PART 1

HEALTH SOCIOLOGY AND THE SOCIAL MODEL OF HEALTH

> *The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.*
>
> BENJAMIN DISRAELI

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At the heart of health sociology is a belief that many health problems have social origins. The focus of health sociology is not on medical treatment or individual cures for ill-health. While individuals suffer ill-health and require health care, some of the causes and cures can often lie in the social context in which they live and work. Health sociology asks you to step outside the square and look beyond medical opinions by adopting a second opinion, which focuses on how health, illness, and the health care system are by-products of the way a society is organised.

This introductory part of the book provides an overview of health sociology: what it is, its major theoretical perspectives, and the types of health research it draws upon.

Part 1 consists of three chapters:

CHAPTER 1: Imagining Health Problems as Social Issues

CHAPTER 2: Theorising Health: Major Theoretical Perspectives in Health Sociology

CHAPTER 3: Well-being and Wellness

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01 IMAGINING HEALTH PROBLEMS AS SOCIAL ISSUES

John Germov

Overview

- What is sociology and how can it be used to understand health and illness?
- What social patterns of health and illness exist?
- What is the social model of health and how does it differ from the medical model?

THE FOREST THROUGH THE TREES

We live in a health-obsessed age. We are bombarded with messages from health authorities, health professionals, and fitness gurus to 'do this' and 'not to do that'. Everywhere we turn we are urged to take individual responsibility for our health. Our personal experience of illness means that we tend to view it in an individualistic way—as a product of bad luck, poor lifestyle, or genetic fate. As individuals we all want quick and effective cures when we are unwell and thus we turn to medicine. Yet this is only part of the story. Even the highly individualised and very personal act of suicide occurs within a social context. For example, Australian men have a suicide rate over triple that of women (AIHW 2012). In fact, the social patterning of suicide was first highlighted in the late nineteenth century by the sociologist Émile Durkheim (1858–1917). While Durkheim (1897/1951) acknowledged individual reasons for a person committing suicide, he found that suicide rates varied between countries and between different social groups within a country. By studying such social patterns, health sociology exposes the 'forest through the trees'—how individual health problems can be part of a social patterning of illness that has social origins and requires social solutions.

Key terms

agency
biological determinism
biomedicine/biomedical model
Cartesian dualism
class (or social class)
epidemiology/social epidemiology
eugenics
lifestyle choices/factors
new public health
public health/public health infrastructure
reductionism
social construction/constructionism
social Darwinism
social institutions
social model of health
social structure
sociological imagination
state
structure–agency debate
victim-blaming

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Introduction: the social origins of health and illness

This chapter introduces you to the sociological perspective and how it can be used to understand a wide range of health issues. Health sociology focuses on the social patterns of health and illness—such as the different health statuses between women and men, the poor and the wealthy, or the Indigenous and non-Indigenous populations—and seeks social rather than biological or psychological explanations. It provides a second opinion to the conventional medical view of illness derived from biological and psychological explanations, by exploring the social origins of health and illness—the living and working conditions that fundamentally shape why some groups of people get sicker and die sooner than others.

The social origins of health and illness can clearly be seen when we compare the life expectancy figures of various countries. As we all know, life expectancy in the least developed countries is significantly lower than that in industrially developed and comparatively wealthy countries such as Australia, Sweden, Germany, and Japan. For example, the average life expectancy at birth of people living in the least developed countries of the world is around 20 years less than that for developed countries such as Australia, which has an average life expectancy of 82 years (AIHW 2012; UNDP 2013). As Table 1.1 shows, though, life expectancy varies among developed countries as well. Therefore, the living conditions of the country in which you live can have a significant influence on your chances of enjoying a long and healthy life.

Australian life expectancy is one of the highest in the world, second only to Japan. This is not due to any biological advantage in the Australian gene pool, but is rather a reflection of our distinctive living and working conditions. We can make such a case for two basic reasons. First, life expectancy can change in a short period of time, and in fact it did increase for most countries during the twentieth century. For example, Australian life expectancy has increased by more than 25 years since 1910 (AIHW 2012), which is too short a time frame for any genetic improvement to occur in a given population. Second, data compiled over decades of immigration show that the health of migrants comes to reflect that of their host country over time, rather than their country of origin. The longer migrants live in their new country, the more their health mirrors that of the local population (Marmot 1999).

While the average Australian life expectancy figure is comparatively high, it is important to distinguish between different social groups within Australia. Life expectancy figures are crude indicators of population health and actually mask significant health inequalities among social groups within a country. For example, in Australia those in the lowest socio-economic group have the highest rates of illness and premature death, use preventive services less, and have higher rates of illness-related behaviours such as smoking (AIHW 2012). Furthermore, as Table 1.1 shows, life expectancy for Indigenous Australians is around 12 years less than the national average. In fact, the current life expectancy of Indigenous Australians is closer to that of Australians born in the early twentieth century (AIHW 2012). The indigenous population of New Zealand, the Māori, also have a lower life expectancy—around 7.3 years less than the national average (Statistics New Zealand 2013).

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TABLE 1.1 LIFE EXPECTANCY AT BIRTH, 2010

COUNTRY	LIFE EXPECTANCY	
	Men	*Women*
Australia	79.5	84.0
Indigenous Australians (2005–07)	67.0	73.0
Canada (2008)	78.5	82.7
France	78.0	84.7
Germany	78.0	83.0
Italy (2009)	79.4	83.8
Japan	79.6	86.4
New Zealand (2010–12)	79.3	83.0
Maori (2010–12)	72.8	76.5
Russian Federation	63.0	74.9
Sweden	79.5	83.5
UK	78.6	82.6
US	76.2	81.1

Source: Adapted from OECD 2013; AIHW 2010; Statistics New Zealand 2013

Introducing the sociological imagination: a template for doing sociological analysis

What is distinctive about the sociological perspective? In what ways does it uncover the social structure that we often take for granted? How is sociological analysis done? The American sociologist Charles Wright Mills (1916–62) answered such questions by using the expression **sociological imagination** to describe the distinctive feature of the sociological perspective. The sociological imagination is 'a quality of mind that seems most dramatically to promise an understanding of the intimate realities of ourselves in connection with larger social realities' (Mills 1959, p. 15). According to Mills, the essential aspect of thinking sociologically, or seeing the world through a sociological imagination, is making a link between 'private troubles' and 'public issues'.

SOCIOLOGICAL IMAGINATION
A term coined by Charles Wright Mills to describe the sociological approach to analysing issues. We see the world through a sociological imagination, or think sociologically, when we make a link between personal troubles and public issues.

As individuals, we may experience personal troubles without realising they are shared by other people as well. If certain problems are shared by groups of people, they may have a common cause and be best dealt with through collective action. As Mills (1959, p. 226) states, 'many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues … public issues must be revealed by relating them to personal troubles'. The Australian sociologist Evan Willis (1993; 2011) suggests that the sociological imagination consists of four interrelated parts:

1 *historical factors*: how the past influences the present;
2 *cultural factors*: how culture impacts on our lives;
3 *structural factors*: how particular forms of social organisation affect our lives;
4 *critical factors*: how we can improve our social environment.

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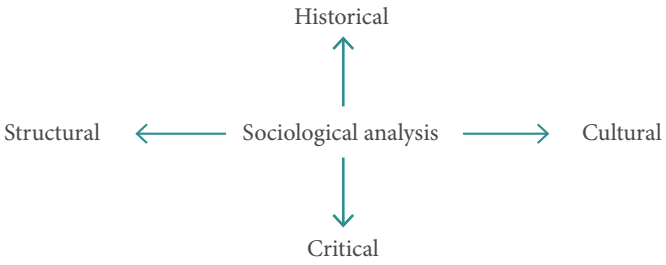
This four-part sociological imagination template is an effective way to understand how to think and analyse in a sociological way.

Figure 1.1 represents the sociological imagination template as a diagram that is easy to remember. Any time you want to analyse a topic sociologically, picture this diagram in your mind.

FIGURE 1.1 THE SOCIOLOGICAL IMAGINATION TEMPLATE



Sociological analysis involves applying these four aspects to the issues or problems under investigation. For example, a sociological analysis of why manual labourers have a shorter life expectancy would examine how and why the work done by manual labourers affects their health, by examining:

1. *historical factors*: to understand why manual workplaces are so dangerous;
2. *cultural factors*: such as the cultural value of individual responsibility;
3. *structural factors*: such as the way work is organised, the role of managerial authority, the rights of workers, and the role of the state;
4. *critical factors*: such as alternatives to the status quo (increasing the effectiveness of occupational health and safety legislation, for instance).

By using the four parts of the sociological imagination template, you begin to 'do' sociological analysis. It is worth highlighting at this point that the template simplifies the process of sociological analysis. When analysing particular topics, it is more than likely that you will find that the parts overlap, making them less clear-cut than the template implies. It is also probable that for some topics, parts of the template will be more relevant and prominent than others—this is all to be expected. The benefit of the template is that it serves as a reminder of the sorts of issues and questions a budding sociologist should be asking.

IS SOCIETY TO BLAME? INTRODUCING THE STRUCTURE–AGENCY DEBATE

As individuals we are brought up to believe that we control our own destiny, especially our health. It is simply up to each individual to 'do what they wanna do and be what they wanna be'. This belief ignores the considerable influence of society. Sociology makes us aware that we are social animals and are very much the product of our environment, from the way we dress to the way we interact with one another. We are all influenced by the **social structure**, such as our cultural customs and our **social institutions**. The idea of social structure serves to remind us of the social or human-created aspects of life, in contrast to purely random events or products of nature (López & Scott 2000).

SOCIAL STRUCTURE
The recurring patterns of social interaction through which people are related to each other, such as social institutions and social groups.

SOCIAL INSTITUTIONS
Formal structures within society—such as health care, government, education, religion, and the media—that are organised to address identified social needs.

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Understanding the structure of society enables us to examine the social influences on our personal behaviour and our interactions with others. Yet to what extent are we products of society? How much **agency** do we have over our lives? Are we solely responsible for our actions or is society to blame? These questions represent a key debate in sociology, often referred to as the **structure–agency debate**. There is no simple resolution to this debate, but it is helpful to view structure and agency as interdependent; that is, that humans shape and are simultaneously shaped by society. In this sense, structure and agency are not 'either/or' propositions in the form of a choice between constraint and freedom, but are part of the interdependent processes of social life. Therefore, the social structure should not automatically be viewed in a negative way, as only serving to constrain human freedom, since in many ways the social structure enables us to live, by providing health care, welfare, education, and work. As Mills maintained, an individual 'contributes, however minutely, to the shaping of this society and to the course of its history, even as he is made by society and by its historical push and shove' (1959, p. 6). Mills was clearly a product of the 'historical push and shove' of his social structure, as he uses the masculine 'he' to refer to both men and women—a usage now seen as dated and sexist.

AGENCY
The ability of people, individually and collectively, to influence their own lives and the society in which they live.

STRUCTURE–AGENCY DEBATE
A key debate in sociology over the extent to which human behaviour is determined by social structure.

Peter Berger long ago warned against depicting people as 'puppets jumping about on the ends of their invisible strings' (1966, p. 140). If we use the 'all the world's a stage and we are mere actors' analogy, we could liken life to a theatre in which we all play our assigned roles (father, mother, child, labourer, teacher, student, and so on). Whether it is how we are dressed as we walk down the street or how we present ourselves at a funeral, customs and traditions dictate expected modes of behaviour. In this sense we are all actors on a stage. Yet, we have the scope consciously to participate in what we do. We can make choices about whether simply to act, or whether to modify or change our roles and even the stage on which we live our lives.

Although we are born into a world not of our making, and in countless ways our actions and thoughts are shaped by our social environment, we are not simply 'puppets on strings'. Humans are sentient beings—we are self-aware and thus have the capacity to think and act individually and collectively to change the society into which we are born. Structure and agency may be in tension, but they are interdependent; that is, one cannot exist without the other. Sociology is the study of the relationship between the individual and society; it examines how human behaviour both shapes and is shaped by society, or how 'we create society at the same time as we are created by it' (Giddens 1986, p. 11).

Social medicine and public health

Recognition of the social origins of health and illness actually occurred prior to the formal development of sociology as an academic discipline, and can be traced to the mid-nineteenth century, with the development of 'social medicine' (coined by Jules Guérin in 1848) or what more commonly became known as **public health** (sometimes referred to as social health, community medicine, or preventive medicine). At this time, infectious diseases such as cholera, typhus, smallpox, diphtheria, and tuberculosis were major killers for which there were no cures and little understanding of how they were transmitted. During the nineteenth century, a number of people such as René Villermé (1782–1863), Rudolph Virchow (1821–1902), John Snow (1813–58), Edwin Chadwick (1800–90), and Friedrich Engels (1820–95) established clear links between infectious diseases and poverty (Rosen 1972; Porter 1997).

PUBLIC HEALTH/ PUBLIC HEALTH INFRASTRUCTURE
Public policies and infrastructure to prevent the onset and transmission of disease among the population, with a particular focus on sanitation and hygiene such as clean air, water and food, and immunisation. Public health infrastructure refers specifically to the buildings, installations, and equipment necessary to ensure healthy living conditions for the population.

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Engels, Karl Marx's collaborator and patron, made a strong case for the links between disease and poor living and working conditions as an outcome of capitalist exploitation in *The Condition of the Working Class in England* (1845/1958). He used the case of 'black lung', a preventable lung disease among miners, to make the point that:

> the illness does not occur in those mines which are adequately ventilated. Many examples could be given of miners who moved from well-ventilated to badly ventilated mines and caught the disease. It is solely due to the colliery owners' greed for profit that this illness exists at all. If the coalowners would pay to have ventilation shafts installed the problem would not exist. (1845/1958, p. 281)

CLASS (OR SOCIAL CLASS)
A position in a system of structured inequality based on the unequal distribution of power, wealth, income, and status. People who share a class position typically share similar **life chances**.

Engels also noted the differences in the death rates between labourers and professionals, claiming that the squalid living conditions of the working **class** were primarily responsible for the disparity, stating that 'filth and stagnant pools in the working class quarters of the great cities have the most deleterious effects upon the health of the inhabitants' (1845/1958, p. 110).

In 1854, a cholera epidemic took place in Soho, London. John Snow, a medical doctor, documented cases on a city map and investigated all of the 93 deaths that had occurred within a well-defined geographical area. After interviewing residents he was able to establish that people infected with cholera had sourced their water from the same public water pump in Broad Street. Snow came to the conclusion that the water from the pump was the source of cholera, and at his insistence, the pump's handle was removed and the epidemic ceased (Snow 1855/1936; Rosen 1972; Porter 1997; McLeod 2000). This case is famous for being one of the earliest examples of the use of **epidemiology** to understand and prevent the spread of disease.

EPIDEMIOLOGY/ SOCIAL EPIDEMIOLOGY
The statistical study of patterns of disease in the population. Originally focused on epidemics, or infectious diseases, it now covers non-infectious conditions such as stroke and cancer. Social epidemiology is a sub-field aligned with sociology that focuses on the social determinants of illness.

Virchow, often remembered in medical circles for his study of cellular biology, also made a clear case for the social basis of medicine, highlighting its preventive role when he claimed:

> Medicine is a social science, and politics nothing but medicine on a grand scale … if medicine is really to accomplish its great task, it must intervene in political and social life … The improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result even more rapidly and successfully. (cited in Rosen 1972, p. 39 and Porter 1997, p. 415)

Virchow was a significant advocate for public health care and argued that the **state** should act to redistribute social resources, particularly to improve access to adequate nutrition. Therefore, social medicine and the public health movement grew from recognition that the social environment played a significant role in the spread of disease (Rosen 1972; Porter 1997). In other words, the infectious diseases that afflicted individuals had social origins that necessitated social reforms to prevent their onset (see Rosen 1972 and 1993 and Waitzkin 2000 for informative histories of social medicine; Porter 1997 for a very readable history of medicine in general; Bloom 2002 for a history of medical sociology; and White 2001 for access to early writings on health sociology).

STATE
A collection of institutions, including the parliament (government and opposition political parties), the public-sector bureaucracy, the judiciary, the military, and the police.

In the UK, Chadwick was a key figure in the development of the first *Public Health Act* (1848), which was based on his 'sanitary idea'—that disease could be prevented through improved waste disposal and sewerage systems. In particular, he focused on removing cesspools of decomposing organic matter from densely populated areas, as well as the introduction of high-pressure flushing sewers, and food hygiene laws to protect against food adulteration. Public health legislation in Australia was first introduced in Victoria in 1854, largely mirroring

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the British Act, with other colonies following suit (Reynolds 1995; Lawson & Bauman 2001). By the early twentieth century, public health had become part of the nation-building project in Australia, as efforts aimed at facilitating a fit, strong, and patriotic 'race' of Australians mixed with ideas about **social Darwinism** and **eugenics** that were prevalent at the time (see Powles 1988; Crotty et al. 2000). In Australia and elsewhere, public health approaches were resisted by many doctors who viewed them as unscientific and as potentially undermining the need for medical services (Porter 1997; Waitzkin 2000). Such views had some popularity given the dominant laissez-faire political philosophy of the time, which supported only minor state intervention in economic and public affairs. Nonetheless, investment in public health was made, perhaps because infectious disease knew no class barriers (that is, it was worth spending money on the poor to prevent the spread of disease to the rich).

Despite the influence of social medicine and the success of public health measures, health care would develop in an entirely different direction. The insights of social medicine would be cast aside for almost a century as the new science of **biomedicine** gained ascendancy.

SOCIAL DARWINISM
The incorrect application of Charles Darwin's theory of animal evolution to explain social inequality by transferring his idea of 'survival of the fittest' among animals to 'explain' human inequality.

EUGENICS
The study of human heredity based on the unproven assumption that selective breeding could improve the intellectual, physical, and cultural traits of a population.

The rise of the biomedical model

In 1878, Louis Pasteur (1822–96) developed the germ theory of disease, whereby illness was caused by germs infecting organs of the human body: a model of disease that became the foundation of modern medicine. Robert Koch (1843–1910) refined this idea via the doctrine of 'specific aetiology' (meaning specific cause of disease) through 'Koch's postulates': a set of criteria for proving that specific bacteria caused a specific disease (Dubos 1959; Capra 1982). The central idea was that specific micro-organisms caused disease by entering the human body through air, water, food, and insect bites (Porter 1997). This mono-causal model of disease, which came to be known as the medical or biomedical model, became the dominant medical paradigm by the early twentieth century. While early discoveries led to the identification of many infectious diseases, there were few effective cures, though.

BIOMEDICINE/ BIOMEDICAL MODEL
The conventional approach to medicine in Western societies, based on the diagnosis and explanation of illness as a malfunction of the body's biological mechanisms. This approach underpins most health professions and health services, which focus on treating individuals, and generally ignores the social origins of illness and its prevention.

One of the earliest applications of the scientific understanding of infectious disease was the promotion of hygiene and sterilisation procedures, particularly in surgical practice, to prevent infection through the transmission of bacteria (Capra 1982). Until the early twentieth century, it had been common practice to operate on patients without a concern for hygiene or the proper cleaning and sterilisation of equipment, resulting in high rates of post-operative infection and death.

The biomedical model is based on the assumption that each disease or ailment has a specific cause that physically affects the human body in a uniform and predictable way, meaning that universal 'cures' for people are theoretically possible. It involves a mechanical view of the body as a machine made up of interrelated parts, such as the skeleton and circulatory system. The role of the doctor is akin to that of a body mechanic identifying and repairing the broken parts (Capra 1982). Throughout the twentieth century, medical research, training, and practice increasingly focused on attempts to identify and eliminate specific diseases in individuals, and thus moved away from the perspective of social medicine and its focus on the social origins of disease (Najman 1980).

Before the development of medical science, quasi-religious views of health and illness were dominant, whereby illness was connected with sin, penance, and evil spirits; the body and

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soul were conceived as a sacred entity beyond the power of human intervention. Therefore, the 'body as machine' metaphor represented a significant turning point away from religious notions towards a secular view of the human body. The influence of scientific discoveries—particularly through autopsies that linked diseased organs with symptoms observed before death, as well as Pasteur's germ theory—eventually endorsed a belief in the separation of body and soul. In philosophical circles, this view came to be known as mind–body dualism and is sometimes referred to as **Cartesian dualism** after the philosopher René Descartes (1590–1650). Descartes, famous for the saying 'I think therefore I am', suggested that although the mind and body interacted with one another, they were separate entities. Therefore, the brain was part of the physical body whereas the mind (the basis of individuality) existed in the spiritual realm and was apparent evidence of a God-given soul. Such a distinction provided the philosophical justification for secular interventions on the physical body in the form of medical therapies. Since the body was merely a vessel for the immortal soul or spirit, medicine could rightly practise on the body while religion could focus on the soul (Capra 1982; Porter 1997). The assumption of mind–body dualism underpinned the biomedical model, whereby disease was seen as located in the physical body, and thus, the mind, or mental state of a person, was considered unimportant.

CARTESIAN DUALISM
A belief that the mind and body are separate entities, also called mind–body dualism and named after the philosopher René Descartes. This assumption underpins medical approaches that view disease in physical terms and thus ignore the psychological and subjective aspects of illness.

The limits of biomedicine

While the biomedical model represented a significant advance in understanding disease and resulted in beneficial treatments, it has come under significant criticism from both within medicine and from a range of social and behavioural disciplines such as sociology and psychology. The major criticism is that the biomedical model underestimates the complexity of health and illness, particularly by neglecting social and psychological factors (Powles 1973).

The idea of specific aetiology in fact only applies to a limited range of infectious diseases. As early as the 1950s, René Dubos (1959, p. 102) argued that 'most disease states are the indirect outcome of a constellation of circumstances rather than the direct result of single determinant factors'. Furthermore, Dubos noted that not all people exposed to an infectious disease contracted it. For example, we may all come into contact with someone suffering from a contagious condition such as the flu, but only a few of us will get sick. Therefore, disease causation is more complex than the biomedical model implies and is likely to involve multiple factors such as physical condition, nutrition, and stress, which affect an individual's susceptibility to illness (Dubos 1959).

The biomedical model, underpinned by mind–body dualism and a focus on repairing the 'broken' parts of the machine-like body, can lead to the objectification of patients. Since disease is viewed only in physical terms, as something that can be objectively observed, treating 'it' takes primacy over all other considerations, and patients may become objectified as 'diseased bodies' or 'cases', rather than treated as unique individuals with particular needs. This form of criticism often underpins claims of doctors' poor interpersonal and communication skills. Such a situation is also related to what Fritjov Capra (1982) calls 'medical scientism'; that is, a reverence for scientific methods of measurement and observation as the most superior form of knowledge about understanding and treating disease. Therefore, patients' thoughts,

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feelings, and subjective experiences of illness are considered 'unscientific' and are mostly dismissed.

A further criticism of biomedicine is its **reductionism**. The development of medical science has led to an increasing focus on smaller and smaller features of human biology for the cause and cure of disease—from organs to cells to molecules and most recently to genes. By reducing its focus on disease to the biological, cellular, molecular, and genetic levels, medicine has ignored or downplayed the social and psychological aspects of illness, so that the experience of disease is treated as if it occurred in a social vacuum. Not only does this marginalise the importance of social support networks, but it also ignores the role played by social factors such as poverty, poor working conditions, and discrimination in affecting an individual's physical and mental health.

REDUCTIONISM
The belief that all illnesses can be explained and treated by reducing them to biological and pathological factors.

A related outcome of reductionism has been an ever-growing number of medical specialists, such as cardiologists (heart specialists) and ophthalmologists (eye specialists), based on the assumption that each body part and function can be treated almost in isolation from the others. Such an approach has fuelled the search for 'magic bullet' cures, resulting in huge expenditure on medical drugs, technology, and surgery. It has also led to a curative and interventionist bias in medical care, often at the expense of prevention and non-medical alternatives.

Reductionism can also lead to **biological determinism**, a form of social Darwinism that assumes people's biology causes or determines their inferior social, economic, and health status. Biological determinism underpins most elitist, racist, and sexist beliefs. For example, some people argue that the poor are poor because they are born lazy and stupid. Such views have often been used to justify slavery and exploitation of blacks, women, children, and workers; it is a very convenient 'explanation', particularly when those at the top of the social ladder espouse it. When people argue that social or health inequalities are biologically determined, the implication is that little can or should be done to change them.

BIOLOGICAL DETERMINISM
An unproven belief that individual and group behaviour and social status are an inevitable result of biology.

A final criticism of the biomedical model is its tendency towards **victim-blaming** (Ryan 1971) by locating the cause and cure of disease as solely within the individual. As Capra states, '[i]nstead of asking why an illness occurs, and trying to remove the conditions that lead to it, medical researchers try to understand the biological mechanisms through which the disease operates, so that they can then interfere with them' (1982, p. 150). Therefore, the individual body becomes the focus of intervention, and health and illness become primarily viewed as individual responsibilities. A preoccupation with treating the individual has the potential to legitimate a victim-blaming approach to illness, either in the form of genetic fatalism (your poor health is the result of poor genetics) or as an outcome of poor **lifestyle choices**. By ignoring the social context of health and illness and locating primary responsibility for illness within the individual, there is little acknowledgment of social responsibility; that is, the need to ensure healthy living and working environments.

VICTIM-BLAMING
The process whereby social inequality is explained in terms of individuals being solely responsible for what happens to them in relation to the choices they make and their assumed psychological, cultural, and/or biological inferiority.

LIFESTYLE CHOICES/FACTORS
The decisions people make that are likely to impact on their health such as those relating to diet, exercise, smoking, alcohol, and other drugs. The term implies that people are solely responsible for choosing and changing their lifestyle.

The critique of the biomedical model above has necessarily been a generalisation and does not imply that all doctors work from within the confines of this model. In fact, many of the criticisms of the model have come from those within the medical profession itself. While it is now widely accepted that the causes of illness are multifactorial, it is still fair to claim that the biomedical model remains the dominant influence over medical training and practice to this day.

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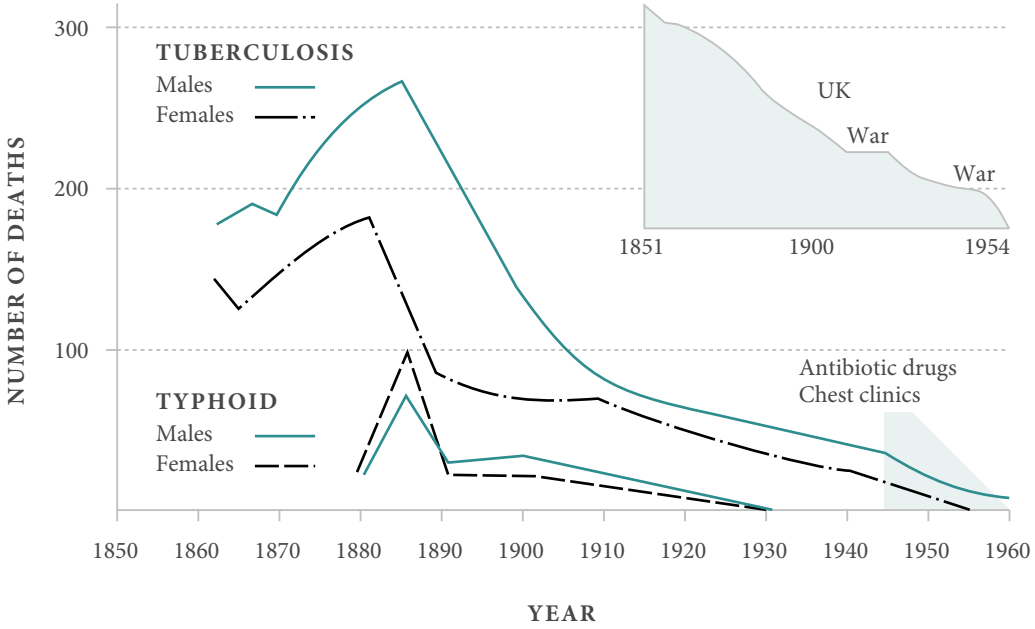
Rediscovering the social origins of health and illness

Thomas McKeown (1976; 1979; 1988), a doctor and epidemiologist, was one of the earliest authors to expose the exaggerated role of medical treatment in improving population health. McKeown argued that the medical profession and governments had overestimated the influence of medical discoveries on improvements in life expectancy during the twentieth century. McKeown (1976; 1979) found that mortality (death) from most infectious diseases had declined before the development of effective medical treatments, meaning that improvements in life expectancy were not substantially due to medical intervention. Similar findings have been reported in the US (McKinlay & McKinlay 1977) and Australia (Gordon 1976; Lawson 1991). Figure 1.2 provides a graphic example of this, showing the declining rate of tuberculosis for Australia—which occurred before effective medical treatment. The same trend occurred in the UK and the US in the period given. Graphs for most infectious diseases tell a similar story (aside from smallpox and polio), indicating that the contribution of medicine to population-level improvements in life expectancy appears to have been smaller than is commonly assumed.

FIGURE 1.2 DECLINE IN THE NUMBER OF TUBERCULOSIS AND TYPHOID DEATHS IN AUSTRALIA



Source: Gordon 1976, after graph by H. Silverstone, Department of Social and Preventive Medicine, University of Queensland; data from O. Lancaster and colleagues

McKeown (1979) suggests that the major reason for the increase in life expectancy throughout the twentieth century was not due to medical treatments, but rather to rising living standards, particularly improved nutrition, which increased people's resistance to infectious disease. While McKeown's work highlighted the importance of social, non-medical interventions for improving population health, Simon Szreter (1988, p. 37) provides a more

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complex argument. He suggests that rather than the '"invisible" hand of rising living standards', it was the state's redistribution of economic resources that increased life expectancy through improved working conditions and a range of public health measures such as better public housing, food regulation, education, and sanitation reforms.

While the exact contributions of public health measures, rising living standards, and medicine to improving population health is impossible to determine, the significance of McKeown's work and subsequent findings has been to highlight the importance of addressing the social origins of health and illness. As McKeown states, 'improvement in health is likely to come … from modification of the conditions which lead to disease, rather than from intervention in the mechanism of disease after it has occurred' (1979, p. 198).

It is important to note that McKeown himself was not anti-medicine, but wanted to reform medical practice so that it focused on prevention of what he saw were the new threats to health: 'personal behaviour', as evidenced through smoking, alcohol consumption, drug taking, poor diet, and lack of exercise. Therefore, he still viewed health care in individualistic terms, by focusing preventive efforts at the level of modifying the behaviour of individuals (see Box 1.1).

There is no denying the significant role medicine has played in the treatment of illness, particularly in trauma medicine, palliative care, and general surgery, as well as the prevention of illness through immunisation. The primary expertise of doctors lies in combating disease and attempting to treat individuals once they are ill. Yet as we have seen, this is only part of the story and has tended to obscure the social origins of health and illness.

BOX 1.1

DOING HEALTH SOCIOLOGY: FROM RISK-TAKING TO RISK-IMPOSING LIFESTYLE FACTORS

While the notion of 'lifestyle diseases' or 'diseases of affluence' is a clear indication of the social origins of illness, most disease prevention efforts have aimed to reform the individual, rather than pursue wider social reform (often ignoring the fact that diseases of affluence tend to affect the least affluent much more). By solely targeting risk-taking individuals, there has been a tendency toward victim-blaming: ignoring the social determinants that give rise to risk-taking in the first place, such as stressful work environments, the marketing efforts of corporations, and peer group pressure. As Michael Marmot (1999, p. 1) incisively puts it, there is a need to understand the 'causes of the causes'. In other words, rather than just focusing on risk-taking individuals, there is also a need to address 'risk-imposing factors' and 'illness-generating social conditions' (Waitzkin 1983; Ratcliffe et al. 1984)—the social, cultural, economic, and political features of society that create unhealthy products, habits, and lifestyles.

The World Health Organization (WHO) effectively acknowledged this limitation of biomedicine in 1946, when it included in its constitution the now-famous holistic definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946). This often-quoted definition implies that a range of biological, psychological, and social factors influence health. Furthermore, health is conceptualised as 'not merely the absence of disease', but rather in the positive sense of

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'well-being'. While this definition has been criticised for its utopian and vague notion of 'complete well-being', it is of symbolic importance because it highlights the need for a broader approach to health than the biomedical model alone can deliver.

SOCIAL MODEL OF HEALTH
Focuses on social determinants of health such as the social production, distribution, and construction of health and illness, and the social organisation of health care. It directs attention to the prevention of illness through community participation and social reforms that address living and working conditions.

The widespread recognition of the biomedical model's limitations, from those within and outside the medical profession, has led to the development of a variety of multifactorial models, such as the biopsychosocial model (Engel 1977; 1980; Cooper et al. 1996), the web of causation model (MacMahon & Pugh 1970), and the ecological model (Hancock 1985). While these models represent a significant advance on the biomedical model in acknowledging the multiple determinants of health, to greater and lesser degrees they remain focused on health interventions aimed at the individual, particularly through lifestyle/behaviour modification and health education. What is required is an explicitly **social model of health** in order to propose effective health interventions at the population and community levels (Waitzkin 1983; Ashton & Seymour 1988; Baum 2008).

The social model of health

NEW PUBLIC HEALTH
A social model of health linking 'traditional' public health concerns about physical aspects of the environment (clean air and water, safe food, occupational safety), with concerns about the behavioural, social, and economic factors that affect people's health.

The social model of health, sometimes referred to as the **new public health** approach, focuses attention on the societal level of health determinants and health intervention. The two terms are used interchangeably by some authors, but have different disciplinary origins, with the new public health approach arising from the health sciences (particularly public health), and the social model drawn primarily from the field of health sociology. Some new public health approaches arising from the health sciences have been criticised by sociologists for an over-reliance on individualistic solutions in practice (see Lupton 1995; Petersen & Lupton 1996). Yet there are significant examples of sociologically informed approaches that can make it problematical to draw distinctions between the two terms (see especially Beaglehole & Bonita 1997; Baggott 2000; Baum 2008). A recent further development has been the promotion of an ecological public health model (see Rayner & Lang 2012), which suggests a greater need to address the complex interrelatedness of humans and their (natural and social) environment. For our purposes we will use the term 'social model of health', as it better reflects the unique theories, research methods, and modes of analysis of health sociology discussed in this book.

The social model of health has been used as a general umbrella term to refer to approaches that focus on the social determinants of health and illness (see Broom 1991; Gillespie & Gerhardt 1995). As Dorothy Broom (1991, p. 52) states: 'the social model locates people in social contexts, conceptualises the physical environment as socially organised, and understands ill health as a process of interaction between people and their environments.' It is one of the aims of this book to map out in more detail what a social model of health entails. Table 1.2 contrasts the key features of the biomedical model with the social model to highlight the different focuses, assumptions, benefits, and limitations of each. It is important to emphasise that the social model does not deny the existence of biological or psychological aspects of disease that manifest in individuals, or deny the need for medical treatment. Instead, it highlights that health and illness occur in a social context and that effective health interventions, particularly preventive efforts, need to move beyond the medical treatment of individuals. In exposing the social origins of illness, it necessarily implies that a greater balance between individual and social interventions is required, since the vast majority of health funding continues to

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be directed towards medical intervention. Therefore, the social model is not intended as a replacement for the biomedical model, but rather coexists alongside it.

The social model assumes that health is a social responsibility by examining the social determinants of individuals' health status and health-related behaviour. While the biomedical model concentrates on treating disease and risk-taking among individuals, the social model focuses on societal factors that are risk-imposing or illness-inducing (for example, toxic pollution, stressful work, discrimination, and peer pressure), and in particular highlights the health inequalities suffered by different social groups based on class, gender, ethnicity, and occupation, to name a few. What should be clear from the comparison offered in Table 1.2 is that health issues have a number of dimensions.

TABLE 1.2 A COMPARISON OF BIOMEDICAL AND SOCIAL MODELS OF HEALTH: KEY CHARACTERISTICS

	BIOMEDICAL MODEL	SOCIAL MODEL
Focus	• Individual focus: acute treatment of ill individuals • Clinical services, health education, immunisation	• Societal focus: living and working conditions that affect health • Public health infrastructure and legislation, social services, community action, equity/access issues
Assumptions	• Health and illness are objective biological states • Individual responsibility for health	• Health and illness are social constructions • Social responsibility for health
Key indicators of illness	• Individual pathology • Hereditary factors, sex, age • Risk-taking factors	• Social inequality • Social groups: class, gender, 'race', ethnicity, age, occupation, unemployment • Risk-imposing factors
Causes of illness	• Gene defects and micro-organisms (viruses, bacteria) • Trauma (accidents) • Behaviour/lifestyle	• Political/economic factors: distribution of wealth/income/power, poverty, level of social services • Employment factors: employment and educational opportunities, stressful and dangerous work • Cultural and structural factors
Intervention	• Cure individuals via surgery and pharmaceuticals • Behaviour modification (non-smoking, exercise, diet) • Health education and immunisation	• Public policy • State intervention to alleviate health and social inequalities • Community participation, advocacy, and political lobbying
Goals	• Cure disease, limit disability, and reduce risk factors to prevent disease in individuals	• Prevent illness and reduce health inequalities to aim for an equality of health outcomes
Benefits	• Addresses disease and disability of individuals	• Addresses the social determinants of health and illness
Criticisms	• Disease focus leads to lack of preventive efforts • Reductionist: ignores the complexity of health and illness • Fails to take into account social origins of health and illness • Medical opinions can reinforce victim-blaming	• Utopian goal of equality leads to unfeasible prescriptions for social change • Overemphasis on the harmful side effects of biomedicine • Proposed solutions can be complex and difficult to implement in the short-term • Sociological opinions can underestimate individual responsibility and psychological factors

The social model logically implies that any attempts to improve the overall health of the community need to address overall living and working conditions such as poverty, employment opportunities, workplace health and safety, and cultural differences. The social model gives equal priority to the prevention of illness along with the treatment of illness, and aims to alleviate health inequalities. Such issues necessitate community participation and state interventions—including social services and public policies (such as workplace safety and

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pollution controls)—which lie outside the strict confines of the health system or individuals' control. It must be acknowledged that this makes the interventions proposed by advocates of the social model more complex and difficult to achieve, given their broad thrust, long-term implications, and need for intersectoral collaboration.

THE THREE MAIN DIMENSIONS OF THE SOCIAL MODEL OF HEALTH

The social model arose as a critique of the limitations and misapplications of the biomedical model. Sociological research and theorising, which underpins the social model of health, have comprised three main dimensions that are reflected in the structure of this book:

1. *The social production and distribution of health and illness* highlights that many illnesses are socially produced. For example, illnesses arising from exposure to hazardous work practices are often beyond an individual's control and therefore need to be addressed at a societal level, such as through occupational health and safety legislation. Furthermore, there is an unequal social distribution of health, whereby some social groups suffer higher rates of morbidity and mortality. Therefore, a focus on the social production and distribution of health examines the role that living and working conditions can play in causing and alleviating illness.
2. *The social construction of health and illness* refers to how definitions of health and illness can vary between cultures and change over time—what is considered a disease in one culture or time period may be considered normal and healthy elsewhere and at other times. For example, homosexuality was once considered a psychiatric disorder despite the lack of scientific evidence of pathology. It is no longer medically defined as a disorder. This is an example of how cultural beliefs, social practices, and social institutions shape, or construct, the ways in which health and illness are understood. Notions of health and illness are not necessarily objective facts, but can be **social constructions** that reflect the culture, politics, and morality of a particular society at a given point in time.
3. *The social organisation of health care* concerns the way a particular society organises, funds, and utilises its health services. A central focus of study has been the dominant role of the medical profession, which has significantly shaped health policy and health funding to benefit its own interests, largely to the detriment of preventive approaches and nursing, allied, and alternative health practitioners. Unequal relationships between the health professions can prevent the efficient use of health resources and the optimal delivery of health care to patients.

SOCIAL CONSTRUCTION/ CONSTRUCTIONISM: The socially created characteristics of human life, based on the idea that people actively construct reality, meaning it is neither 'natural' nor inevitable. Therefore, notions of normality/ abnormality, right/ wrong, and health/ illness are subjective human creations that should not be taken for granted.

Conclusion

> Question: What do you get when you cross a sociologist with a member of the Mafia?
> Answer: An offer you can't understand.
>
> *(GIDDENS 1996, p. 1)*

A common accusation made of sociology is that it is just common sense dressed up in unnecessary jargon. The subject matter of sociology is familiar, and as members of society it is easy to think we should all be experts on the subject. This familiarity can breed suspicion

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and sometimes contempt. All disciplines have specialist concepts to help classify their subject matter and sociology is no different. Sociological concepts, such as those you have been introduced to in this chapter, are used to impose a sense of intellectual order on the complexities of social life; they are a form of academic shorthand to summarise a complex idea in a word or phrase.

As this chapter has shown, to understand the complexity of health and illness we need to move beyond biomedical approaches and incorporate a social model of health. Sociology enables us to understand the links between our individual experiences and the social context in which we live, work, and play. With a sociological imagination, seeing health problems as social issues can be a healthy way of opening up debate on a range of topics previously unimagined.

SUMMARY OF MAIN POINTS

- Much of health sociology has arisen as a critique of the dominance of the medical profession and its biomedical model.
- Health sociology examines social patterns of health and illness, particularly various forms of health inequality, and seeks to explain them by examining the influence of society. When groups of people experience similar health problems, there are likely to be social origins that require social action to address them.
- The sociological imagination, or sociological analysis, involves four interrelated features—historical, cultural, structural, and critical—which can be applied to understand health problems as social issues.
- Health sociology challenges individualistic and biological explanations of health and illness through a social model of health that involves three key dimensions: the social production and distribution of health, the social construction of health, and the social organisation of health care.

SOCIOLOGICAL REFLECTION

A SOCIOLOGICAL AUTOBIOGRAPHY

Apply the four parts of the sociological imagination template to explain the person you have become. In other words, write a short sociological autobiography by briefly noting the various things that have influenced you directly or indirectly in terms of your beliefs, interests, and behaviour.

- Historical factors: how has your family background or key past events and experiences shaped the person you are?
- Cultural factors: what role have cultural background, traditions, and belief systems played in forming your opinions and influencing your behaviour?
- Structural factors: how have various social institutions influenced you?
- Critical factors: have your values and opinions about what you consider important changed over time? Why or why not?

Complete another sociological reflection, this time applying the sociological imagination template to a health problem of interest to you. Briefly note any key points that come to mind under the four parts of the template. What insights can you derive by adopting a sociological imagination?

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DISCUSSION QUESTIONS

1 How can illness have social origins? Give examples in your answer.

2 What are the advantages and limitations of the biomedical model?

3 What have been some of the consequences of the dominance of biomedical explanations for our understanding of health and illness?

4 Why did the insights of social medicine/public health approaches have such a limited influence over the development of modern medicine?

5 What are the three key dimensions of the social model of health? Provide examples of each in your answer. What are the advantages and limitations of the model?

6 In 1946, the World Health Organization defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Why might some groups regard this definition as 'radical' and utopian? Who might these groups consist of? What do you think of the definition?

FURTHER INVESTIGATION

1 The influence of the biomedical model is waning—the future belongs to public health. Discuss.

2 Illness is simply a matter of bad luck, bad judgment, or bad genetics. Critically analyse this statement by applying a sociological imagination to explore the social origins of illness.

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American Sociological Association: Medical Sociology: <www2.asanet.org/medicalsociology>.

Australian Institute of Health and Welfare (AIHW): <www.aihw.gov.au>.

British Sociological Association: Medical Sociology (MedSoc) Study Group: < www.britsoc.co.uk/medsoc>.

Public Health Association of Australia (PHAA): <www.phaa.net.au>.

World Health Organization (WHO): Social Determinants of Health: <www.who.int/social_determinants/en>.

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02

THEORISING HEALTH: MAJOR THEORETICAL PERSPECTIVES IN HEALTH SOCIOLOGY

John Germov

Overview

- What is sociological theory?
- Why is sociological theory necessary?
- What are the main theoretical approaches in health sociology?

THEORY AND THE REAL WORLD

We often think of theory as somehow divorced from reality, but we actually make use of theories every day of our lives. For example, when some people suggest that violence on television or in the lyrics of popular music may lead to increased acts of violence in the wider community, they are espousing a theory of why things happen. People commonly espouse everyday theories for the differences between women and men, rich and poor, black and white, heterosexuals and homosexuals, to name but a few. Such theories can influence how people relate to one another, how tolerant they are of others, and whether they support social policies and laws aimed at addressing various forms of discrimination and inequality. So, rightly or wrongly, people have theories about how and why social life is the way it is. Such everyday theories or opinions are usually based on unacknowledged prejudices and lack reliable supporting evidence. What sets sociological theories apart from everyday opinions is that they attempt to explain social life by presenting a logical, detailed, and coherent account derived from systematically researched evidence.

Key terms

agency
biological determinism
biomedicine/biomedical model
capitalism
communism
deviance
emotional labour
functional prerequisites
gender/sex
ideal type
labelling theory
McDonaldization
meta-narratives/meta-analysis
modernity/modernism
patriarchy
rationalisation
reflexive modernity
risk society
sexual division of labour
sick role
social closure
social construction/constructionism
social control
social structure
socialism
stigma/stigmatisation
structuration
structure–agency debate
total institutions

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Introduction

STRUCTURE–AGENCY DEBATE
A key debate in sociology over the extent to which human behaviour is determined by social structure.

A theory is an explanation of how things work and why things happen. Theories allow us to make sense of our world—they provide answers to the 'how' and 'why' questions of life—by showing the way certain facts are connected to one another. This chapter provides an overview of the main theoretical perspectives in health sociology. Differences between the theoretical perspectives are discussed, particularly with reference to the **structure–agency debate** and the different questions addressed by each perspective. The chapter ends with a plea for theoretical pluralism and a caution against confusing perspectives with specific theories.

Theoretical perspectives in health sociology: an overview

> The Answer to the Great Question Of … Life, the Universe and Everything … Is … Forty-two.
>
> *(ADAMS 1979, p. 135)*

As the above quote from *The Hitchhiker's Guide to the Galaxy* implies, the search for a 'theory of everything' is likely to be a futile task. Even if we could construct a theory that explains every imaginable social problem, public issue, or human action, its complexity is likely to be so great as to make it unusable. A theory attempts to simplify reality and generalise its common and related features relevant to the topic at hand. The sheer variety of social life and the diversity of human behaviour mean that there is no single sociological 'theory of everything'. As Fritjov Capra puts it: 'All scientific theories are approximations to the true nature of reality … each theory is valid for a certain range of phenomena. Beyond this … new theories have to be found to replace the old one' (1982, p. 93).

As you read the chapters of this book and consult the wider literature, you will quickly become aware that there are many different and sometimes opposing sociological theories on a topic. Over the years, many sociological theories have been developed and advocated by sociologists, making it frustrating for those new to sociology to steer a course through the maze of theories that exist. One way to navigate through this theory maze is to start by grouping them into the following seven major theoretical perspectives or frameworks:

- structural functionalism
- Marxism
- Weberianism
- symbolic interactionism
- feminism
- contemporary modernism
- postmodernism.

Theoretical perspectives are a form of shorthand to group similar theories of society together. Within each perspective there exist many individual theories developed by different authors, but they all tend to share the core features of the particular perspective. Any attempt

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to group theories in this way involves simplification as it becomes necessary to focus on the similarities within the one perspective at the expense of the differences between specific theories. For example, many Marxist theorists today would disagree with some of Karl Marx's ideas, but they nonetheless share the core assumptions and principles of a Marxist perspective.

A key distinction between theoretical perspectives is in relation to the structure–agency debate, with some perspectives favouring the structure side of the debate and others more the **agency** side. Figure 2.1 depicts sociological perspectives along a structure–agency continuum, with structuralist approaches at one end and agency approaches at the other. Structuralist approaches assume that **social structures**, such as the economic and political system, shape individual and group behaviour; that is, that they determine the type of person you are: how you think, feel, and act, as well as your chances of health, wealth, and happiness. Agency approaches maintain that society is fundamentally the product of individuals acting socially or collectively to make the society in which they live. These perspectives focus on small-scale aspects of social interaction—such as that which occurs in a classroom between teachers and students or between health professionals and patients—rather than focusing on the education or health system as a whole.

AGENCY
The ability of people, individually and collectively, to influence their own lives, and the society in which they live.

SOCIAL STRUCTURE
The recurring patterns of social interaction through which people are related to each other, such as institutions and social groups.

FIGURE 2.1 THEORETICAL PERSPECTIVES ALONG THE STRUCTURE–AGENCY CONTINUUM

For our purposes here, it is important to realise that most sociological theories fall between these two extremes—indeed many contemporary modernist sociological theories attempt to integrate structure as well as agency. Few authors writing within any of the perspectives completely deny the roles that social structure or individuals play in any given social situation; nevertheless, a bias to one side of the continuum is usually displayed.

Key features of major theoretical perspectives

Table 2.1 summarises the key features of the major theoretical perspectives in health sociology and how 'at a glance' they apply to health issues. Greater detail on each perspective is provided in the remainder of the chapter.

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TABLE 2.1 THE SEVEN MAJOR THEORETICAL PERSPECTIVES IN HEALTH SOCIOLOGY

THEORETICAL PERSPECTIVE	KEY THEORISTS	KEY CONCEPTS	FOCUS OF ANALYSIS	HEALTH EXAMPLE
Structural functionalism	Émile Durkheim Talcott Parsons Robert Merton	value consensus functional prerequisites sick role	Structuralist focus: shows how various parts of society function to maintain social order	The 'sick role' (social expectations of how doctors and patients should behave) exposes the management of illness as a social experience
Marxism	Karl Marx Friedrich Engels Vicente Navarro Howard Waitzkin Evan Willis	class conflict capitalism medical-industrial complex commodification of health care	Structuralist focus: shows how the unequal distribution of scarce resources in a capitalist society is based on class division and highlights who benefits and who is disadvantaged	Analyses the links between class and health status, and between class, medical power, and profit-maximisation
Weberianism	Max Weber Robert Alford Magali Larson George Ritzer Anne Witz	bureaucracy ideal type rationalisation McDonaldization	Combines a primary focus on agency with structuralist tendencies: shows how the increasing regulation of social life takes place and may stifle human creativity; also explains the multiple forms of social inequality and social conflict	Examines how health professionals are increasingly subject to regulation and managerial control, producing greater efficiency and uniformity in health care delivery but potentially decreasing the effectiveness of patient care
Symbolic interactionism	George H. Mead Erving Goffman Herbert Blumer Howard S. Becker Anselm Strauss	the self labelling theory stigma total institutions negotiated order	Agency-focused: emphasises how individual and small-group interaction construct social meaning in everyday settings to construct and change social patterns of behaviour	Uncovers how and why certain forms of behaviour are treated as deviance, exposing the stigma, negative consequences, interactionism, and biased treatment of social groups whose behaviour is deemed 'abnormal' (e.g. homosexuals)
Feminism	Ann Oakley Sylvia Walby Arlie Hochchild Rosemary Pringle	patriarchy gender sexual division of labour	Consists of a range of strands that are either structuralist or agency focused; seeks to explain and address the unequal position of women in society	Exposes sexism, biological determinism, and gender inequality in health research, theory, and treatment
Contemporary modernism	Norbert Elias Ulrich Beck Pierre Bourdieu Anthony Giddens	figurations civilising processes habitus risk society reflexive modernity	A diverse group of sociological theories that attempt to integrate structure and agency	Explores how health risks are defined and acted upon by individuals, health professionals, and social institutions (e.g. government health-promotion campaigns)
Postmodernism	Michel Foucault Nicholas Fox David Armstrong Deborah Lupton	discourse panopticon bio-power surveillance performativity subjectivity	Agency focused: critiques theories based on universal truths and structuralist assumptions; concentrates on subjectivity, diversity, and fragmentation	Examines how discourses of normality and panoptic effects serve to discipline and control particular social groups

STRUCTURAL FUNCTIONALISM (ALSO KNOWN AS FUNCTIONALISM OR CONSENSUS THEORY)

Émile Durkheim (1858–1917), Talcott Parsons (1902–79), and Robert Merton (1910–2003) are the key theorists of the functionalist perspective, which is more commonly known as structural functionalism following the widespread influence of Parsons' work. Popular in the US, this perspective studies the way social structures function to maintain social order and

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stability. Structural functionalism focuses on large-scale social processes and is based on the assumption that a society is a system of integrated parts, each of which have certain 'needs' (or **functional prerequisites**) that must be fulfilled for social order to be maintained. Hence, functionalists study various parts of society to understand how they interrelate and function to promote social stability and consensus.

The structural functionalist analysis of health care has been primarily influenced by the work of Parsons (1951), who viewed the health of individuals as a necessary condition of a stable and ordered society. He conceptualised illness as a form of **deviance**; that is, he viewed it as stopping people from performing various social roles, such as paid work and caring for children, which were essential to the functioning of society. In Parsons' terms, 'health is intimately involved in the functional prerequisites of the social system … too low a general level of health, too high an incidence of illness, is dysfunctional … because illness incapacitates the effective performance of social roles' (1951, p. 430).

For Parsons, illness disrupts the normal functioning of society, and thus it is important that the sick are encouraged to seek expert help, so that they return to health and can perform their social roles. The pathway to health was achieved through the **sick role**; that is, the social expectations that dictate how an individual sick person is meant to act and be treated.

According to Parsons, the sick role involves a series of rights and responsibilities. Once sick, it is the right of individuals to be exempted from their normal social roles such as those of the parent, employee, or student. This exemption from performing duties is legitimated by medical diagnosis and treatment. For example, students regularly have to provide medical certificates to support their case for not performing their student roles of turning up to class or submitting work on time. A further right of the sick person is not to be held personally responsible for the illness. Since illness is generally beyond individuals' control, they should be able to rely on others to care for them while they are ill. Sick people also have certain responsibilities. For example, they are expected to seek medical assistance and comply with the recommended treatment. Moreover, they are obliged to recover and resume their normal social duties.

The 'sick role' concept directs attention to the social nature of the illness experience and focuses attention on the doctor–patient relationship, but the importance of the concept also lies in the many critiques it has inspired as a result of its limited application to chronic, terminal, and permanently disabling conditions, as well as its uncritical acceptance of the role of the medical profession and its neglect of the limitations of the **biomedical model**.

MARXISM (ALSO KNOWN AS CONFLICT THEORY)

The term 'Marxism' refers to a wide body of theory and political policies based on the writings of Karl Marx (1818–83) and Friedrich Engels (1820–95). Marx was a philosopher, economist, and sociologist. He was also politically active, and since his death his writings have not only inspired many sociologists but have also laid the foundations for numerous political movements around the world. Marxism, also known as 'conflict theory', asserts that society is dominated by a conflict of interest between two social classes within **capitalist** societies—the bourgeoisie (the capitalist class) and the proletariat (the working class). The influence and contribution of Marxism in sociology is widespread, but the perspective's core concern remains that of class analysis, especially due to its emphasis on class conflict as the defining feature of social life and the catalyst of social change towards its desired goal of **socialism** and ultimately **communism**.

FUNCTIONAL PREREQUISITES
A debated concept based on the assumption that all societies require certain functions to be performed for them to survive and maintain social order. Also known as functional imperatives.

DEVIANCE
Behaviour or activities that violate social expectations about what is normal.

SICK ROLE
A concept used by Talcott Parsons to describe the social expectations of how sick people are expected to act and of how they are meant to be treated.

THEORYLINK
See Chapter 5 for a functionalist perspective of health inequality and Chapter 20 for its approach on professions.

BIOMEDICINE/ BIOMEDICAL MODEL
The conventional approach to medicine in Western societies, based on the diagnosis and explanation of illness as a malfunction of the body's biological mechanisms. This approach underpins most health professions and health services, which focus on treating individuals, and generally ignores the social origins of illness and its prevention.

CAPITALISM
An economic and social system based on the private accumulation of wealth.

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SOCIALISM
A political ideology with numerous variations, but with a core belief in the creation of societies in which private property and wealth accumulation are replaced by state ownership and distribution of economic resources. See also **communism**.

COMMUNISM
A utopian vision of society based on communal ownership of resources, cooperation and altruism to the extent that social inequality and the state no longer exist. Sometimes used interchangeably with socialism to refer to societies ruled by a communist party. See also **socialism**.

THEORYLINK
Chapters 5 and 20 discuss Marxist approaches applied to health inequality and the medical profession.

Chapter 6 discusses workplace health and mortality and morbidity among the working class.

Much of Marx's theory has been reinterpreted and modified, and is now often referred to as neo-Marxism. The Marxist perspective of health and illness, reflected in the contemporary writings of Howard Waitzkin (1983; 2000), Lesley Doyal (1979), Vicente Navarro (1976; 1986), and Australian sociologist Evan Willis (1989), focuses on the role of the medical profession and the impact of working and living conditions in capitalist society and how these contribute to illness. In particular, Marxist perspectives have highlighted that the exploitation of workers and the pursuit of profit can create dangerous work environments and poor living conditions, resulting in higher mortality and morbidity rates among the working class.

Marxist analyses of health care tend to focus on the professional power of doctors to serve class interests by placing profit-maximisation above access to optimal health care. Navarro and Waitzkin have been strong critics of the medical profession's individualistic focus and its continued reliance on the biomedical model. By locating the cause and treatment of illness in individuals and ignoring what Waitzkin (1983; 2000) calls 'illness-generating social conditions', the medical profession is viewed as performing an ideological function by masking the real causes of illness and thereby supporting the capitalist system. According to Navarro (1986, p. 35), in capitalist societies the influence of work on health 'is of paramount importance' since workers 'have no control over their work and, thus, over their lives, including their health'. In the Australian context, there has been significant research documenting workplace health hazards.

Willis (1989) highlighted the profit-orientation and entrepreneurial ethos of the medical profession and its tendency to align itself with upper-class interests. For example, a significant section of the medical profession opposes forms of public health provision, as exemplified by the Australian Medical Association's (AMA) continued opposition to the Medicare system. Furthermore, fee-for-service, self-regulation, and the suppression of competition from other health practitioners (Willis 1989) are indicative of medicine's alignment with 'the economic and ideological patterns of capitalism' (Connell 1988, p. 214). This has resulted in a commonality of lifestyles and interests between doctors and the upper class so that 'doctors as a group … have particular political and economic interests they do not share with most of their patients: interests in maintaining a sharp division of labour in health care, in a substantial amount of public ignorance about health, and in seeing that self-help arrangements for health care remain marginal or ineffective' (Connell 1988, p. 214).

WEBERIANISM

Max Weber (1864–1920) ranks along with Marx as one of the most influential theorists in sociology. Weber (1921/1968) produced a theory of society that acknowledges the way in which people both shape and are shaped by the social structure. Weber's writings are extensive, but his major contributions concern his analysis of bureaucracy and his account of power and social inequality through the concepts of class, status, and party (political parties and pressure groups).

Like Marx, Weber viewed class as important and believed that social conflict was a defining characteristic of increasingly complex societies. Rather than seeing two basic classes as in Marx's theory, Weber also considered the importance of the middle classes, which he saw as consisting of those occupational groups with qualifications and skills that provided them with market advantages (higher wages, prestige, and better working conditions) over those in manual occupations.

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Weber suggested that in addition to social class, status groups and parties were also a source of group formation and social inequality. Status groups reflect cultural and sometimes legally conferred privileges, social respect, and honour. They are usually based on membership of specific professional, ethnic, and religious groups, and members tend to share common interests and lifestyles. Status group membership is often restricted through what Weber termed a process of **social closure**.

SOCIAL CLOSURE
A term first used by Max Weber to describe the way that power is exercised to exclude outsiders from the privileges of social membership (in social **classes**, professions, or status groups).

While class and social status tend to be closely related, they need not be. Moreover, other groups, or parties in Weber's terms, could also serve the basis for collective interests and social inequality. Parties refer to groups attempting to wield power and include political parties and associations such as unions and professional bodies, as well as various interest/pressure groups.

In the health sector, Robert Alford's (1975) work on the competing interest groups is often cited. He argues that health policy and the delivery of health care are a compromise between three main vested interest groups: professional monopolists (doctors), corporate rationalists (public and private sector managers), and equal health advocates (various patient-rights groups). Alford, like many Weberians, acknowledges that some groups (such as doctors) are clearly dominant and exercise more power, but nonetheless maintains that other groups can and do exert influence.

THEORYLINK
See Chapter 19 for more on Alford's ideas.

Another strand of Weber's work concerns the process of **rationalisation**, which he considers to be the overarching trend in society, epitomised by the growth of bureaucracy. Weber (1921/1968) predicted that the 'future belongs to bureaucratisation' (p. 1401) and described an **ideal type** bureaucratic organisation as having a highly specialised and hierarchical division of labour bounded by formal rules and regulations (pp. 221–3). For Weber, bureaucracies are an effective response to social complexity and democracy by attempting to eliminate fraud, mismanagement, and inefficiency through conformity to standardised procedures. Despite what he acknowledges are the significant benefits of bureaucracy, he enunciates a fear that social life was to become so governed by objective and informal rules that people would become entrapped by an 'iron cage' of regulations that would limit their creativity and individuality.

RATIONALISATION
The standardisation of social life through rules and regulations. See **McDonaldization**.

IDEAL TYPE
A concept originally devised by Max Weber to refer to the abstract or pure features of any social phenomenon.

American sociologist George Ritzer (1993) has produced an updated version of Weber's notion of rationalisation, conceptualising the social trend as the **McDonaldization** of society—in which the highly regulated nature of work in fast food restaurants has become a template used in many industries, including health care. For example, health care delivery is increasingly subject to regulations and performance indicators so that it becomes predictable and uniform, which may make health professionals more consistent in their treatment, but may also dehumanise interaction with patients and lessen the flexibility and quality of care provided.

McDONALDIZATION
A term coined by George Ritzer to expand Weber's notion of rationalisation; defined as the standardisation of social life by rules and regulations, such as increased monitoring and evaluation of individual performance, akin to the uniformity and control measures used by fast food chains.

THEORYLINK
See Chapter 20 for a discussion of the McDonaldization of health care delivery.

SYMBOLIC INTERACTIONISM

Symbolic interactionism is associated with key theorists such as George Herbert Mead (1863–1931), Charles Cooley (1864–1929), Howard Becker (1928–), Erving Goffman (1922–82), Anselm Strauss (1916–96), and Herbert Blumer (1900–87). Blumer coined the term in 1937. The perspective arose as a reaction against structuralist approaches such as structural functionalism, which tends to view humans as simply responding to external influences. Instead, symbolic interactionists focus on agency and how people construct, interpret, and

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give meaning to their behaviour through interaction with others. The core philosophical assumption is that humans create reality through their actions and the meanings they give to them. Therefore, society is the cumulative effect of human action, interaction, and interpretation, and these are more significant than social structures, hence the focus of the perspective.

Symbolic interactionism provides a theoretical bridge between sociology and psychology by concentrating on small-scale social interaction and how this impacts on individuals' identity or image of themselves (often referred to as 'the self' or 'self-concept'). Cooley's (1906/1964) term 'the looking-glass self' encapsulates this approach, whereby the reactions of others influence the way we see ourselves and thus how we in turn behave. For example, if people regularly tell you that you are attractive and intelligent, this reaction can impact on what you believe and how you behave.

Symbolic interactionism emphasises that health and illness are perceived subjectively, and are **social constructions** that change over time and vary between cultures. Therefore, what is considered an illness is socially defined and passes through a social lens that reflects the culture, politics, and morality of a particular society at a particular point in time. Such a viewpoint has been used to great effect by interactionist theorists to expose many medical practices and opinions that are based on social (or moral), rather than biological, factors. Many interaction studies have also focused on patients' subjective experiences of illness, interactions between patients and health professionals, and interactions among health professionals (especially between doctors and nurses).

Becker (1963) argues that deviance is created through social interaction when certain behaviours or groups of people are labelled as deviant by social institutions such as the police, courts, and mental health authorities. **Labelling theory** examines the effect that being labelled deviant has for the individual concerned. Such an approach draws attention to how and why certain behaviours and groups of people are labelled deviant. For example, in the 1960s, African Americans involved in street protests or 'race riots' were labelled as exhibiting deviant, abnormal, and even pathological behaviour. Labelling theory exposed the way that medicine (in this case psychiatry) could be used as an instrument of **social control** to constrain the actions of 'difficult' social groups (see Roach Anleu 1999).

Goffman (1961; 1963) examined **stigma** and focused attention on what he termed **total institutions** such as asylums. According to Goffman, people become stigmatised when they possess an attribute that negatively affects social interaction. He identified three forms of stigma: physical deformity, individual characteristics (mental disorder), and 'tribal' factors (based on 'race', ethnicity, and religion). In his terms, these resulted in tainted or 'spoiled identities', whereby social interaction was affected by negative traits associated with the particular stigma. For example, people may react to others with physical disabilities through outright discrimination or may treat them as if they were also mentally incompetent. A person diagnosed with schizophrenia may be treated as (and often called) a 'schizophrenic' as if that were the sole characteristic of who the individual is; the stereotype associated with the condition overrides the actual personality, actions, and achievements of the individual concerned.

Goffman's (1961) analysis of institutionalisation (the incarceration of people for some form of treatment or sanction) focused on the experience from the perspective of the 'inmates'. His

SOCIAL CONSTRUCTION/ CONSTRUCTIONISM
The socially created characteristics of human life based on the idea that people actively construct reality, meaning it is neither 'natural' nor inevitable. Therefore, notions of normality/ abnormality, right/ wrong, and health/ illness are subjective human creations that should not be taken for granted.

LABELLING THEORY
Focuses on the effect that social institutions and professions (such as the police, the courts, and psychiatry) have in labelling (defining and socially constructing) behaviours and activities as deviant.

SOCIAL CONTROL
Mechanisms that aim to induce conformity, or at least to manage or minimise deviant behaviour or resistance to dominant norms, values, and practices.

THEORYLINK
See Chapter 12 for more on labelling theory.

STIGMA/ STIGMATISATION
A physical or social trait, such as a disability or a criminal record, that results in negative social reactions such as discrimination and exclusion.

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observations of the interaction between inmates and institutional staff reflected the overt and covert forms of power relationships imbued in what he termed the 'total institution'. While such institutions served to impose highly regimented and authoritarian forms of conformity on inmates, often to the detriment of their personal and health needs, they also resulted in a hidden 'under-life' through which people kept a sense of their individual identity by resisting or undermining authority in secret ways (see also Scheff 1966). Goffman's insights on the negative effects of institutionalisation have had a wide social impact and did much to place the issue on the public agenda.

TOTAL INSTITUTIONS
A term used by Erving Goffman to refer to institutions such as prisons and asylums in which life is highly regulated and subjected to authoritarian control to induce conformity.

FEMINISM

Feminist perspectives in sociology first arose in the 1960s and were primarily aimed at addressing the neglect of gender issues and in some cases the blatant sexism of traditional sociological theories, exposing that most mainstream sociology was in fact 'male-stream' (Abbott et al. 2005). Women's experiences as workers, partners, carers, or victims of abuse were rarely studied or theorised. For example, most traditional theories of social class (such as Marxism) excluded the study of women and concentrated on fathers and sons, rather than mothers and daughters. Furthermore, some approaches perpetuated sexist assumptions about the role of women in society, such as Parsons' view of women as performing 'expressive roles' in society, and fulfilling the 'function' of providing emotional care and support of men and families. Hence, feminist perspectives addressed the question 'What about the women?' and focused on social inequality between women and men.

Feminism is a broad social and intellectual movement that addresses many issues from a range of academic disciplines. There are many 'feminisms', most of which can be grouped into four schools of thought:

- liberal feminism
- radical feminism
- socialist and Marxist feminism
- postmodern feminism.

There are numerous comprehensive introductions to feminist perspectives (see, for example, Wearing 1996; Tong 1998; Beasley 1999; Abbott et al. 2005).

Despite the diversity of approaches, feminist perspectives all highlight the importance of **patriarchy**. Feminists argue that the social structure is patriarchal, with social institutions such as the legal, health, and education systems, as well as the wider culture, reflecting sexist values and supporting the privilege of men. They challenge biological assumptions about women's nature, highlighting that **gender** is a social construction and identifying gender-role socialisation and sex discrimination as keys to understanding inequality between the sexes.

Feminist perspectives of health care have underpinned the women's health movement and have drawn attention to:

- the **sexual division of labour** in health care, particularly the historical role of women healers, the subordination of female-dominated professions such as nursing, the performance of **emotional labour**, the role of women as informal carers outside the health

PATRIARCHY
A system of power through which males dominate households. It is used more broadly by feminists to refer to society's domination by patriarchal power, which functions to subordinate women and children.

GENDER/SEX
This pair of terms refers to the socially constructed categories of feminine and masculine (the cultural identities and values that prescribe how men and women should behave), and the social power relations based on those categories, as distinct from the categories of biological sex (female or male).

SEXUAL DIVISION OF LABOUR
The nature of work performed as a result of gender roles. In contemporary English-speaking societies, the stereotype is that of the male breadwinner and the female homemaker, even though this pattern is far from an accurate description of most people's lives.

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system, and the effect of the increasing entry of women into the medical professions (Ehrenreich & English 1973; 1974; 1979; Hothschild 1979; Broom 1991; Gibson & Allen 1993; Pringle 1998; Wicks 1999);

- sexism and **biological determinism** in health care, particularly medical research and treatment, according to which much health research has been conducted on men and extrapolated to women, and women's specific health concerns have been under-researched or falsely assumed to be the result of their menstrual cycles (that is, women as 'helpless victims of their hormones') (Barrett & Roberts 1978);
- unwarranted and sometimes harmful interventions in the management of pregnancy, childbirth, contraception, reproductive technology, and gynaecological disorders (Frankfort 1972; Oakley 1980; Doyal 1995; Annandale & Clarke 1996);
- the issues of sexuality, rape, and domestic violence as key health issues requiring the need for appropriate health policies and specialised training of health workers (Doyal 1995; Abbott et al. 2005);
- body image and eating disorders (Wolf 1990; Bordo 1993; Bartky 1998; Williams & Germov 2008).

EMOTIONAL LABOUR
The use of feelings by employees as part of their paid work. In health care, a key part of nursing work is caring for patients, often by providing emotional support.

BIOLOGICAL DETERMINISM
An unproven belief that individual and group behaviour and social status are an inevitable result of biology.

THEORYLINK
Chapter 7 discusses gendered health and the contributions of various feminist writers.

Today, feminist perspectives and concerns are a central feature of sociology and health sociology in particular. Feminism has exposed the sexism and biological determinism of medical approaches, and facilitated increasing attention on women's health rights in terms of health research, funding, and the provision of appropriate services (see Annandale 2004 for a review of feminist theories applied to health).

CONTEMPORARY MODERNISM: THE THEORETICAL SYNTHESISERS

Modernity refers to social life in the modern era or 'modern times', which is characterised by the rise of industrial society and the dominance of science and rationality over superstition and tradition. Marx, Weber, and Durkheim were some of the original (or classical) modernist sociological theorists who attempted to understand social change brought by industrialisation, capitalism, and rationalisation (Ritzer & Goodman 2004; Cuff et al. 2005). Influenced by this tradition, though dealing with social life that has changed significantly since the time of the classical theorists, contemporary theorists of modernity are a diverse group of writers who are difficult to classify because their work is a synthesis of various theories and concepts (notably drawn from Marxism, Weberianism, and structural functionalism). Key theorists include Norbert Elias (1897–1990), Pierre Bourdieu (1930–2002), Zygmunt Bauman (1925–), Jürgen Habermas (1929–), Anthony Giddens (1938–), Ulrich Beck (1944–), and Manuel Castells (1942–), some of whom are often grouped under the banner of 'critical theory'. The perspective of 'contemporary modernism' is thus a linguistic convenience to identify some of the shared concerns of these authors, a distinguishing feature of which is their attempt to integrate structure and agency, such as Giddens' **structuration** theory (Ritzer & Goodman 2004).

MODERNITY/ MODERNISM
A view of social life that is founded upon rational thought and a belief that truth and morality exist as objective realities that can be discovered and understood through scientific means. See **reflexive modernity** and **post-structuralism/ postmodernism**.

STRUCTURATION
A concept developed by Anthony Giddens to indicate the interrelationship between structure and agency.

According to Giddens and Beck, we live in an era of **reflexive modernity** (Beck et al. 1994), whereby people's increased access to global travel, media, and information and communication

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technologies (ICTs), along with increased rates of education (in developed countries at least), have displaced traditional values and modes of living with a multitude of lifestyle choices. While people are much freer to choose their lifestyles, values, and identities (Giddens 1991), they are also more conscious of the increased risks of social life in the face of environmental pollution, corporate corruption, and terrorism, which Beck (1992) argues is characteristic of living in a **risk society** (see also Beck 1999; Adam et al. 2000). In the context of health and illness, contemporary modernist approaches can be applied to study health promotion, risk factors, and health-related behaviour.

POSTMODERNISM

The terms 'postmodernism' and 'post-structuralism' are often used interchangeably (Ritzer 1997), and, even though distinctions can be made between the two, for our purposes we will focus on their similarities and treat them as one (and for simplicity only use the term 'postmodernism'). Postmodernism arose in the 1980s and reflects a diverse range of sociological theories from many academic disciplines, making it difficult to categorise or treat systematically; however, to greater or lesser degrees, most social (not necessarily sociological) postmodern theorists who fall under the umbrella of postmodernism share the following key assumptions:

- The rejection of universal truths about the world, instead suggesting that reality is a social construction: therefore, all theoretical perspectives (whether they be in the natural, health, or social sciences) reflect the vested interests of one group or another, and thus all knowledge is merely a claim to truth, reflecting the subjectivity of those involved.
- The rejection of grand theories or **meta-narratives**: postmodern perspectives are critical of structuralist perspectives such as structural functionalism and Marxism, which suggest there is an overriding logic of social organisation. They dispute the existence or importance of unifying trends and structural determinants such as functional prerequisites, class conflict, patriarchy, or rationalisation.
- Since no perspective is neutral and there are no universal structural determinants of social life, postmodernists focus on how truth claims about the world are socially constructed. Thus, there is no single reality or ultimate truth, only versions or interpretations of what is 'real', 'true', 'normal', 'right', or 'wrong'. Postmodernists adopt a pluralist approach and claim that social life is characterised by fragmentation, differentiation, and subjectivity, reflecting people's differences in terms of their culture, lifestyle, and vested interests. Such a perspective supports tolerance of diversity, but can imply that 'almost anything goes'.

The main social theorists are Michel Foucault (1926–84), Jean-Francois Lyotard (1924–98), Jean Baudrillard (1929–2007), and Fredric Jameson (1934–). In sociology, the work of Foucault has had the most influence, especially his historical work on asylums, prisons, and hospitals, which uncovered how knowledge and power are used to regulate and control various social groups (see Box 2.1).

REFLEXIVE MODERNITY
A term coined by Ulrich Beck and Anthony Giddens to refer to the present social era in developed societies, in which social practices are open to reflection, questioning, and change, and therefore in which social traditions no longer dictate people's lifestyles. See **modernity**.

RISK SOCIETY
A term coined by Ulrich Beck (1992) to describe the centrality of risk calculations in people's lives in Western society, whereby the key social problems today are unanticipated hazards, such as the risks of pollution, food poisoning, and environmental degradation.

META-NARRATIVES/ META-ANALYSIS
The 'big picture' analysis that frames and organises observations and research on a particular topic.

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BOX 2.1
DOING HEALTH SOCIOLOGY: SURVEILLANCE

Foucault's (1979) conceptualisation of the panopticon (all-seeing place) as a metaphor for his theory of surveillance and social control has been a key legacy of his work. The panopticon was developed by Jeremy Bentham in the eighteenth century as an architectural design for a prison, consisting of a central observation tower surrounded by circles of cells so that every cell could be observed simultaneously. According to Foucault:

> All that is needed, then, is to place a supervisor in a central tower and to shut up in each cell a madman, a patient, a condemned man, a worker, or a schoolboy … [resulting in] a state of consciousness and permanent visibility that assures the automatic functioning of power … in short, that the inmates should be caught up in a power situation of which they themselves are the bearers. (1979, p. 200–1)

Therefore, control could be maintained by the assumption of being constantly under surveillance, so that individuals subjected to the disciplinary gaze were 'totally seen without ever seeing, whilst the agents of discipline see everything, without ever being seen' (Foucault 1979, p. 202). The idea that social control of people's behaviour can be exerted in such an indirect and self-induced way has been a significant insight. For example, the wide promotion of the thin ideal of female beauty in Western societies results in panoptic effects whereby many women perceive themselves to be under constant body surveillance and undergo numerous disciplined activities with detrimental health consequences in an attempt to conform to the pressure to be thin (see Williams & Germov 2008).

Postmodernism has significantly influenced feminist perspectives. Postmodern feminism focuses on agency and subjectivity, exploring 'differences' among women in terms of class, religion, 'race', and ethnicity. Postmodern feminists stress that women use their agency to mediate, resist, and in some cases overcome patriarchy (see Butler 1990; Barrett & Phillips 1992; McNay 1992; Pringle 1995; Weedon 1997; Bartky 1998). In her book *Sex and Medicine*, Rosemary Pringle (1998) explores the impact that increasing numbers of female doctors are having on the organisation and delivery of health care. While not discounting the patriarchal basis of the medical profession, Pringle shows how female doctors are making a difference, and while 'struggles go on at a local level and outcomes vary' (1998, p. 222), their efforts have been primarily responsible for establishing the viability of women's health centres and addressing sexism in medical practice.

Conclusion

Despite the differences between the theoretical perspectives discussed here, the distinctions between specific sociological theories produced by individual authors are likely to be less clear-cut. As Judith Bessant and Rob Watts state (1999, p. 34), sociologists 'constantly "hover" between and in and out of different traditions', and specific sociological theories are not 'as neat or coherent' as grouping them into theoretical perspectives implies. While sociologists generally align themselves with particular perspectives, they tend to be in less disagreement than the differences between perspectives might imply. This is partly due to the fact that

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sociologists attempt to incorporate the insights of a range of perspectives into their specific sociological theory.

While the existence of so many perspectives can be challenging, new theories and perspectives are likely to continue to emerge. Sociological theories change over time as society itself changes and new knowledge, ideas, and capabilities emerge. This is as true of the natural sciences as it is of the social sciences. In response to social change and the development of new insights, theories are regularly modified, reinterpreted, and even rejected.

It is worth noting that the theoretical perspectives presented in this chapter are more complex than can be discussed here. Furthermore, no attempt has been made to evaluate the theoretical perspectives, a feature beyond the scope of this introductory chapter. The aim has been to convey a basic understanding of some of the main assumptions, concepts, and approaches to explain the differences between perspectives and the insights they offer, and help lay the foundations of understanding for various sociological theories you will encounter in this text and the wider literature.

At this point it is important to sound a note of caution about the use and critique of sociological theories. This chapter began by using the framework of theoretical perspectives as a useful form of shorthand to convey the types of theories sociologists have developed. There is a danger then that when attempting to evaluate how well a specific sociological theory fits the evidence, the mistake is made of critiquing the general perspective to which the theory belongs, rather than assessing the insights of the specific theory itself. This is not an argument to ignore the various limitations of theoretical perspectives that many authors have exposed, but rather a warning against falling into the trap of dismissing a theory because it is allegedly guilty of all the sins of the perspective with which it is associated. A much healthier approach to adopt is a position of theoretical pluralism; that is, to accept that many theories have something to offer, even though you may have a preference for a certain theoretical perspective. Because different theoretical perspectives often address different levels of analysis and different issues, and attempt to find answers to varied questions, they should be viewed as potentially complementary rather than automatically oppositional (Turner 1995). It is up to you to judge how well a particular theory fits the researched evidence.

SUMMARY OF MAIN POINTS

- Sociologists seek to interpret their findings by offering a 'how' and/or 'why' explanation—a theory—for what they seek to understand.
- There is often disagreement over which 'how' and 'why' explanations, or sociological theories, best explain certain aspects of social life. Just as there are people with different opinions, there are sociologists who offer different theories to explain social life.
- One way to understand the range of sociological theories that exists is to group the theories into seven main theoretical perspectives: structural functionalism, Marxism, Weberianism, symbolic interactionism, feminism, contemporary modernism, and postmodernism.
- Differences between the theoretical perspectives are based on a range of philosophical assumptions and levels of focus, which direct attention to particular aspects of social life and how they should be investigated.

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- The use of theoretical perspectives oversimplifies the reality of sociological theorising, so that some sociologists may adopt different theoretical positions according to the topic under study or may incorporate the insights of other perspectives into their own sociological theory.
- A specific sociological theory should not necessarily be discarded due to the perceived limitations of the theoretical perspective to which it belongs. While it is important to be aware of the underlying assumptions and limitations of theoretical perspectives, a specific sociological theory should always be evaluated on its merit.

SOCIOLOGICAL REFLECTION

WHAT'S YOUR THEORY?

Sociological theories can help us understand how and why certain health problems exist. As this chapter has shown, most theories can be grouped into seven major theoretical perspectives:

1 structural functionalism

2 Marxism

3 Weberianism

4 symbolic interactionism

5 feminism

6 contemporary modernism

7 postmodernism.

Which theoretical perspective do you prefer? Why? Identify some of the key insights into understanding health and illness that your preferred perspective provides.

DISCUSSION QUESTIONS

1 Why is theory necessary? Provide examples in your answer.

2 What are some of the limitations of adopting one theoretical perspective and ignoring others?

3 Identify perspectives that focus their attention on studying the interactions between health professionals and patients; what do they add to our sociological understanding of health and illness?

4 Which perspectives focus on health inequality and what do they add to our sociological understanding of health and illness?

5 What insights into health issues and health care have feminist perspectives provided?

6 What insights do postmodern perspectives of health and illness provide?

FURTHER INVESTIGATION

1 Choose two of the perspectives discussed in this chapter and examine the similarities and differences in their approach to studying health and illness.

2 The sick role is no longer applicable to the experience of illness and health care. Discuss.

3 Compare modernist and postmodernist perspectives on a health issue of your choice.

4 Marxist theorists suggest that health care is increasingly commodified in Australia. Discuss.

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WEB RESOURCES

Social Theory & Health: <www.palgrave-journals.com/sth>.

SocioSite: Sociological Theories and Perspectives: <www.sociosite.net/topics/theory.php>.

DOCUMENTARIES/FILMS

Understanding Sociology (1998), three volumes

Halo Vine Video, Middlesex, UK. Volume 1: 'Theory and Method' (classical sociology: positivism, interpretivism, and realism), 42 minutes; Volume 2: 'Making Sense of Sociological Theory' (Marxism, structural functionalism, and interactionism), 58 minutes; Volume 3: 'From Modernity to Postmodernity' (modern ways of thinking, the postmodern critique, and postmodern views of gender and the media), 47 minutes. Clips available online: <http://onlineclassroom.tv/sociology>.

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03 WELL-BEING AND WELLNESS

Daniela Heil

Overview

- What do 'well-being' and 'wellness' mean, and how have they been conceptualised and critiqued from different perspectives?
- In what ways are social and cultural determinants interrelated with notions of well-being and wellness?
- How have well-being and wellness been conceptualised in Australia?

EXPERIENCING WELL-BEING AND WELLNESS

Judy got married in her early 20s, and only three days after the wedding, she discovered that her husband was cheating on her. Despite the enormous betrayal, she tried to live with his transgressions, and stayed in the distant relationship for seven years, until she eventually filed for divorce, claiming 'irreconcilable differences'.

It was not long after the divorce that Judy was diagnosed with breast cancer and underwent a double mastectomy and radiation therapy. Despite Judy having suffered more emotional and health-related trauma than many, she maintains a positive outlook on life: she feels as if she has learned much about others, but importantly about herself, as a consequence of the hardship she has undergone. Judy feels that these insights into others and into herself are a gift, and one that has equipped her with deep insights about life and the many courses it can take. She feels at peace with herself and looks at the future with hope and positivity.

In contrast, Judy's friend Rosita, who is the CEO of a large bank, does not feel she has quality of life. She works every day of the week and has little time for a social life, or for sleep. She suffers from insomnia on the few occasions when she does go to bed before midnight, and she often suffers headaches and stomach pains from the lack of sleep, the large amounts of coffee she drinks to stay alert, and from the stress that affects her round the clock. 'My work is my life,' she says, and though she loves what she does, she sometimes questions whether the sacrifices she continues to make are worth it: 'The large salary I earn gathers interest in the bank,' she says, 'and I keep dreaming of taking a long trip, but there never seems to be time for it. I haven't had a holiday for six years.'

Key terms

agency
biomedicine/biomedical model
biopsychosocial model
economic rationalism/economic liberalism
ethnicity
gender/sex
'race'
salutogenesis
sick role
social gradient of health
socio-economic status (SES)
victim-blaming

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Introduction: origins and concepts of well-being and wellness

What do we mean when refer to 'well-being' and 'wellness'; how do we attend to these concepts and how should we use and work with them? As to be expected for a debate in the social sciences, meanings of well-being and wellness cover a wide range of understandings. For instance, they can point to the state of feeling well and being in good health, or experiencing a prosperous condition, with a particular emphasis on the moral or physical welfare of a person or community. Thus, well-being and/or wellness refer to satisfactory states of being, draw attention to positive connotations, and seemingly suggest definite meanings of the concepts. Does this make an understanding of the concepts any easier? Individual experiences may still differ widely, as in the vignette above.

Well-being and wellness are often used interchangeably, as if they mean the same thing, and as though everyone has an agreed and shared understanding of what they comprise, but even though well-being and wellness are terms that appear to convey widespread agreement, they are not easily defined or explained. While well-being puts a greater emphasis on the subjective and experiential state of being in the world, and thus stresses the dynamic and socially constructed components of what it means to be well, wellness conveys greater emphasis on the current positioning or state persons are in and how they feel at a particular moment in time.

The term wellness first appeared 'as part of a parallel transformation in the definition of health toward a more holistic perspective that is interrelational, positive in nature' (Foster & Keller 2007, p. 9), and also takes understandings of healthy human functioning into account. In comparison to health, the wellness movement has continued to come to the fore since the end of the Second World War, elaborating the point that people's health needs had changed and that, from then onwards, the whole person (that is, body, mind, mindful body, spirit, emotions, and feelings) would have to be taken into consideration.

In 1946, the World Health Assembly (1948, p. 1), which would two years later become the World Health Organization (WHO), introduced a holistic definition of health for the first time, explaining it as 'a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity'. The statement does not only explain health in terms of going beyond the physical restrictions of one's body, but simultaneously emphasises the idea of the mindful body (compare Scheper-Hughes & Lock 1987) to be taken into consideration when thinking about well-being holistically; that is, beyond one's bodily boundaries, and referring to people's **agency** and their interactions with each other.

AGENCY
The ability of people, individually and collectively, to influence their own lives and the society in which they live.

Often, both well-being and wellness are equated with the more esoteric term of happiness (see, for example, Ahmed 2010; Diener 2000; Johnston et al. 2012; Mathews & Izquierdo 2009; Selin & Davey 2012). The common characteristic is that that both terms indicate positive orientations, connotations, perceptions, or feelings, which draw attention to the constitution of meanings and understandings that derive from the interrelationship of personal and public realms.

Well-being and wellness continue to be contested concepts (see, for example, Carlisle et al. 2009). They are ubiquitously and interchangeably used in everyday practices and

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communications, including health-related contexts, policy formulations, the media and, more generally, both public and private conversations (in relation to well-being, see Buchanan 2000; Buunk & Gibbons 1997; CERI 2001; Crisp & Hooker 2000; Diener & Suh 2000a; Eckersley et al. 2001; in relation to wellness, see Conrad 1994; Ferreira & Lang 2006; Friesen 2010; Schuster et al. 2004; Weaver 2002).

While one is usually aware when one experiences happiness, well-being, or wellness on a personal level, it is usually difficult, if not impossible, to propose to others what should be done to achieve happiness, to predict well-being, and to define the paths to be taken towards being and feeling well. This suggests the prevalent idea that well-being, wellness, and happiness are often considered to be personal issues that are reliant on subjective reporting, but Isaac Prilleltensky and Ora Prilleltensky (2012, p. 61) argue that well-being is not only subjective but 'also relational, organizational and communal'. They propose that well-being is 'inclusive of social indicators such as levels of unemployment, organizational climate and social capital' that 'have a potent influence on the well-being' of individuals.

Paul Ward and Samantha Meyer (2009, p. 340) propose to work with the concept of 'social quality' rather than 'well-being'. They indicate a preference for 'social quality' because it puts a particular emphasis on 'the extent to which people are able to participate in the social, economic and cultural life of their communities under conditions which enhance their wellbeing and individual potential' (Beck et al. 2001 cited in Ward & Meyer 2009, p. 340). Here, the interrelationship between individuals and their social and cultural environments is not only considered to be a continuum, but also a prerequisite for the identity formation of individuals.

Further, the idea of equating social quality and well-being draws attention to Anna Cronin de Chavez and colleagues' (2005, p. 73) work, which emphasises 'a much broader definition and understanding of quality of life', ensuring that, in addition to health, research now includes 'social, psychological, interpersonal, emotional, cultural, spiritual and environmental dimensions'. In comparison, there is 'a growing recognition that subjective conceptualisations, or the ways in which people make sense of their own lives, are central to understanding quality of life' from the perspective of individuals (2005, p. 73).

With reference to psychological approaches to well-being and wellness, a particular criticism has been the lack of attention given to interactions between individuals and their ongoing engagement with social and environmental factors. While it is immanent that the psychological literature addresses well-being or quality of life by presenting a particular emphasis on the individual, psychological approaches seldom manage to go beyond the individual perspectives and each of their subjective experiences (Diener 1984; 2000; Larsen et al. 1985; Sell & Nagpal 1992); however, several authors have made efforts to bring the social and cultural arenas to the fore as well (Diener & Fujita 1997; Diener & Suh 2000a; 2000b).

To date, only a limited number of references in the disciplines of sociology (Eckersley et al. 2001; Konu & Rimpela 2002) and anthropology (Adelson 2000; Mathews & Izquierdo 2009) have been published on the subject of well-being, wellness, or happiness. While the sociological references provide a greater emphasis on social determinants, the references in the anthropological arena include considerations in regard to the cultural determinants and to politics as well. According to de Chavez and colleagues (2005), the reason for this might be situated in the fact that both disciplines usually tend to take the interrelationship between

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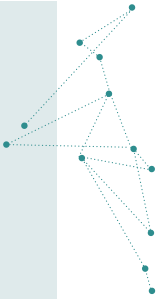
individuals and their greater societal and cultural frameworks for granted, and thus are not necessarily inclined critically to explore, or question, the dynamics reflective of the discourse. At the same time, we need to keep in mind that the discourse of well-being and wellness is a recent one, with new and different disciplinary (such as psychology, economics, and public health, as well as anthropology) and interdisciplinary publications on the topic continuing to come to the fore.



BOX 3.1
DOING HEALTH SOCIOLOGY: WELLNESS AND HEALTH

Anita is the mother of Franca, who was diagnosed with autism a couple of years ago. After the diagnosis, Franca's parents have frequently observed that their daughter seems to stand out, in comparison and reference to 'other children not diagnosed with autism'. Since they learned that Franca is 'a child with autism', Anita and her husband have been relieved rather than distraught, because they finally received confirmation what it was 'that has been troubling and difficult for' their daughter, after not knowing for many years 'what's wrong with her'.

When referring to the confirmation of Franca's diagnosis, Anita stresses one point in particular:

> Of course, we were upset to learn that she does not have anything that can be fixed, and that it is not something that can be addressed easily or quickly either, but the doctor, when informing us about the diagnosis and related circumstances, expected us to react in a particular way. He said, 'Your child is not someone that fits a particular norm'; and because we are her parents, he expected us to treat her accordingly. Yes, of course, it would be good for Franca if she were able to do what other children, who are both healthy and well, are able to do, but what that particular doctor and many others seem to forget is that she is our daughter, and that she is who she is. This is the way in which she experiences the world; she is the child we have brought up, and we love her the way she is. The label [compare Waxler 1981] of autism that continues to be applied to her does not make her better or worse than other human beings around the globe. Franca is who she is, and if the schooling and education she currently receives are able to make a difference to how she experiences us, and the world around her, that would be great. If not, we are happy to continue to have her the way she is now.

This example demonstrates different perspectives of understanding difference; how different people in a certain social and cultural environment bring their perceptions and understandings into the debate, as well as how meaning is generated and maintained in response to others in our socially and culturally constructed environment.

Well-being as an alternative conception of health?

Though health and well-being are frequently used in the same context, they are not the same, and their apparent equation does distract from their distinctive meanings (see Heil 2003; 2010). A prominent figure in addressing the question whether well-being and wellness can be considered alternative conceptions of health was George Engel (1913–99). Engel (1977) established the

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BIOPSYCHOSOCIAL MODEL
This model is an extension of the **biomedical model**. It is a multifactorial model of illness that takes into account the biological, psychological, and social factors implicated in a patient's condition. As with the biomedical model, it focuses on the individual patient for diagnosis, explanation, and treatment.

BIOMEDICINE/ BIOMEDICAL MODEL
The conventional approach to medicine in Western societies, based on the diagnosis and explanation of illness as a malfunction of the body's biological mechanisms. This approach underpins most health professions and health services, which focus on treating individuals, and generally ignores the social origins of illness and its prevention.

biopsychosocial approach, focusing on the idea that human illness and health derive from the complex interactions of biological, psychological, and social factors. According to Hilton Koppe (2002, p. 374), the biopsychosocial approach considers 'the disease and the person's illness experience, as well as the context of their life'. Thus, the focus continues to be on the individual, with regard to their engagements with others in their social and cultural context and environment. Hence, while 'health' matters, there is also an awareness and shift that has been generated toward emphasising a broader and greater context. Similarly, while aiming to expand on the famous WHO statement of health that emphasises 'complete physical, mental and social well-being', Koppe (2002, p. 375) intends to go even further than that, including each 'person's inner world and experiences, as well as their relationship with the world around them'.

Tonya Schuster and colleagues (2004, p. 350) maintain that 'definitions of health are social constructions and fundamental aspects of the sociocultural and sociohistorical environment' in which they are situated. While the starting point for them is a focus on the individual, this focus does not only take biological considerations into account, but also includes human beings in psychological and social terms, thus understanding them as 'creative agents enmeshed in social, economic, political, religious, ethnic, age, and gender relations that influence how they perceive and enact their everyday lives' as well (Schuster et al. 2004, p. 350). Accordingly, a reliance on Engel's (1977) biopsychosocial approach is also demonstrated here.

According to de Chavez and colleagues (2005, p. 81), the phrase 'health and well-being' (or 'well-being and health') 'has been increasingly used where a broad definition of health is intended', and thus 'has gained particular usefulness and significance in health promotion and public health'. This suggests that the concepts of well-being and wellness have come to the fore because the terms have the potential to unite the objectives of different disciplinary approaches and sectors. A point de Chavez and colleagues (2005, p. 71) further suggest in that regard is that 'an integrated approach to improving economic, social and environmental wellbeing is essential to improving health and reducing inequalities'.

Within the social science arena, we need to be careful that we do not continue to prioritise approaches that seek to work with definite solutions rather than understandings that reflect socially constructionist, dynamic meanings. That is, while anyone may find that their own understanding of 'what it means to be well' is consistent with a definite approach, de Chavez and colleagues (2005, p. 72) state that 'how such wellbeing might be operationalized and achieved is clearly *not* specified'. The concepts of well-being and wellness have frequently become tied into **biomedical** understandings and approaches to health, but a constructive consequence of this integration has been that the social determinants rather than the biomedical determinants have come to the fore (Marmot 1999; Marmot & Wilkinson 1999; Saggers & Gray 2007; see also Ward & Meyer 2009).

THEORYLINK
See Chapter 1 for more on the biomedical model.

Well-being objectively and subjectively: social constructions of well-being

In general terms, a person's 'inside point of view' or 'inner experience' is equivalent to 'the subjective' point of view; this is sometimes referred to as the *emic* perspective. There is also an outside point of view—the *etic* perspective—whereby there is an external, 'objective'

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perception (compare Pike 1954). The latter refers to official standpoints, such as decisions made by policy- or law-makers, whereas the former speaks of the individual experience. It is ideal when the two perspectives agree with each other, but this is not always the case—and especially not when it comes to complex notions such as health and well-being.

Starting from the social constructionist premise that someone's quality of life presents 'a dynamic interaction between the external conditions' of their life and their 'internal perceptions of those conditions, the subjective approach assumes that perceptions of what constitutes "good" and "quality" are embedded in the context of personal values, goals, talents, histories, and life experiences' (de Chavez et al. 2005, pp. 73–4). What this suggests in regard to well-being and wellness is that 'ownership of the term lies with the user' (McMahon et al. 2010, p. 283), but working with subjective accounts and reports of well-being is insufficient when entirely comprehensive accounts of well-being are to be achieved. In that regard, Eckersley (2001, p. 63) maintains that it is often 'difficult to reconcile self-reports of subjective well-being with more objective perspectives that take into account other domains of well-being' as well. He notes that 'there is a range of evidence that suggests a positive bias in the results of happiness and life-satisfaction surveys' (Eckersley 2001, p. 63). By putting a greater emphasis on the subjective experiences of well-being and, consequently, potentially ending up undermining the objective factors of well-being, we risk minimising the complexities and dynamics inherent in the debate (Eckersley 2000; 2001; 2005).

Subjective well-being is just one way of studying, exploring, and promoting well-being, and clearly only one component among others if comprehensive, holistic understandings are to be achieved. Although demographic factors such as **socio-economic status (SES)**, **gender**, or **ethnicity** only present a portion of the numerous components comprised in subjective well-being, in some societies these factors are also interrelated with higher levels of discrimination, oppression, morbidity, and mortality (Marmot 2004; Wilkinson 2005). Accordingly, we need to take into consideration that while some people may report medium levels of subjective well-being, they are potentially 'also enduring a higher burden of disease, exclusion, marginalization and death' (Prilleltensky & Prilleltensky 2012, p. 63). This suggests that a comprehensive analysis of social realms needs to be done so that subjective *as well as* objective perspectives are included (Busseri & Sadava 2011; Eckersley 2009).

Social determinants of well-being

The social determinants of health have continuously interplayed with the greater arena of well-being, with increasing attention being paid to factors that go well beyond the primarily physically oriented characteristics of health. The shift to explore well-being and wellness much more thoroughly derives to a huge extent from acknowledging the idea that one should think beyond biomedically oriented frameworks and practices, as well as their application.

Similar to the social determinants of health, the social determinants of well-being and wellness have put a particular emphasis on elaborating 'the causes of the causes' of well-being and wellness (Ward & Meyer 2009, p. 343), rather than simply providing descriptions of what well-being or wellness are. To a huge extent, the shift towards addressing 'the causes of the causes' has derived in response to recognising, and officially acknowledging, how vital and essential the social determinants of health actually are, with reference to focusing on the

SOCIO-ECONOMIC STATUS (SES)
A statistical measure of relative inequality that classifies individuals, households, or families into one of three categories—low SES, middle SES, or high SES—derived from a combination of income, occupation, and education.

GENDER/SEX
This pair of terms refers to the socially constructed categories of feminine and masculine (the cultural identities and values that prescribe how men and women should behave), and the social power relations based on those categories, as distinct from the categories of biological sex (female or male).

ETHNICITY
Sociologically, the term refers to a shared cultural background, which is a characteristic of all groups in society. As a policy term, it is used to identify migrants who share a culture that is markedly different from that of Anglo-Australians. In practice, it often refers only to migrants from non-English-speaking backgrounds (NESB migrants).

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interrelationship between health, well-being, and social care systems (Commission on Social Determinants of Health 2005).

Considering the social determinants in isolation does not account for their 'complex and inter-connected nature' (Ward & Meyer 2009, p. 343). Accordingly, comprehensive studies and research are recommended to include the following issues: social cohesion, social capital, social inclusion or exclusion, community engagement and empowerment, the effects of SES, and deriving from the latter, the inequities in access to resources and services (see Wilkinson & Marmot 2003).

SOCIAL GRADIENT OF HEALTH
A continuum of health inequality in most countries from high to low, where the poorest group of people have the worst health status, and each group above it has progressively better health, with the most socio-economically advantaged group having the best health status.

Paying attention to the social determinants of health, Richard Wilkinson and Michael Marmot (2003) mention the **social gradient**, which refers to the idea that a person's life expectancy is shorter—and experiencing the majority of diseases is more common—the further down the social ladder he or she is positioned in the societal context. This does not only relate to social status and psycho-social ranking in comparison to others, but also includes level of education and, commonly, SES positioning as well. Further, psychological, social, and biological circumstances should not be considered isolated from each other (compare Engel 1977). Factors such as experiencing stressful circumstances over extended periods of time can produce impacts on health and, more generally, on wellness-related issues.

Wilkinson and Marmot elaborate the importance of assuring 'a good start in life' (2003, p. 14), so that positive 'foundations of adult health are laid' and a person continues being socially included (for example, having good quality of life, being financially independent, and not being discriminated against socially). In addition to either being unemployed or having work, this would include the extent to which a person is in control of his or her job and socially integrated in the workplace. Support from others, whether people are isolated or well-integrated regarding social relationships, is important and should be taken into consideration as well. Finally, food supply, dietary intake, exposure to drugs or alcohol, etc. are also determinants that are influenced by every human being's wider social setting.

While the social determinants of health underpin the social determinants of well-being, there is a difference that needs to be taken into account because of the particular ways in which personal experiences and perceptions are translated into well-being. While health is socially determined and constructed, in the same way that well-being is, the concept of health allows for an external review of someone's state of health, while the concept of well-being does not.

SALUTOGENESIS
The development of the wellness movement. Its focus is on health rather than wellness.

Salutogenesis, or the salutogenic movement, derives from the work of the medical sociologist Aaron Antonovsky (1923–94), whose professional interest focused on the relationship between wellness, health, and stress. The term salutogenesis links the Latin word *salus*, meaning 'health', with the Greek word *genesis*, which translates into 'origin'. While biomedically oriented approaches in the Westernised world have increasingly come to ask about the origin of illness and disease, Antonovsky's salutogenic approach proposes that an equally important question be asked: 'What is the origin of health?'

Antonovsky used the term salutogenesis for the first time in 1979. He focused on the influence of a variety of sources of stress on people's health and, in that way, was able to demonstrate that people who experience hardly any stress have much greater resistance to illness and disease than people who experience stress regularly and for extended periods of time. Antonovsky's research focused on the question, 'What explains movement toward the health end of the health–illness continuum?', which eventually led him to formulating that experiencing wellness constitutes and maintains a 'sense of coherence' (1990, p. 1) that comprises

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three components: comprehensibility, manageability, and meaningfulness. His hypothesis was that 'the stronger the sense of coherence, the greater the likelihood of moving toward the health end of the continuum' (1990, p. 1). For Antonovsky, the crucial determinants towards a sense of coherence are located in both macro-social and historical factors. Underlining the social constructionist approach inherent to the salutogenic movement, Antonovosky (1990) maintains that there are many different ways in which a strong sense of coherence can be achieved and, clearly, health is not the only value in human life. Within the salutogenic orientation, there is a direct relationship between the strength of the sense of coherence and a person's ability to employ cognitive, affective, emotional, and instrumental strategies that are likely to improve coping for oneself and, hence, produce and assure wellness at the same time.

The concept of salutogenesis has come to the fore within the arenas of alternative medicine and health promotion (Antonovsky 1996), highlighting that while modern medicine and biomedical approaches put particular emphasis on problems located in patients' bodies that need to be fixed, the social origins and constructions of health are equally important and also need to be taken into consideration. An important point of the salutogenesis debate is that considerations of wellness and well-being derive from approaches introducing health, and are thus primarily conceptualised in those terms as well. Hence, while well-being is meant to present a broader and wider realm, it is usually mainly focused on the individual and not necessarily on taking the wider realm of social and emotional wellness into account.

Antonovsky's starting point with reference to the salutogenic approach is that a primary emphasis on pathogens 'dominates health research and clinical practice in the industrialized world' (1990, p. 2). He maintains that the pathogenic paradigm with which so many of us are familiar emphasises individuals, the materiality of the body, and the assumption that there is a mechanistic interrelationship among each individual's body parts. Antonovsky's starting point is 'that specific pathogens or disease agents' have commonly been considered 'to threaten the integrity of the organism', and that 'the resulting symptoms are diagnosed in terms of diseases' (1990, p. 3). Hence, he proposes that the particular emphasis of research is 'directed to identifying the pathogens' as well as 'the search for their elimination' (1990, p. 3). He refers to this paradigm as responsive to the mode of industrial production, either comprising a free market or reflective of a centralised planning type that has dominated the developed world.

A particular message of Antonovsky's is thus the shift from pathogenesis—or, in other words, an approach elaborating a particular emphasis on health-related risk factors—to the formulation of the salutogenic question that stresses the origins of health—or, in other words, salutary factors. The salutogenic approach considers 'the struggle to move toward health as permanent and never fully successful' and one that thus 'focuses our concentration on those salutary factors which will help people to cope as successfully as possible throughout their lives' (Antonovsky 1990, p. 6). Antonovsky refers to a 'sense of coherence' in terms of:

> a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement. (1990, pp. 7–8)

He suggests that the stronger a person's 'sense of coherence', the more successfully one is able to cope and deal with 'inevitable, continual, built-in stressors in human existence' (1990, p. 8).

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Well-being and wellness in Australia

INFLUENCES ON THE HEALTH PROFESSIONS: COMPLEMENTARY AND ALTERNATIVE MEDICINE, HEALTH CARE, AND HEALTH PROMOTION

Within the disciplinary contexts of complementary and alternative medicine (CAM), the concepts of well-being and wellness have been 'used primarily as a platform for encouraging healthy living practices' (McMahon et al. 2010, p. 283). Often, this includes dietary considerations. Persons seeking CAM treatment and practices are frequently considered to be more actively engaged in personal health care and addressing aspects of self-assessing well-being. Within Australian CAM settings and frameworks, meanings of well-being often embody holistic principles of health that encompass all aspects of life. The use of CAM has grown significantly over the past decades, with the percentage of current users ranging from 30 to 60 per cent of the population (Sointu 2011, p. 356).

THEORYLINK
See Chapter 22 for more on CAM and Chapter 24 for a discussion of health promotion.

See Chapter 2 for more on the sick role.

Often, a sense of dissatisfaction with biomedical practices and encounters is seen to underlie the rise of the complementary and alternative health arena. While the use of CAM refers to the rejection of the Parsonian **sick role** by health consumers, it promotes the idea of treatments and practices that address the whole person. Correspondingly, there has been a growing use of complementary and alternative health practices, which has drawn attention to the disjunctures and inconsistencies between patients' expectations, their perceptions, and experiences; and, in comparison to that, the solutions and practices that continue to be proposed in biomedically provided options and frameworks. While this emphasises Antonovsky's salutogenic approach, it also captures 'a decline in the importance of biomedical understandings of disease' (Sointu 2011, p. 356). Thus, health- and illness-related understandings in many CAM contexts resonate strongly not only with people's personal and lived experiences of illness, but also their broader societal conceptualisations of the responsible and empowered self and, interrelated with that, their bodies (Sointu 2011).

SICK ROLE
A concept used by Talcott Parsons to describe the social expectations of how sick people are expected to act and of how they are meant to be treated.

The wellness and well-being debate within CAM frameworks refers to the consumer being at the centre and, hence, defines wellness through values such as individual agency, self-fulfilment, and self-control. In comparison to CAM, 'other disciplines, such as health promotion' encounter difficulties when aiming 'to move beyond the health outcomes model, only recently adopting broader, more socially based, concepts such as "living well"' (de Chavez et al. 2005, p. 81). According to de Chavez and colleagues, 'the contribution to understanding wellbeing made by health promotion is disappointing' (2005, p. 75). An exception to this is David Buchanan's (2000) work, which refers to well-being in terms of integrity and living well rather than with regard to discrete health outcomes. While claiming that there can be no single definition of 'the good life' (see also Heil 2010), Buchanan argues that well-being is dependent on the justice of social conditions and, therefore, potentially related to social capital.

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BOX 3.2
DOING HEALTH SOCIOLOGY: NEOLIBERALISM AND SELF-RESPONSIBILITY

Shifts in health policy and social policy have occurred to encompass the promotion of both health and well-being during periods comprising neoliberal agendas or **economic rationalism**, and crises of legitimation of governments. The underlying agenda of neoliberal governments with respect to promoting 'well-being' or 'wellness' is that both concepts focus attention on the responsibility of individuals to look after themselves. Correspondingly, the cause *as well as* the solution of any well-being- and wellness-related problem has become, and is commonly understood to be, situated *and* located within individuals. Thus neoliberal governments tend to rely on the individualistic argument that they have not initiated these health problems, and therefore have no responsibility to resolve them—essentially adopting a **victim-blaming** stance.

WELL-BEING AND WELLNESS AND ABORIGINALITY IN AUSTRALIA

With reference to the ethnographic setting of an all-Indigenous Australian community context, approaches to well-being have continued to adopt the individualising paradigm inherent in what is conventional Western approaches to health (Heil 2010; 2012). The understanding taken from health-oriented debates and transferred to seemingly more broadly oriented understandings of well-being is the concept of an embodied self and an individual's personal understandings of what it means to be healthy and well.

Indigenous Australians have been in marginalised positions throughout Australia since the arrival of the European colonisers. Non-Indigenous influences have shaped a range of often competing understandings of Indigenous well-being and wellness, often positioning Indigenous Australians as marginalised for their socially and culturally distinctive and different practices and understandings; but Indigenous Australians have also been described as groups deserving to enjoy safety and security (see, for example, Brady 2004).

Indigenous Australians, their particular identities and cultural understandings, and their conceptualisations of well-being or wellness have been portrayed from different perspectives. For instance, Indigenous Australian activist Roberta Sykes (1989) has positioned her work firmly within the context of colonial disadvantage. She refers to 'health' as the pre-colonial state, when Indigenous Australians were still in control of their own lives, and their lifestyles were still characterised by a 'healthy diet' and 'lots of exercise' (p. 187). Sykes constructs an understanding of 'illness' as the permeation of European disease and practice into Indigenous Australian life. By emphasising diet and physical activity, her point of reference is physically oriented. For instance, she links Indigenous Australian cultural practices of hunting and gathering, which determined daily routines, to the changes introduced by colonisation, and which turned physically active lives into sedentary lifestyles; however, Sykes also maintains that 'the inter-relatedness between health and all other Black community concerns has to be

ECONOMIC RATIONALISM/ ECONOMIC LIBERALISM
A political philosophy based on small-government and market-oriented policies, such as deregulation, privatisation, reduced government spending, and lower taxation.

VICTIM-BLAMING
The process whereby social inequality is explained in terms of individuals being solely responsible for what happens to them in relation to the choices they make and their assumed psychological, cultural, and/or biological inferiority.

THEORYLINK
See Chapter 8 for more on Indigenous health inequality.

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explored in order to be understood. Implicit in the subject of health is a feeling of well-being' (Sykes 1989, p. 198). With this statement, Sykes is considering the overall circumstances of Indigenous Australian people as colonised subjects. In addition, Sykes also introduces, for the first time with reference to Indigenous Australians, the concept of 'well-being or happiness' as distinct from 'health'. She maintains that:

> the inter-relationship between health and well-being or happiness is complex. Rarely do sick people enjoy a feeling of well-being. Good health may not necessarily bring happiness, but without good health a person is unlikely to experience 'well-being'. On the other hand, unhappiness has been found to be a major factor in many forms of illness. Some doctors even feel that stress, pressure and unhappiness *cause* illness. (1989, p. 202)

Though Sykes' statement clearly suggests that Indigenous Australian health and Indigenous Australian well-being do *not* present equivalents, she makes the point that there is an inter-relationship between the two concepts; that is, while being healthy does not necessarily generate wellness, contentment, or happiness, she sees health as a prerequisite for Indigenous Australian people's well-being.

Other debates addressing Indigenous Australian well-being and Indigenous Australian health refer to the socio-economic foundation of health inequities (see, for example, Robinson 1995; Saggers & Gray 1991; Stanner 1974; Thomson 1985) and racism (Cavalli-Sforza & Cavalli-Sforza 1995; Cowlishaw 1997; Kelm 1998; Macdonald 1990; Mitchell 1996; Morris 1997; Morris & Cowlishaw 1997), as well as the politics of Aboriginality, and policies to accommodate Indigenous Australian people's social and cultural differences, in Australia as well as Canada (Adelson 1998; 2000; Anderson 1994; 1997; Austin-Broos 2011; Bennett 1999; Fletcher 1992; Myers 1986b; Niezen 2003). These issues have contributed to establishing and maintaining unhappiness, and feelings of insecurity and lack of appreciation within mainstream Australian society. Though Indigenous Australians report experiences of culturally inappropriate treatment by non-Indigenous Australians, there have also been indications/proposals for Indigenous experiences of feeling culturally safe (Henry et al. 2004; Houston 1998; 2001; Wilkes et al. 2002).

Sykes (1989) equates well-being with the idea of 'happiness' and describes it in terms of needs being met. She emphasises the issue of racism, and maintains that an essential difference between non-Indigenous and Indigenous Australians is that the latter neither grow up with nor experience their needs being met as an inherent component of their everyday life. Correspondingly, a sense of everyday security, a safety net, and being respected as equals does not form an integral part of Indigenous Australian people's lives; hence, they live with permanent feelings of marginalisation rather than experiencing wellness or well-being. As has been noted by Gillian Cowlishaw and Barry Morris:

> the tradition of differentiating between race and culture, and between racism and ethnocentrism, is one that relies on separating the concepts from the circumstances which generate them and which continue to give them efficacy in society. The formation and reproduction of groups in a hierarchical society has always relied on some notion of *given* characteristics which define members of a group, and thus has also relied on the circumstance that primary social relations are the focus of personal and emotionally laden identities which command loyalty, rather than on some superficial, external cultural markers which can be discarded at will. (1997, p. 7)

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They hence suggest that **'race'** as a cultural construct is both entangled with, and situated within, the dynamics and complexities of cultural understandings. Obviously, this does not only apply to non-Indigenous cultural understandings, but Indigenous ones as well.

'RACE'
A term without scientific basis that uses skin colour and facial features to describe what are alleged to be biologically distinct groups of humans. Race is actually a social construction used to categorise groups of people and sometimes implies assumed (and unproven) intellectual superiority or inferiority.

Ian Anderson (1997) acknowledges the Australian mainstream health system's construction and domination of Indigenous health problems; but at the same time, one of his primary concerns is to ascertain what health constitutes and means for Indigenous Australian people(s). Drawing on debates about Australian Indigenous Australian health, Anderson arrives at the concept of well-being as a much more appropriate term to be used. He further comments that meanings and understandings of Indigenous Australian well-being have been insufficiently explored (Anderson 1999; see also Mobbs 1991).

What is it that constitutes Indigenous Australian understandings of wellness or well-being without recourse to biomedical parameters? With reference to Indigenous Australian settings and contexts, the notion of well-being has frequently been equated with sewerage, food, water, electricity, housing, economic independence, being in a position to pursue traditional practices, and land rights (see, for example, Mobbs 1991; NAHSWP 1989). Both Indigenous Australian people and non-Indigenous Australian activists have frequently summarised this position as a 'holistic approach to health'. The notion of 'holism' has most frequently been used in debates that take an oppositional stance to biomedical conceptions of health. Under these circumstances, 'holism' usually refers to the treatment of the whole person, meaning a holistic approach to health that connects people with each other, with place, and with the law.

Over the past few decades, this notion of holism with reference to Indigenous Australians has served as a tool to sustain the idea that there are distinctive differences between Indigenous Australian understandings and biomedically oriented understandings of the concept of health; however, what is meant by 'holism'—in detail, as well as more broadly—has never been sufficiently explored. A point on which many people who use this term agree, though, is that a holistic approach to Indigenous Australian health not only attempts to move away from a narrowly individualistic, biomedical model of disease and physical symptoms (see also Scott 1999), but also seeks to address a much greater range of impacting issues.

Anderson (1999, p. 65) states that the core elements of Indigenous Australian understandings involve 'the physical, social, emotional, cultural and spiritual well-being not only of the individual but of the whole community'. He extends the notion of 'health' to 'well-being' and, in so doing, takes a much broader arena into consideration. Well-being comprises 'people, place and law, and is a whole-of-life view, including the traditional concept of life-death-life as well as the relationship to the land' (Anderson 1999, p. 65). What differentiates Anderson's approach to well-being from the one used by the WHO is his inclusion of a 'cultural' ingredient.

This whole-of-life view has enabled the move away from the conventional focus on the individual and his or her malfunctioning body. The new approach includes social interaction with others, social and cultural issues, and conceptions that involve more than the biomedical practices as applied in mainstream health contexts.

From non-Indigenous perspectives, 'understandings of what it means "to be well" and "to enjoy life" have primarily emphasised an individualistic', and individualising, 'approach to happiness and wellbeing' (Heil 2012, p. 205). In comparison, Anderson (1999, p. 65) maintains that 'Aboriginal ideas of well-being imply that bodies can be conceived as transforming products of the relationship between our internal experience and our connection with other

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people'. What this means is that we must prioritise both if comprehensive, socio-cultural considerations and acknowledgment of Indigenous Australian understandings of 'being well' and 'enjoying life' are to be achieved.

Conclusion

Well-being and wellness and are concepts that have received particular attention since the early 1990s. This is often framed in manners that address individuals and the contributions they can make to improve and maintain their wellness and well-being, and that of their family as well.

From the ensuing debate, it seems that a stalemate or impasse has been reached, with different perspectives and positionings arguing for either increased government control and regulation, or increased individual responsibility. This 'either/or' division may not end up being a productive approach in the long term; instead, the meanings and understandings that continue to be created, maintained, and changed over time might end up acknowledging the relative importance and interaction of numerous, culturally different individuals, the nation state and, more widely, social structures and systems.

Prilleltensky and Prilleltensky (2012, p. 63) have emphasised and elaborated on the 'role of relationships and collective dynamics on personal well-being', measured both by subjective reports and by objective indicators, such as unemployment and levels of illness and disease. More recently, they have expanded what they call the 'web of wellness' to include the role of organisational determinants. They argue that the time has come to address problems, and this includes considering concepts such as well-being and wellness comprehensively and synergistically. Though research has shown that 'the mere act of working with others on collective problems can improve self-esteem, self-efficacy, social support and empowerment', they add as well that 'it is not only the outcome that matters', but also 'the process itself' (Prilleltensky & Prilleltensky 2012, p. 65).

While some argue that the findings deriving from literature reviews and research depict well-being as a multifaceted concept that requires clearer definition, further attention and agreement in regard to mediating different perspectives (see, for example, de Chavez et al. 2005), others prefer to maintain and reiterate the point that well-being and wellness have become 'the new kids on the block' in regard to looking after oneself and others. The concepts of well-being and wellness reflect particular social dynamics and social and structural circumstances and, therefore, contain many meanings, as do other concepts in the social sciences. Accordingly, these concepts do not necessarily clearly indicate at all what is meant by well-being and wellness or what they address. The social and cultural determinants—the constituents—are crucial in regard to forming, establishing, maintaining, reiterating, and changing the understandings of well-being and wellness, and their perceptions and experiences by others. As the section on Indigenous Australian well-being has indicated, for instance, the concepts are social and cultural as well as structural constructs, and thus cannot be understood to be anything definite or static. Thus, many researchers understand well-being and wellness to be useful concepts, as they provide an opportunity and indication for demonstrating, illustrating, and presenting social and cultural determinants and their dynamic constituents with reference to different people's past, present, and future.

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SUMMARY OF MAIN POINTS

- Well-being, wellness, and happiness are often considered to be equivalents, primarily depending on the context and situation in which they are used. There is continued debate and discussion about what exactly the terms denote.
- Well-being and wellness are often considered to be vague concepts, because they do not appear to comprise definite ideas, approaches, or answers. While biomedical approaches traditionally focus on illness, a salutogenic approach focuses on health in the form of well-being and wellness.
- Concepts of well-being and wellness combine biological, psychological, social, economic, and cultural factors.
- Well-being and wellness involve activities and engagements between the individual and the social. This means that SES, ethnicity, and socio-cultural factors influence individual experiences and group definitions of these notions. Some commentators are incorporating these aspects into a holistic approach. *Etic* and *emic* perspectives can help explain the clashes between individual and societal views.

SOCIOLOGICAL REFLECTION

CROSSING THE LINE

Watch the documentary film *Crossing the Line* (2005). Paraphrase the understandings of well-being and wellness from the perspectives of the different parties portrayed in the film: the health care providers, the policy-makers, the educators, the Indigenous Australian nurses, the doctors at the Mornington Island hospital, the local Indigenous Australian people, and the visiting medical students.

- How does the film portray the social determinants of well-being and wellness by each of the parties engaged or involved?
- What assumptions about Indigenous Australian health, well-being, and wellness are made, in terms of medical treatment as well as everyday life?
- What assumptions about well-being and wellness are made in reference to how health care, health issues, and the different health professionals are represented?
- Are the health professionals portrayed in the film concerned about the well-being and wellness of the local Indigenous Australian people? Who is, and who is not?
- What assumptions about well-being and wellness are made in relation to local Indigenous Australian people's health, health care, and medical treatment?

DISCUSSION QUESTIONS

1 How aware are you of your personal well-being or wellness?

2 How are well-being and wellness portrayed in media representations?

3 To what extent do you think media reports affect public understandings of well-being and wellness?

4 Why is it important in health sociology to distinguish between 'health', 'well-being', and 'wellness'?

5 What do you consider to be the relationship between health and well-being/wellness?

6 To what extent do you think cultural difference(s) matter in regard to the ways in which health, well-being, and wellness are presented?

7 To what extent do we need to consider other people, as well as cultural background and understandings, to understand our personal well-being and wellness?

8 To what extent do you think well-being and wellness should be incorporated into Indigenous Australian health care practices?

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FURTHER INVESTIGATION

1 Critically examine what media reports and documentaries mean when they refer to well-being or wellness.

2 Research the nature of conditioning well-being and wellness, and who is behind its promotion. What objective and subjective messages and experiences are being conveyed through well-being and wellness?

3 The media has a responsibility for shaping public understanding of well-being and wellness. Explore and discuss this statement in class.

FURTHER READING

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Wiesmann, U. & Hannich, H.J. 2010, 'A salutogenic analysis of healthy aging in active elderly persons, *Research on Aging*, vol. 32, no. 3, pp. 349–71.

WEB RESOURCES

ABC Health & Wellbeing: <www.abc.net.au/health>.

Better Health Channel: Wellbeing: <www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/wellbeing?open>.

The National Wellness Institute of Australia: <www.wellnessaustralia.org>.

Salutogenesis: Discovering the Causes of Health: <www.slideshare.net/FarrowPartnership/salutogenesis-discovering-the-causes-of-health>.

Salutogenesis: Health in the River of Life: <www.salutogenesis.hv.se/eng/English.2.html>.

WellBeing: Your Guide to Natural Health, Therapy, Holistic Healing and Sustainable Green Living: <www.wellbeing.com.au>.

Wellbeing Australia: Building Health Communities: <www.wellbeingaustralia.com.au/wba>.

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DOCUMENTARIES/FILMS

Beating About the Bush (1993): 55 minutes.

A documentary about the urban band Djaambi, which comprises Indigenous and non-Indigenous people. The documentary illustrates their arrival in the remote Aboriginal community of Papunya, and demonstrates their inability to find an audience at Papunya. Instead, they participate in the bleak housing conditions and minor flooding experiences of locals. The documentary illustrates the band's hopes that their visit will leave positive effects within the community.

Crossing the Line (2005): 56 minutes.

A documentary film that illustrates the journeys of Amy and Paul, two medical students from Tasmania and Melbourne who travel to a remote all-Aboriginal community on Mornington Island to complete an eight-week placement. The documentary draws attention to the tension between each student's personal and social experiences with different people in the community and the professional distance they are expected to maintain. The film makes a useful contribution to comparing biomedical-oriented approaches of health with what it means to be well and feel well in culturally safe terms, with a particular emphasis in regard to elaborating on the related cultural differences.

Time Bomb (2003): 28 minutes.

A documentary addressing Indigenous health issues, interspersed with shots of the Areyonga community (approximately 220 kilometres west of Alice Springs). The documentary shows Frank Djara communicating health issues through painting and talking about sickness to his people. Including references to the foreign treatment of sickness with Western medicines, a crucial issue referred to in the documentary is the cultural safe translation necessary to administer appropriate health care.

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