of reported missed days of work due to poor mental or physical health (United Health Foundation 2007:1). The first two, increases in rates of obesity and uninsured (i.e., limited access to health care) emerge as highly detrimental to family health. Both issues are discussed more fully in Chapters 3, 4, and 6, but a brief review follows.

Overweight and Obese

In 2003 to 2004, approximately 67 percent of American adults (20 to 74 years of age) were overweight or obese⁷ with 32 to 34 percent overweight and another 34 to 33 percent obese (National Center for Health Statistics 2007:40). The prevalence of obesity also varies by sex, age, race, and ethnicity. For example, in 2001 to 2004 one-half of non-Hispanic black women were obese as compared to nearly one-third of non-Hispanic white women, while the prevalence of obesity in men, remained similar by race and ethnicity (2007:40). More alarming, however, are increasing rates of being overweight and obese among children (6 to 11 years of age) and adolescents (12 to 19 years of age). In 2001 to 2004, 17.5 percent of children (6 to 11 years of age) and 17.0 percent of adolescents (12 to 19 years of age) were overweight (2007:292). The condition of being overweight is common even among preschool children (two to five years of age) with a rate of 14 percent, double than what it was in 1988 to 1994 (2007:292). Table 1.2 offers a view of overweight among American children and adolescents by age, sex, race, ethnicity, and poverty level.

It is tempting to focus on one determinant domain, for example, behavioral patterns, when studying complex issues such as obesity of family members. To do so, however, skews our understanding of how best to intervene and work toward prevention since complex conditions involve many determinants with underlying disparities and inequalities. The incidence of obesity in families is shaped by the interconnections and interactions of all five determinants. For example, obesity, as most health conditions, often has a genetic predisposition that interacts with social determinants (e.g., education, socioeconomics) as well as environmental exposures, such as available food sources and physical activity options. These three determinants interact with behavioral patterns that family members engage in

⁷ Overweight and obese are determined by the measure of body mass index (BMI). For adults (20 to 74 years of age) overweight ≥ 25 but < 30 , obese ≥ 30 . For children, overweight is defined as BMI at or above the sex- and age-specific ninety-fifth percentile BMI cut points from the 2000 CDC growth charts [National Center for Health Statistics, 2008b. "Prevalence of Overweight among Children and Adolescents: United States, 1999–2002." p. 41. Retrieved May 3, 2008. (www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm)].

Table 1.2 Overweight Children and Adolescents by Age, Sex, Race, Ethnicity, and Poverty Level: United States, 1976–1980 to 2001–2004

Age, Sex, Race and Hispanic Origin, and Poverty Level	1976–1980	1988–1994	2001–2004
6–11 years of age			
Percentage of Population			
<i>Both sexes</i>	6.5	11.3	17.5
<i>Boys</i>	6.6	11.6	18.7
Non-Hispanic or Latino:			
Black or African American	6.8	12.3	17.2
White	6.1	10.7	16.9
Hispanic origin	13.3	17.51	25.6
<i>Girls</i>	6.4	11.0	16.4
Non-Hispanic or Latino:			
Black or African American	11.2	17.0	24.8
White	5.2	9.8	15.6
Hispanic origin	9.8	15.3	16.6
<i>Percentage of poverty level^a</i>			
Below 100%		11.4	20.0
100%–less than 200%		11.1	18.4
200% or more		11.1	15.4
12–19 years of age			
<i>Both sexes</i>	5.0	10.5	17.0
<i>Boys</i>	4.8	11.3	17.9
Non-Hispanic or Latino:			
Black or African American	6.1	10.7	17.7
White	3.8	11.6	17.9
Hispanic origin	7.7	14.1	20.0

Table 1.2 (continued)

Age, Sex, Race and Hispanic Origin, and Poverty Level	1976–1980	1988–1994	2001–2004
<i>Girls</i>	5.3	9.7	16.0
Non-Hispanic or Latino:			
Black or African American	10.7	16.3	23.8
White	4.6	8.9	14.6
Hispanic origin	8.8	13.4	17.1
<i>Percentage of poverty level^a</i>			
Below 100%		15.8	18.2
100%–less than 200%		11.2	17.0
200% or more		7.9	16.3

Source: Adapted from the U.S. Department of Health and Human Services. 2007. “Health, United States, 2007, Table 75.” p. 292. Retrieved March 13, 2008. (www.cdc.gov/nchs/data/hus/07.pdf).

^a2008 Poverty guidelines: Income per year for a family of one person = \$10,400, two persons = \$14,000, three persons = \$17,600, four persons = \$21,200 (higher levels in Alaska and Hawaii) as defined by the U.S. Department of Health and Human Services. 2008a. “The 2008 HHS Poverty Guidelines.” Retrieved August 3, 2008. (<http://aspe.hhs.gov/poverty/08Poverty.shtml>).

(e.g., choosing healthier foods) and do not engage in (e.g., daily physical activity). Finally, the political determinant of health care (policy and services) determines whether or not preventive measures are provided, and/or needed medical intervention and follow-up treatment occur.

Overweight and obesity, therefore, are not “just about eating too much,” but rather represent a complex condition that threatens health and health-related quality of life. Family members who are overweight or obese experience elevated risks of heart disease, diabetes, and some cancers, as well as conditions such as hypertension, arthritis, and other musculoskeletal problems. These diseases and conditions account for excess medical expenditures estimated at \$92.6 billion in 2002 dollars, plus even higher lifetime costs that go underreported (Finkelstein, Fiebelkorn, and Wang 2003:1). Chapters 2 through 5 explore possible family roles in addressing acute and chronic health concerns. The political determinant of access to equitable and quality health care is the other measure where the United States lags, which will be discussed in Chapter 6.

Access to Health Care

Schoen and her colleagues (2007b) surveyed approximately 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States about their health care systems. When compared to the other six countries, American adults had the highest incidence of foregoing needed medical care, as well as skipping required medications, because of cost. Such concerns over the affordability of health care might have spurred 34 percent of American respondents to state that their country's health care system required significant rebuilding, the highest percentage among the seven countries surveyed (Schoen et al. 2007b:1–2). Concerns fueling this call for improving delivery of American health care include issues of being uninsured and underinsured.

Uninsured and Underinsured

Increasingly, Americans are losing health care coverage in the workplace (that is “group health insurance”) and often are forced to go without insurance due to high cost of “non-group health insurance” coverage. The percentage of Americans under 65 years of age without health insurance increased from 15.3 percent (44.8 million) in 2005 to 15.8 percent in 2006, increasing the ranks of the uninsured to 47 million (U.S. Census Bureau 2007a:1). In mid-2008, the U.S. Census Bureau reported that 45.7 million Americans were uninsured, a decrease from the 47 million estimate. This new statistic reflected the 1.3 million children who were added to Medicaid and State Children's Health Insurance Program (SCHIP) coverage due to the efforts at the state level. Cathy Schoen and her colleagues argued that this 45.7 million statistic failed to capture the dramatic spike in unemployment and the subsequent loss of health care coverage, and according to their data approximately 42 percent or 75 million Americans were uninsured or underinsured in 2007 (Schoen et al. 2008a:w298).

The continued growth in the number of uninsured has reshaped the image of “what is important” in a job for families. In late 2007, when 1,200 fully employed American adults over 18 years of age were asked what is most vital in a job they listed the following (Center for State and Local Government Excellence 2007:3):

- Health insurance coverage was first at 84 percent
- Job security was next at 82 percent
- Retirement and pension were tied for third at 76 percent
- Flexible, family-friendly workplace was fifth at 71 percent
- Pay was 10th at 65 percent

Finding health insurance and job security ranked at the top of job desires is not surprising with a decreasing percentage of families covered by employment-based,

group health insurance, as well as the escalating out-of-pocket health costs even for those with group health insurance. In 2006, the percentage of families covered by group health insurance dropped to 59.7 percent, and the percentage of family members covered by government health programs decreased to 27.0 percent (DeNavas-Walt, Proctor, and Smith 2007:58). For those without group health insurance or government programs (e.g., Medicare and Medicaid) the only alternatives are “non-group” (individual) coverage or no coverage. Paul Jacobs and Gary Claxton (2008) argue that their analysis of non-group policies reveals two significant problems.

- Non-group policies may be unreliable in their payments for routine, necessary medical care and services.
- Non-group policies tend toward higher costs in monthly premiums, deductibles, and co-pays plus are under less regulation than group plans.

In fact, Jacobs and Claxton (2008:1) reported that cost for non-group policies vary significantly: “for example, over the 2006–2007 period, annual premiums for single coverage varied by age from \$1,163 to \$5,090, and between \$2,325 to \$9,201 for family coverage depending on the age and number of family members covered.”⁸ While affordability was a major factor in the decision to or not to purchase non-group health insurance, especially among lower income families, even among those at higher income levels most of those families eligible for non-group coverage did not purchase it (2008:7). Choosing not to purchase health insurance is a serious decision, yet the rationale for this action often is complex. In addition to high cost, other factors impact the decision not to purchase coverage, such as lower levels of financial literacy (e.g., confusion with insurance products, such as co-payments, deductibles, coverage limitations), as well as dissatisfaction with coverage adequacy. Insurers in many states may raise premiums or limit eligibility due to current health status or family health history (Jacobs and Claxton 2008:8). The issue of family health history and genetics information privacy and confidentiality are discussed in Chapter 2.

Mirroring this decreasing trust in health care coverage, in 2007, Gallup’s annual Health and Healthcare poll revealed that 73 percent of Americans thought that the health care system is “in a state of crisis” or “has major problems” with 72 percent describing health care as “only fair” or “poor” (Gallup 2007:1). Families are increasingly concerned not only if they have health coverage, but how adequate their policies are in terms of what is and is not covered and the cost of out-of-pocket health expenses.

⁸ America’s Health Insurance Plans. 2007. “Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums Availability, and Benefits.” Center for Policy and Research, December 2007. Retrieved January 3, 2008. (www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

Concerns over health care coverage negatively impact families' health-related quality of life and overall well-being. The Kaiser Health Security Watch monitors Americans' concerns related to their ability to access and pay for health care. In 2008, 43 percent of American families responded that they were "very worried" about their incomes not keeping up with rising health care costs, 56 percent were "very" or "somewhat" worried about the quality of health care getting worse and not being able to afford needed health care (55 percent) and prescription drugs (50 percent) (Brodie et al. 2008:1). More families felt the strain of health care costs both directly (e.g., out-of-pocket purchases of monthly premiums, medications, co-pays) and indirectly on family well-being. For example, an indirect strain is when higher health care costs result in lower increases in annual paychecks as employees pick up more of their health insurance coverage leaving less for other family needs as revealed with Tyra's family in Case 1.1. Between 2001 and 2007, employee's health insurance premiums rose 78 percent (Jacobs 2008:1). There also are health-related quality of life costs due to increased stress and strain related to families' concerns over whether they can afford needed medical services and rising out-of-pocket health expenses.

Historically, such health care worries are greater "for different demographic groups, with members of racial and ethnic minority groups, people with lower incomes, the uninsured, and women . . ." (Brodie et al. 2008:1), but as the gap between the haves and the have-nots continues to grow, so do family worries and emotional strains over health care. Poverty plays a crucial role in this trend, and while U.S. Census figures note that the overall poverty rate declined slightly (from 12.6 to 12.3 percent) between 2005 and 2006; this decline was largely concentrated among those over 65 years of age who are covered by the Medicare health plan. Growing frustration over health expenditures is spilling over into more middle-income families who are bearing an unfair burden of health costs that threaten to lower their standard of living. Eighty percent of the uninsured are native or naturalized U.S. citizens and 70 percent are from families with at least one full-time worker (National Coalition on Health Care 2007:1). Thus lower- and middle-income families are not only failing to share in economic gains enjoyed by higher-income groups, they are also struggling under the weight of health insurance coverage disparities, which are discussed more fully in Chapters 4 and 6. Karen Seccombe (2007) explains that poor and low-income families not only suffer greater risks of serious medical problems, but often delay or forgo needed treatment. Hispanic families were more likely than non-Hispanic white, non-Hispanic black, or non-Hispanic Asian families to be uninsured for at least part of a year. The percentage of uninsured Hispanics increased to 34.1 percent or 15.3 million in 2006, while the percentage of uninsured African Americans increased to 20.5 percent or 7.6 million

(DeNavas-Walt, Proctor, and Smith 2007:21). These rates did not improve in 2007 when over 30 percent of Hispanic and 15 percent of non-Hispanic black Americans were without health insurance coverage (Cohen, Martinez, and Free 2008:10).

The demographic of age also emerges in health insurance coverage disparity. The number of children under 18 years of age without health insurance increased to over nine million in 2007 (Children's Defense Fund 2008:1). The Medicare, Medicaid, and SCHIP Extension Act of 2007, passed in December 2007, extended federal funding for those already enrolled in SCHIP, but failed to meet the growing need for health care among poor children and neglected to improve enrollment policy for the six million children who were eligible for SCHIP, but not enrolled (2008:1).

A far less recognized health care access factor is the significantly high percentage of young adults between 18 and 34 years of age who are uninsured. Findings from the 2006 and 2007 National Health Interview Surveys reveal that the percentages of young adults who were uninsured at the time of the surveys were over 25 percent, with males more frequently being without health insurance coverage than females, see Table 1.3.

These findings also indicate “a total of 54.5 million (18.4 percent) individuals of all ages were uninsured for at least part of the year prior to the interview” with 31.1 million (11.9 percent) of people under 65 years of age being uninsured for over one year (Cohen, Martinez, and Free 2008:3–4). What this means for families is that access to affordable quality health care coverage remains a major concern, especially for young working adults. What these data do not explain as completely, however, is about the millions of family members who are inadequate or “underinsured” in terms of health care, see Chapter 6. In 2007, a study of 2,905 Americans between 18 and 64 years of age found that 29 percent of those with health insurance were underinsured since they had to postpone required medical care due to out-of-pocket costs not covered by their health plans. Forty-three percent of the insured stated that they were “completely” to “somewhat” unprepared to cope with a costly medical emergency (Consumer Reports 2007:1). Young adults aged 19 to 29 years represent one of the fastest growing and largest segments of uninsured and underinsured Americans (Kriss et al. 2008:1). Consider Trent's situation in Case 1.2.

Case 1.2 Trent: Uninsured Young Adults

When Trent graduated from college, he worried about his college debt, but ignored the warning from the college about losing his health insurance coverage after graduation. Typically, young adults lose their health care coverage as dependents under their parent or guardian on their 19th birthday, if they are not enrolled in a post-secondary school. Full-time students, such as Trent, are considered dependents and

Table 1.3 Percentage of Uninsured Individuals under 65 Years of Age, by Age and Sex, January–September, 2007

Age and Sex	Percentage Uninsured Jan.–Sept., 2007
Under 18 years	
Total	9.2
Female	9.2
Male	9.1
18–24 years	
Total	28.1
Female	25.1
Male	31.1
25–34 years	
Total	26.2
Female	21.5
Male	30.8
35–44 years	
Total	19.2
Female	17.1
Male	21.2
45–64 years	
Total	13.3
Female	12.4
Male	14.3

Source: Cohen, Robin A., Michael E. Martinez, and Heather L. Free. 2008. Adapted from the National Center for Health Statistics, “Health Insurance Coverage: Early Release of Estimates from the National Interview Survey, January–September 2007.” National Center for Health Statistics (Figure 4, p. 13). Retrieved March 10, 2008. (<http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200803.htm>).

continue to be covered until soon after graduation or age 23 when all coverage ends. Trent's first entry-level job did not provide group health insurance coverage and he could not afford an adequate health insurance plan without a high deductible of \$2,500⁹ plus a \$300 per month premium, which was a fourth of his monthly take-home pay. Trent, therefore, found himself in a situation experienced by many American young adults being forced to forgo health insurance coverage, simply hoping that he did not need medical care or hospitalization. Unfortunately, illness fails to impact only the insured. On his way home from work, Trent fell on icy stairs and suffered a compound fracture of his wrist. Without insurance he ended up in an emergency room as an 'uninsured' patient. A few weeks after the accident, the hospital bill arrived with the amount of \$2,775 for the emergency room, X-rays, and cast with future fees for follow up medical visits. Trent's parents dipped into their own savings to help him pay this bill. "Trent, you simply have to have health insurance. Let's look into buying a non-group, individual policy," they coaxed. The high cost of quality non-group health insurance, particularly plans with regular preventative care, included staggeringly high-deductibles¹⁰ along with monthly premiums that proved cost prohibitive. Sixty-three percent of non-group plans restrict benefits and have additional cost sharing that may prohibit families from accessing needed health services (Kaiser Family Foundation 2002:1). Trent was in the process of looking into purchasing health insurance when he noticed that his left testis was slightly swollen and lumpy. He thought that perhaps he had some kind of an infection or maybe a sexually transmitted disease, so he stopped in at a neighborhood sexual health clinic for what he thought would be a routine test. The physician examined Trent and told him he needed to see a specialist immediately. "Why, can't you just give me some antibiotic or something?" asked Trent. "Mr. Smith, this is not a sexually transmitted disease, you need to see an oncologist," said Dr. Isha. "Are you saying you think I have cancer?" Trent said as he bolted out of his chair. Dr. Isha stood and calmly told Trent, "We won't know until we run some tests, but your symptoms do warrant immediate treatment." "But I don't have health insurance. How am I going to pay for this?" Trent whispered as he dropped into the chair. "Look, the important thing is that you get treatment. Let's call your parents and get you to a specialist," the doctor added as he reached for the phone. Trent was fortunate that the oncologist was able to save his life, but Trent had to quit his job while focusing on treatment and recovery. The strain and

⁹ All costs are estimated based on actual insurance costs.

¹⁰ High-deductible health plans, also known as consumer-driven health plans, work if you stay healthy. They generally have annual deductibles of \$1,000 or more and monthly premiums that can be \$100 or more [Medical News Today. 2007. "Los Angeles Times Examines High-Deductible Health Plans." Retrieved January 3, 2008. (www.medicalnewstoday.com/articles/73091.php)].

worry only added to concerns over mounting medical bills that became a burden not only for Trent, but for his near-retirement-aged parents who were now financially responsible for their adult child.

Some may argue that it was Trent's responsibility to have health insurance. To some extent that is true, yet when Americans cannot afford health care coverage, the nation as a whole also bears significant responsibility. The other lesson of Case 1.2 is that even the "healthy" need to have coverage for illness because disease can and does strike without regard if one is or is not insured. While testicular cancer is rare, it is the most common form of cancer in young men between 15 and 34 years of age, who are most often uninsured.

While over 47 million uninsured hit numerous headlines in 2008, this number failed to reveal the full extent of health care coverage problem for families. Those who are underinsured have insurance and are not counted among the uninsured, but being underinsured hardly covers the real costs of health care. The federal government's inadequate response to the health insurance coverage needs of under and uninsured young adults, such as Trent in Case 1.2, in the first few years of the twenty-first century, spurred state legislatures¹¹ to take action. In the past few years, 17 states passed laws allowing young adults to stay on the family group policy longer. For example, Delaware, Indiana, and South Dakota requiring health plans cover young adults on their parents' or guardians' insurance until age 24, while in Colorado, Idaho, Maine, Maryland, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas, Washington, and West Virginia the age was set at 25 years, and in New Hampshire and Utah young adults are covered by their parent's policies until age 26. New Jersey set the coverage until their 30th birthday as long as they do not have dependents of their own. These state laws cover all young adults except in Idaho, Rhode Island, and South Dakota, where the laws apply only to full-time students (Commonwealth Fund Commission 2007:8). See Chapter 6 for further discussion of international, national, and state health care issues.

Family health has emerged as a fundamental issue in the early twenty-first century. Prior to the 1980s, traditional family social scientists hardly addressed the multidimensional nature of families in terms of their health and well-being. The following section offers an overview on the evolution of the dynamic concept of family health and well-being, and the role twenty-first century social scientists played in its development.

¹¹ For a complete listing of state legislative actions, see National Conference for State Legislatures. 2008. "Covering Young Adults through Their Parents' or Guardian's Health Policy." Retrieved February 20, 2008. (www.ncsl.org/programs/health/dependentstatus.htm).

Family Health Concept: From Insularism to Interdisciplinary

Family social scientists and practitioners in the twenty-first century not only need an understanding of global families (Karraker 2008), but also of “healthy families.” Prior to the 1980s, family social sciences appeared to ignore the biological dimension of families. Likewise, medical sciences only began to recognize the impact of outside determinants, such as family relationships, on individuals’ health in the later decades of the twentieth century. The early beginnings of a multidimensional, interactive view of family health emerged in the medical community.

Reconnecting Mind–Body–Spirit in Health Care

In Western culture, the impetus for introducing a multidimensional understanding of health began as early as the 1920s and 1930s with biomedical research on the interconnections of emotions and the neuroendocrine and immune systems.¹² While Eastern traditions always embraced mind–body–spirit connections in terms of health and well-being, Western science and philosophy forwarded the seventeenth century doctrine of universal mechanism.¹³ Whether out of fear of punishment from the Catholic Church¹⁴ or solely based on his personal beliefs, an influential seventeenth century philosopher, René Descartes, advanced the concept of separating the mind from the body in which the mind (e.g., thought and emotion) remained in the domain of the Church and the body (e.g., biology and physics) in that of science (Wozniak 1992). One significant result of this artificial severing was the current “biomedical model.” In the biomedical model,¹⁵ disease and illness are explained in biological terms eliminating psychological and social dimensions. Under this model, health was defined as the absence of disease. For conventional medicine, the biomedical model remains highly effective in diagnosing and treating disease, especially with the powerful determinant of genetics on health. Yet, the biomedical model is incomplete in studying chronic illness (e.g., cancer, heart conditions, diabetes, asthma) and

¹² For a historical review of emotions and disease interconnections see Brown, Theodore M. 2005. “Emotions and Disease in Historical Perspective.” Retrieved May 4, 2008. (www.nlm.nih.gov/hmd/emotions/historical.html).

¹³ The universal mechanical model reflected the view that nature could be defined and understood in terms of matter and motion (Cohen, Bernard I. 1985. *Revolution in Science*. Cambridge, MA: Harvard University Press). Hence, sciences such as biology and physics were to ignore intangibles including human emotion or thought or social context. This model is no longer accepted.

¹⁴ The Catholic Church burned the philosopher Giordano Bruno at the stake and forced Galileo to recant his theories simply for challenging Church dogma and power (Rowland, Ingrid D. 2008. *Giordano Bruno: Philosopher/Heretic*. Rome: Farrar, Straus and Giroux).

¹⁵ Traditionally, the biomedical model focused on physical processes (e.g., biochemistry, physiology, pathology) of diseases, while ignoring social, and/or psychological dimensions, such as social disparities, emotional embodiment, or health care with limited access, uneven quality, and inefficiency [Williams, Simon, Ellen Annandale, and Jonathan Tritter. 1998. “The Sociology of Health and Illness at the Turn of the Century: Back to the Future?” *Sociological Research Online* 3(4). Retrieved June 3, 2008. (www.socresonline.org.uk/3/4/1.html)].

the impacts of behaviors, social circumstances, and/or environmental exposures since it ignores psychological and sociological aspects of illness, health, and healing. A new model was needed and took form in the “biopsychosocial model.”

The Biopsychosocial Model and Beyond

Challenges to the biomedical model approach to health care continued into the twentieth century when scholars and health practitioners, such as Robert Ader and Nicholas Cohen (1975), George Engel (1977; 1980) and Aaron Antonovsky (1979), offered more inclusive approaches to health care. Ader and Cohen (1975) were among the earliest scientists to argue that emotions impact health and healing. They coined the term *psychoneuroimmunology* (i.e., the interactive relationship among an individual’s psychology, neurology, and immunology) to explain that a state of the mind (e.g., depression, anxiety) affects the immune system and thus predisposing an individual to risk factors. For example, while depression does not cause one to “catch a cold,” untreated depression can negatively affect the immune system thus increasing the risk of contracting a virus. This indirect impact of emotions on physical health also influences noninfectious, chronic illnesses, for example, cardiovascular disease, cancers, type 2 diabetes (Ader 2000). More recently, molecular neuroscientists support this “bi-directional communication” between our emotions and immune systems and have coined the term *neuroimmunomodulation*¹⁶ (i.e., communication between one’s nervous and immune systems) in support of the psychoneuroimmunology concept.

Engel (1977) boldly expressed a “need for a new medical model” that would include the impacts of psychological and sociological factors related to health and well-being. He proposed the “biopsychosocial model” that, as the name implies, recognizes that biological, psychological, and social factors interact and influence individuals’ health and resulting health care as illustrated in Figure 1.2.

The biopsychosocial model embraces the concept of health-related quality of life, and thus includes issues such as perceptions, socioeconomic factors, culture, and family relations. These issues directly influence health-promoting behaviors and treatments such as diet, exercise, medication taking, counseling, and so forth. For example, the biopsychosocial model not only requires gathering more information from patients and their families, but brings together integrated teams of professionals including physicians, nurses, psychiatrists, family therapists, family

¹⁶ For more information on neuroimmunomodulation, see International Society for NeuroImmuno-Modulation. 2008. “What is the International Society for NeuroImmunoModulation (ISNIM)?” Retrieved July 2, 2007. (www.isnim.org); and Greer, Steven. 2000. “What’s in a Name: Neuroimmunomodulation or Psychoneuroimmunology?” *Annals of the New York Academy of Sciences* 917:568–574.

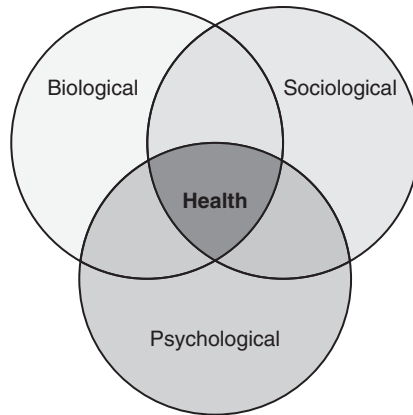


Figure 1.2 Biopsychosocial Model

sociologists, social workers, family educators, and other health-related disciplines. Psychosocial factors play especially pivotal roles in illnesses and disorders that involve behavioral choices and treatments. When treating a young adult with type 2 diabetes, for example, it is beneficial to include the individual's family in discussions regarding treatment, health behaviors, attitudes, family communication and support, nutritional knowledge, and regular physical activity, in addition to treating the biological needs related to hypertension and high blood sugar. Doing so helps to educate the family about the condition as well as clarifies how best to support the ill family member and encourage creation of a healthful environment in terms of diet, activity, and adhering to medical appointments and medication regimens.

Antonovsky (1979) also contributed to the biopsychosocial approach by encouraging the medical field to shift its focus from the typical pathogenic orientation (i.e., focus on causes of disease) toward a salutogenic approach (i.e., focus on causes of health). At the core of this philosophical approach is what Antonovsky (1994) termed a “sense of coherence,” an approach to living that embodies three interrelated components of (1) comprehensibility—a cognitive ability to understand and keep events in perspective thus giving a sense of control; (2) manageability—a belief that the individual and or family has the resources (e.g., health insurance) to cope successfully; and (3) meaningfulness—an ability to find meaning from situations and the demands they create plus learn from the experiences, such as reinterpreting problems as challenges (Grochowski 2006a:65–66). This approach to living helps foster an emphasis on

prevention by encouraging individuals and their families to engage in healthful behaviors as discussed in Chapter 3, such as reducing consumption of soft drinks, cessation of smoking, exercising more, using positive communication styles, obtaining recommended vaccinations, and seeking professional help for emotional concerns.

Along with a more inclusive multidimensional definition of health, the biopsychosocial model presented a new “whole person” approach to health care and helped foster the emergence of “integrative medicine,” which combines high-quality evidence-based conventional and complementary¹⁷ medicines (Grochowski 2006b; Kam 2007). Francesc Borrell-Carrió and her colleagues argue that this interdisciplinary nature of the biopsychosocial model, therefore, demands collaboration among patients, their families, family science scholars, practitioners, and health care providers (2004:582):

[The] biopsychosocial model was a call to change our way of understanding the patient and to expand the domain of medical knowledge to address the needs of each patient. It is perhaps the transformation of the way illness, suffering, and healing are viewed that may be Engel’s most durable contribution.

In conjunction with this transformation in patient–medical care “partnerships” and collaborative relationships between physical and social sciences, is a keen emphasis on the vital roles and influences of families on the health and well-being of their members, which emerges as a paramount area for family scientists. Kathleen Ell and Helen Northen (1990) argued that the theoretical underpinning of the biopsychosocial model, which sparked family-focused medical care and health promotion efforts, reflects a general systems paradigm.

General Systems and Related Family Health Theories

The general systems theory was originally proposed by biologist Ludwig von Bertalanffy (1968) who noted the nonlinearity of the interactions of a system’s components. Springing from this early work, “systems theory” was adapted throughout biological and social sciences. This paradigm resulted in shifts away from mechanistic to holographic views, from direct cause–effect to mutual causality, from hierarchically ordered to interactive influences, and toward seeing problems as complex, diverse challenges. Within the systems paradigm exists an

¹⁷ Complementary or alternative care approaches include acupressure, acupuncture, massage, chiropractic, herbal therapies, homeopathy, yoga, meditation, and so forth.

ecological approach that recognizes the importance of a multidimensional environmental context in which individuals and their families adapt to changes (stressors). According to Janet Grochowski (1997; 2000), families appear to have significant resilience potential when responding to stressors as “strategic living communities©,” that is families positively adapting to change from a strength-centered perspective bolstered by encouragement and support from outside communities. The social-ecological approach found in population (public) health is an example in which complex conditions, such as chronic diseases, are approached from a context of multiple determinants (e.g., Family Health Determinants Model, Figure 1.1). Likewise, the influence of systems theory and thinking on family theory is evident.

During the 1980s and early 1990s the field of family social science bloomed. This period witnessed the beginning of medical science inviting family science professions into clinic settings as well as the start of the National Council of Family Relations in 1984 and the *Family Relations: Interdisciplinary Journal of Applied Family Studies*, with a special issue “The Family and Health Care” (Doherty and McCubbin 1985). “Family systems theory” played a major role during this early period. In family systems theory, families are viewed as entities or systems with subsystems (family members) who are seeking to find and/or to maintain balance or harmony. Studying how families strive to find balance serves as a helpful tool in understanding the complexity of family health. For example, family therapy expanded the use of family systems theory as a means to better understand patterns and boundaries of family life.

Knowledge is built on the foundation laid by the efforts of earlier scholars and practitioners. The pioneering work of social scientists, such as Rubin Hill’s (1949) research on families under stress (i.e., ABCX model), M. Sussman’s (1976) studies on the family lives of elders, T. J. Litman’s (1974) landmark article naming the family unit as crucial in medical care plus his research revealing the economics of family health (1976), and Lois Pratt’s (1976) engaging work on family health factors that “energize” families, led the field to focus on the interactive impacts of families and health.

“Family stress and coping theory” examines how families respond to stressors (changes) and factors that enhance and hinder healthful coping. How families perceive the stressors is vital to determining their response and coping strategies that impact how a family adjusts, adapts, or goes into a family crisis (McCubbin and Patterson 1983; Boss 1988). Family stress response, therefore, impacts the overall family’s health promotion and health maintenance efforts (i.e., “health work” as discussed in Chapter 3).

The following parsimonious multidisciplinary listing offers foundational efforts in the field:

- William Doherty and Macaran Baird's (1987) focus on a need for family-centered medical care;
- William Doherty and Thomas Campbell's (1988) work on families during illness;
- Norman Garnezy (1981) and Joseph Matarazzo's (1982) examination of the psychosocial impacts of stress on adolescence;
- Göran Dahlgren and Margaret Whitehead's (1991) proposal for greater emphasis on health equity;
- Michael Rutter's (1987) focus on psychosocial resilience in families;
- Marilyn McCubbin's (1989) and John Rolland's (2003; 2004; 2005) works on families with chronically ill children;
- John Rolland and Janet Williams's (2005) incorporation of a biopsychosocial approach in the advanced medical world of genetics; and
- The efforts of Catherine Gilliss (1989), Perri Bomar (1996; 2004), Marion Broome, et al. (1998), and Bonnie Benard (1991) to engage families in healthful behaviors and enhance family resilience.

While family theories, such as family systems, are valuable in studying and understanding various family health concerns, there remains an underlying reality that theories are tools, not absolutes. Kerry Daly argues that there is “a significant disjunction between the way families live their lives and the way we theorize about families” (2003:771). It is important to remember that while the everyday realities of families (i.e., emotions, attitudes, perceptions, myths, spirituality) are crucial in studying family health and current family theory, these realities alone do not provide for complete understanding of the complexity of family health.

During the early twenty-first century, interest in families and their health expanded rapidly among practitioners and researchers from numerous disciplines and professions. This growth began with increasing recognition of family health as a dynamic process composed of multiple dimensions and impacted by five determinant domains that interact and change over time. Understanding the interactions of these five determinants demands strong collaboration among social and biological sciences. For example, completion of the human genome opened a new era in understanding, treating, and in time, preventing some negative health conditions. Yet, these biological discoveries cry out for social and psychological contributions as families and medical communities learn how to best use this genetic information, see Chapter 2. The complexity of family health demands interdisciplinary approaches, therefore, scholars and clinicians from physical and social sciences

need to work collaboratively with families for all health issues whether at local (see Chapters 2, 3, and 4), national (see Chapter 6) or global (see Chapter 5) levels. The process of family health weaves our biological, behavioral, social, environmental, and political determinants into a dynamic reality that demands collaboration, caring, and commitment from all of us.

Conclusion and Book Organization

Families and Health offers a unique approach that may prove valuable to family health scholars and practitioners in their efforts to better understand and assist twenty-first-century families. Family health is not a static state merely measured by the health status of its individual members, but rather a complex process that includes multiple dimensions responding to the dynamic determinants of biology (genetics), behavioral patterns, social-cultural circumstances, environmental exposures, and health care policies and services. *Families and Health* does not purport to review all the literature on family health care,¹⁸ nor exhaust the theories related to promoting health in families.¹⁹ What *Families and Health* provides, however, is an innovative model that adds depth and functionality to the study of families and their health and well-being.

Families, as well as scholars and clinicians, not only need to understand the impacts of these interacting determinants, but become responsive and proactive in the enhancement, maintenance, and promotion of family health. The concept of “family health promotion” adds an inclusive dimension to the field of family health. Perri Bomar explains that “[f]amily health promotion is the process of achieving family well-being in the biological, emotional, physical, and spiritual realms for individual members and the family unit” (1996:11). Prevention and reducing the risk of disease and illness go hand in hand with promoting healthful living. Families need to engage in “health work” a term coined by Moyra Allen (Allen and Warner 2002) to label the process families use in maintaining or attaining family health and well-being. Emphasizing family health promotion and assisting families in learning their unique health work required to enhance and maintain desired levels of family health are indeed focal points in the twenty-first century for medical and social science professionals. The Family Health Determinants Model

¹⁸ See medical resources, for example, American Medical Association. 2004. *American Medical Association Family Medical Guide*. New York: Random House; Harvard Medical School. 2004. *Harvard Medical School Family Health Guide*. New York: Free Press; Johns Hopkins. 1999. *Johns Hopkins Family Health Book*. New York: HarperCollins; and Mayo Clinic. 2003. *Mayo Clinic Family Health Book*. New York: William Morrow; plus Web sites, for example, Mayo Clinic. (www.mayoclinic.com); National Institute of Health. (www.nlm.nih.gov); and Harvard Medical School. (www.health.harvard.edu).

¹⁹ See Bomar, Perri J. 2004. *Promoting Health in Families: Applying Family Research and Theory to Nursing Practice*. Philadelphia, PA: Saunders.

presented in *Families and Health* reflects this proactive approach to family health, plus the model also serves as an organizational tool for the remaining five chapters. While each chapter focuses on a specific determinant domain, the vital element of interaction among determinants remains the primary focus throughout the body of each chapter.

Chapter 2, *Biology and Family Health: Beyond Genomics*, explores the powerful determinant of genes on health and the vital nature of family health histories. Issues of confidentiality and protection from misuse of genetic data also surface as critical issues for families. The chapter discusses the impact of chronic illnesses, such as breast cancer and Alzheimer's Disease, on families and how members cope with caring for loved ones with declining health. Family health includes life transitions from birth to death. This chapter concludes with a section on hospice and palliative care in aiding families as they live with those who are dying.

Chapter 3, *Behavior Patterns: Families' Health Choices*, explores the multifaceted aspects of families' health behavior patterns. Chronic illnesses (e.g., cardiovascular disease, cancer, diabetes) not only drive up the cost of health care, but also lower the quality of life for patients and their families. A significant percentage of chronic disease can be reduced or prevented through engaging in healthful behavior patterns. While many families understand it is important to engage in healthful behaviors, such as getting vaccinated, stop smoking, healthier eating, and regular physical activity, they often do not choose such behaviors. This chapter includes discussion on behavior and family systems theories in order to aid in understanding more effective intervention and prevention strategies to engage families in healthful behavior patterns. Accessing, evaluating, and using health information and support through online strategies holds great promise and challenge as the budding science of "consumer health informatics" aims to enhance patient-physician partnerships in treatment and prevention of illnesses. Three timely family health concerns, nonimmunization of children, women's cardiovascular risks, and higher overweight and obesity rates in youths, serve as examples of the significant impact of families' health behaviors. A primary theme of this chapter is family "health work" as it applies to the choices and actions that families need to engage in and the support they may need in order to pursue more healthful behavior patterns.

Chapter 4, *Social Determinants and Family Health*, presents the complex determinant of social-cultural circumstances. This chapter discusses the often graded relationship between social position and health status that impacts all families within a social hierarchy with some segments of the population experiencing health disparities in terms of higher prevalence of diseases that result in greater health care needs (Thomas 2003). Health disparities are disproportionate risks or

burdens of disease, illness, disability, and death that befall specific groups of a population along racial-ethnic, gender, socioeconomic status, education, geographic location, disability, and/or sexual orientation demographics. Examples of health conditions where health disparities in prevalence and severity exist include infant mortality, cardiovascular disease, diabetes, cancer, HIV infection/AIDS, undervaccination, and mental illness (e.g., anxiety and depression). Chapter 4 also discusses the troubling discrimination and stigmatization of certain health conditions, such as HIV/AIDS and mental illness. Mental health is indispensable to the individual well-being, interpersonal relationships (e.g., family and friends), and full participation in one's community. The passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was a major step in working toward parity of mental illness in terms of respect, treatment, and support. Case studies presented in this chapter examine health disparities in one community, underscore the pivotal roles families play in fostering mental health and securing treatment for mental illness, and explore the need for accurate health information and education for all aspects of family health (e.g., sexuality education). Comprehensive and culturally sensitive health education along with effective communication strategies aid families in achieving their role as "partners" with the medical community in a quest for better family health.

Chapter 5, *Environmental Exposures and Global Family Health*, offers a more global view of family health. Human actions (e.g., war, genocide, violence, stigmatization and discrimination, waste, pollution, destruction of natural resources, overuse of pediatric antibiotics, stressful work atmospheres) and inactions (e.g., inadequate allocation of resources, limited access to health care, and ineffective responses to epidemics and pandemics, or ignoring work–family conflicts) result in devastating global health conditions. Such negative actions or inactions foster an array of unhealthy environmental exposures including family displacement, urban crowding, poverty, rapid spread of infectious diseases, climate change (e.g., increased frequency of draughts, floods, storms), rise in the prevalence of asthma, and/or unhealthy psychosocial worksites that tear at the fabric of families and threaten families' collective health and well-being. This chapter, therefore, discusses how unhealthy environmental exposures not only play a role in increased risks of acute diseases (e.g., malaria, HIV/AIDS), but also directly and indirectly influence the prevalence and severity of chronic illnesses (e.g., cardiovascular disease, asthma). The safety, equity, and psychosocial environment of worksites are included in this chapter since work–family and family–work conflicts greatly impact the health of families throughout the world.

Chapter 6, *Health Care and Families*, examines concerns over the access, equity, quality, and efficiency of American health care as compared to that in other

developed nations. The health care in the United States is ailing not only in terms of high costs resulting in increasing numbers of uninsured, underinsured, and those families seeking medical treatment abroad (i.e., medical tourism), but also in terms of inadequate quality and efficiency in delivery of health services. This chapter argues for health care reform and redesign that focuses on primary care and creating “patient-centered medical homes” that promise more effective care through universal use of health information technology (e.g., electronic medical records), better coordination, higher levels of safety, focus on patient–provider collaborations and interdisciplinary cooperation (e.g., integrative medicine), plus greater availability of care when needed, that is, timeliness. The field of “biomedical and health informatics” also plays a crucial role in the redesign and delivery of health care. Health care is a vital determinant of family health. Several health care reform proposals, for example, “Massachusetts Health Insurance,” “Building Blocks,” and the “President Obama” administration plans, are discussed, as the promise of authentic health care reform ignites American families. Meaningful improvement of health care in the United States, therefore, requires that health care is affordable and equitable for all citizens, is delivered with high quality and efficiency, has increased accountability and leadership among providers, and focuses on enhancing meaningful responsible partnerships between providers, patients, and their families.

Critical Thinking Questions

1. Choose a health condition that you are most interested in. Explain how each of the five health determinants, as outlined in the Family Health Determinants Model (Figure 1.1), can positively and negatively impact this condition and family health.
2. Assume you are charged with contacting university seniors about health insurance coverage after graduation. How would you prepare for this assignment? Outline four or five talking points of what you would convey to these seniors to be most convincing. Try this out on a small group of friends and record their responses to this presentation.
3. Explain the concept of *interdisciplinary* to your classmates. For example, outline or draw what an interdisciplinary approach to studying cancer, diabetes, or heart disease might look like.