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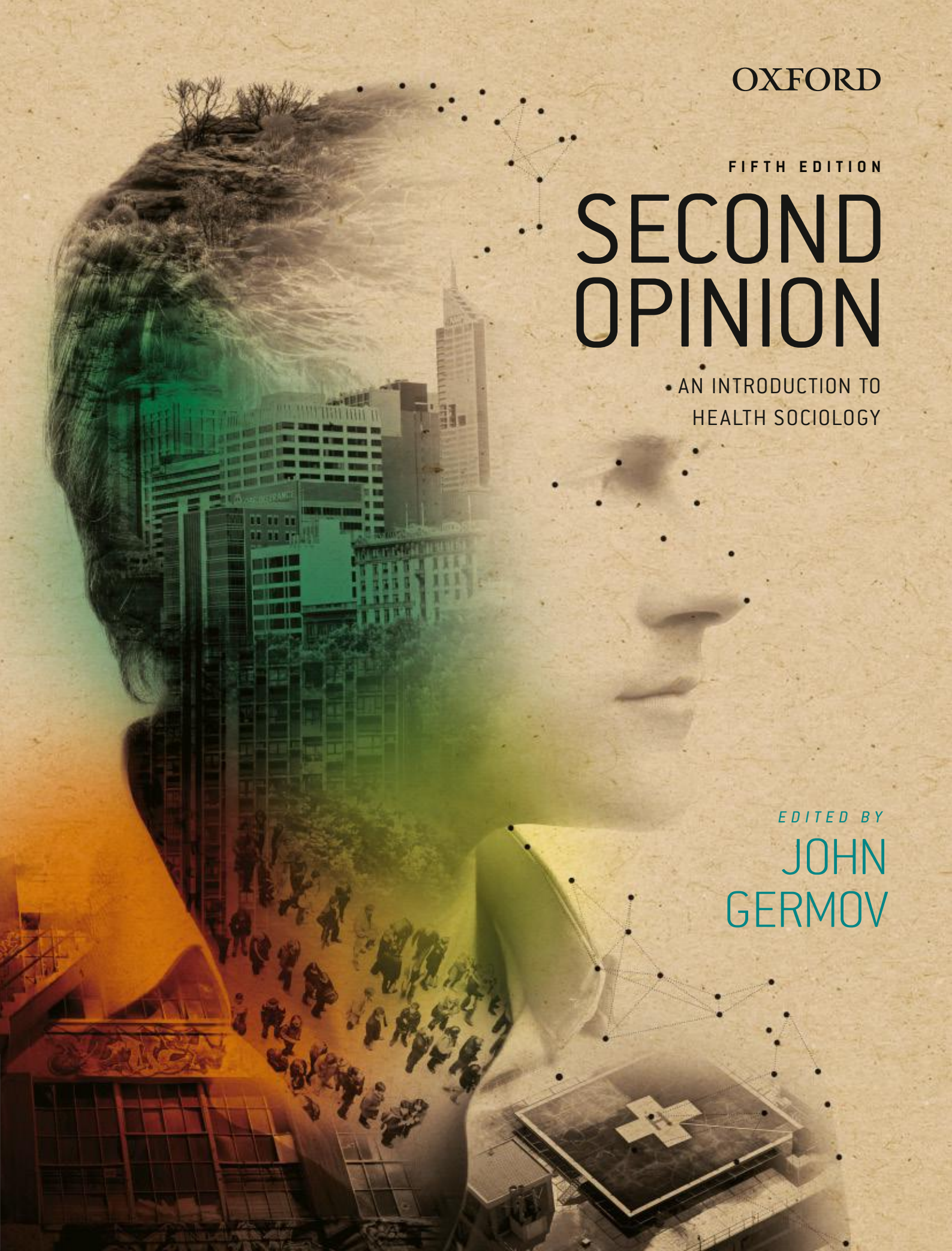
FIFTH EDITION

SECOND OPINION

• AN INTRODUCTION TO
HEALTH SOCIOLOGY

EDITED BY

JOHN
GERMOV



.....
FIFTH EDITION

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HEALTH SOCIOLOGY

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GERMOV

OXFORD
UNIVERSITY PRESS
AUSTRALIA & NEW ZEALAND

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PREFACE TO THE FIFTH EDITION

It has been well over 15 years since the first edition of *Second Opinion*. This latest edition features new and updated chapters to ensure that the book remains relevant, topical, and interesting to its large and varied readership. That said, *Second Opinion* retains its accessible yet authoritative overview of key debates, research findings, and theories in the field of health sociology.

New to the fifth edition

- **New chapters** on Drug Use and Abuse in Australia (Maria Freij and John Germov) and Well-being and Wellness (Daniela Heil)
- **New authors joining:** Maria Freij and John Germov joining Dorothy Broom for the chapter on Gendered Health; Annalee Stearne joining Dennis Gray and Sherry Sagggers for the chapter on Indigenous Health; and Tanya Lawlis joining Lauren Williams for the chapter on Allied Health
- **An improved reader-friendly dual-colour layout** with a wide range of pedagogic features; each chapter begins with a topical vignette to draw attention to relevant sociological issues; all chapters include highlighted 'Doing health sociology' boxes that show the application of health sociology to real-life issues of health policy and practice; in addition, an updated list of recommended documentaries and films has been added to each chapter
- **Updated book website:** the website now includes online access to chapter-relevant YouTube and MOOC videos, supplementary reading, chapters from previous editions, and updated web links for all websites recommended in the book.

Guide to the book

In addition to being a contemporary reader on the field of health sociology, the book is also designed to be used as a teaching text, with the following pedagogic features:

- An **overview** opens each chapter, with three main questions the chapter seeks to address
- **Introductory vignettes** grab readers' interest and encourage a sociologically reflexive approach to the topic
- **Key terms and concepts** are highlighted in bold and defined in separate margin paragraphs; these also appear in a glossary at the end of the book
- **'Doing health sociology' boxes** highlight the insights of sociological research and theories for informing health care practice, health policy, and public understanding of the social origins of health and illness
- **TheoryLink notes** clearly cross-reference theoretical discussions in different chapters
- **Summary of main points**
- **Sociological reflection exercises** are self-directed or class-based exercises that help students apply their learning and highlight the relevance of sociological analysis
- **Discussion questions**
- **Further investigation** essay-style questions
- **Further reading**
- Recommended chapter-specific **web resources**
- Recommended chapter-specific **documentaries and films**

- The **appendix on essay writing** provides advice for students on the planning, writing, and referencing of health sociology essays, including tips on the critical use of web resources, how to reference the web, and how to reference chapters in this book
- The **expanded *Second Opinion* website** <www.oup.com.au/germov5e>:
 - **Links to all the web resources** recommended in the book
 - **Supplementary readings**
 - **Access to chapters from previous editions**

Teaching resources for lecturers

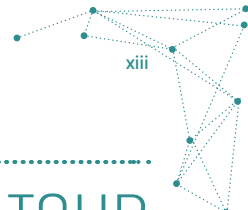
The Instructor's Resource Manual, Test Bank, and PowerPoint slides are available **free of charge** from the publisher for those using the book as a course text.

- **Instructor's Resource Manual:** includes case studies and short tutorial exercises for each chapter to facilitate student discussion
- **Test Bank of Multiple-choice Questions:** over 200 questions and answers organised by chapter
- **Downloadable PowerPoint slides** of all diagrams and tables in the book

Suggestions, comments, and feedback

I am very interested in receiving feedback on the book and suggestions for future editions. Please contact me at: <John.Germov@newcastle.edu.au>.

*John Germov
The University of Newcastle
June 2013*



GUIDED TOUR

Overview

- What is class and how can it help to explain health inequality?
- What is the sociological of health?
- What can be done to address class-based health inequality?

CLASS MATTERS

By all have come from better homes of class—we see it every day in the differences between low-priced and expensive cars, between urban and free dining restaurants, public and private schools, and between school and exclusive suburbs. In suburbs over the world, Australians have regularly reported they believe that classism exist, and have no trouble placing themselves into a class—only 1 per cent claim they have no class affiliation (Waters & Barker, 2011). Debates over the importance of class focus on the extent to which it determines your life chances, that is, your chances of social mobility, of getting an education, and of getting a certain type of job. While most people acknowledge the existence of class, few recognize that health status is one of the clearest indicators of class inequality in Australia. Health access to free public health services in Australia, working-class people have higher rates of death, illness, and disability as a result of their living and working conditions.

Overviews

open each chapter and outline the three main questions the chapter seeks to address.

Introductory vignettes

spark the readers' interest and encourage a sociologically reflexive approach to the topic.

'Doing health sociology' boxes

highlight relevant elements of sociological research and theory that inform health care practice and policy, and public understanding of the social origins of health and illness.

TheoryLink notes

highlight and cross-reference relevant theoretical discussions in different chapters.

BOX 5.1
DOING HEALTH SOCIOLOGY: LAY UNDERSTANDINGS OF HEALTH INEQUALITY

In her review of research on lay conceptions of health and illness, Mavis Barker (1997) concluded that many disadvantaged people adopted individualistic explanations rather than linkages to living and working conditions to illness. According to Barker (1997, p. 154), "[i]n acknowledging "inequality" would be to admit an inferior moral status for oneself and one's peers; hence, perhaps, the emphasis on "not giving in to illness," which can be seen as a claim to moral equality even in the face of clear economic inequality. Research by Jenine Pappay and colleagues (2003, p. 27) reports similar findings, and suggests that "strength of character and personal control are emphasized" in the face of social disadvantage, so that "the way the individual responds to them will determine whether health is damaged". Such views make sense in a culture based on individualism and the moral imperative of self-responsibility for health. Furthermore, as Pappay and colleagues (2003, p. 22) state, "the means to avoid ill health [based in terms of individual resilience and strength of character] are, potentially at least, within an individual's control ... It is difficult to envisage what an effective individual response would be to any direct causal relationship between structural factors ... and ill health". Therefore, disadvantaged people's tendency to deny the social origins of health inequality represents a rational response that avoids stigma and offers the hope of self-determination.

MATERIALIST/STRUCTURAL EXPLANATIONS

Materialist/structural explanations concern the role of social, economic, and political factors in determining the social distribution of health and illness. The basis of this view has been a focus on how poor living and working conditions—particularly poverty, discrimination, lack of educational and employment opportunities, and inadequate nutrition and housing—directly influence illness. Materialist/structural explanations have been particularly addressed

THE OUTLINE
See Chapter 2 for a discussion of Materialist and Structural Explanations.

Introduction

Because gender is such a significant dimension of social difference in contemporary Western societies, we tend to take it for granted. It is hard to imagine that gender could be less socially important or organized very differently from the familiar patterns that we see every day. So it can be surprising to learn that, while gender is socially recognized in all known societies, there is wide historical and cultural variation in the way it is expressed and experienced. In every society, at least some work is allocated on the basis of gender; this allocation is called the sexual division of labour. In some societies, females and males undertake sharply differentiated activities, and may be physically segregated for substantial periods, either because of social norms or as a consequence of the sexual division of labour. In other societies, children of both sexes are treated in much the same ways, but gender differences become important in adolescence or early adulthood. In many cultures, only a few activities are specific to one sex, and the sexual division of labour is minimal. Men dominate overtly in certain cultures, whereas, the lives and powers of the two sexes are largely balanced and complementary. In developed economies, the norms and symbols that govern gender tend to vary according to class, subculture, and ethnicity. And everywhere, gender patterns are dynamic: they change over time.

Indeed, the terms themselves are continually contested. In the early 1970s, a distinction was drawn between sex (biological) and gender (psycho-social) (Oakley 1972). Subsequent theoretical discussions have unsettled that clear dichotomy (Garnes 1985; Walsh 2004), and although the contrast is still often invoked, in this chapter the words are often used interchangeably. In the context of each variation and fluidity, making useful generalisations about gender and health is a challenging task. In this book, class and ethnicity, the relationship between health and gender is a complex interaction between material circumstances, physical entities, cultural processes, and social organisation. The discussion here concentrates on the interplay between health and gender in Australia and in similar contemporary developed societies.

KEY TERMS
This page of terms refers to the usually common categories of difference and inequality (structural differences) and states that people should be treated equally, and the social power relations based on these 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 male gender makes most of the work through this pattern as he has an accurate description of most people's lives.

NOTES
Shared expectations about how people ought to act or behave.

Margin notes

illustrate key terms and concepts, which are in bold throughout the text.

SUMMARY OF MAIN POINTS

- Rural health is a relatively new field of academic enquiry, and it is influenced by an eclectic mix of social, behavioural, and clinical sciences.
- Internationally, there is a disparity in health status in favour of urban populations. Australia is reflective of this international trend with comorbidity and mortality data showing a significant 'rural-urban health differential'.
- The economic, political, and technological upheaval experienced by rural communities has implications for health and health care.
- The nature of social interactions in rural communities has implications for both the providers and the recipients of health care services. Dual relationships are common and sometimes unavoidable in rural settings.
- Australia's farming population has a distinctive lifestyle profile, characterised by high rates of occupational injury and fatality.
- Geographically, the health care workforce is unevenly distributed and a range of initiatives to be placed to address this inequity. Problems of access extend beyond mere 'distance to services'.
- Traditional and innovative solutions are required to address rural access issues, since traditional urban-based models of health service delivery may not be appropriate or possible in rural settings.
- Rural health would benefit from the increased contribution of a sociological perspective in the formulation of a theoretically informed evidence base for policy and practice.

Summaries of main points

at the end of each chapter help students identify the most important issues covered in the chapter.

Sociological reflection exercises

at the end of each chapter are self-directed or class-based exercises that help students apply their learning and see the relevance of sociological analysis.

Discussion questions

can be approached in a variety of ways and allow students to revisit the key themes and ideas raised in each chapter.

SOCIOLOGICAL REFLECTION
ACCESS—MORE THAN MEETS THE EYE

You are attending a public forum in a small rural community. The forum has been organised so that community members can discuss access to health services. Some participants consider the main issues to be the lack of public transport, hospitals, and shops. Others regard rural attitudes and the absence of some state services as the major barriers to access. In one part of the discussion someone heatedly complains because that person later things 'have nothing to do with health care'. Do you agree or disagree? Does your answer change if you imagine yourself to be a necessarily unwell colleague with limited English, or someone who is confined to a wheelchair? Reflect on other issues that could function as barriers to access for rural residents.

DISCUSSION QUESTIONS

- People living in rural areas should not expect to be as healthy as their urban-based counterparts. Discuss.
 - a. asthma
 - b. arthritis
 - c. depression.

How does its prevalence in rural areas compare with metropolitan areas of Australia? Outline the ways in which rurality could present issues for its diagnosis, treatment, and/or management.
- Geoneschick is a useful concept for analysing rural communities. In what ways can it be applied to patients and/or health care providers? How does its prevalence in rural areas compare with metropolitan areas of Australia? Outline the ways in which rurality could present issues for its diagnosis, treatment, and/or management.
- What are dual relationships and what is their significance in the health care setting? How does its prevalence in rural areas compare with metropolitan areas of Australia? Outline the ways in which rurality could present issues for its diagnosis, treatment, and/or management.
- Choose one of the following:
 - a. Type 2 diabetes
 - b. asthma
 - c. depression.

How does its prevalence in rural areas compare with metropolitan areas of Australia? Outline the ways in which rurality could present issues for its diagnosis, treatment, and/or management.
- Explain what is meant by the 'social determinants of health'. Is the approach more or less useful than the biomedical model for explaining the rural-urban health differential and/or other rural health issues?
- What are the main occupational health and safety issues for people working on farms? Has increased mechanisation resulted in safer work conditions for Australian farmers?
- The rural-urban health differential will not be solved simply by improving access to health care services. Do you agree or disagree with this statement? Support your argument with reference to recent Australian data.

FURTHER INVESTIGATION

- The medicalisation of obesity has both positive and negative implications. Discuss.
- Examine the ways in which the medicalisation of food has helped to create an obesogenic social environment.
- Examine the arguments for and against a 'fat tax' on certain foods.

FURTHER READING

Australian Institute of Health and Welfare (AIHW) 2012, *Australia's Food and Nutrition 2012*, AIHW, Canberra. <www.aihw.gov.au/publications-detail/?id=10737402399>

Batzon, W. 2006, *Alone to Come: A History of the Future of Food*, University of California Press, Berkeley.

Casper, P. 2013, 'The Absurdities of Fat', *New York Times*, 2 January. <www.nytimes.com/2013/01/02/US/02opinion-absurdity-weight-problem.html?_r=1>

Garrow, J. & Williams, L. (eds) 2006, *A History of Food and Nutrition: The Social Aspects*, 2nd edn, Oxford University Press, Melbourne.

National Health and Medical Research Council (NHMRC) 2013, *Assessing the Impact of Food, AIHW, Canberra*. <www.aihw.gov.au/government/publications/55>

Rozin, M. 2007, *Food Politics: How the Food Industry Influences Nutrition and Health*, 2nd edn, University of California Press, Berkeley.

Paul, R. 2006, *Big Food and Beyond: How the Power of the Big Food Industry is Changing the World*, Black Inc., Melbourne.

Polunin, M. 2006, *The Obesogenic Obstacle: The Growth of the Fast Food Industry in Paris*, *Geoforum*, London.

Schlosser, I. 2001, *Fast Food Nation*, Penguin, London.

Williams, L., Garrow, J. & Young, A. 2011, 'The effect of social class on mid-aged men's weight control practices and weight gain', *Appetite*, vol. 54, no. 3, pp. 718–25.

WEB RESOURCES

Agriculture, Food & Human Values Society (AFHVS) <www.afhvs.org>

Association for the Study of Food and Society (ASFS) <www.asfs-culture.org>

Australian Ag-Food Research Network <www.afrn.org.au>

Australian Bureau of Statistics (ABS) Australian Health Survey 2011. 13. <www.abs.gov.au/australianhealthsurvey>

Food and Agriculture Organization of the United Nations <www.fao.org>

Food and Agriculture Organization of the United Nations, State of Food Insecurity in the World 2012. <www.fao.org/docrep/012/i2490e/i2490e00.htm>

Food Standards Australia New Zealand, Nutrition, Health and Related Issues <www.foodstandards.gov.au/consumer/infocentre/foodandnutrition/infocentre/infocentre.aspx>

International Journal of Sociology of Agriculture and Food <www.ijsof.org>

Further investigation exercises

are essay-style questions that help students prepare for examinations and other forms of assessment.

Further reading, web resources, and documentaries/films sections

list chapter-specific books, websites, and documentaries and films to allow students to research and explore topics further.

DOCUMENTARIES/FILMS

Fast Food Nation (2006) 136 minutes.
After the authors have published and lectured extensively on the food industry's role in the development of public health.

Food Fight: Revolution Never Tasted so Good (2009) 83 minutes.
A documentary exploring alternative food movements. Information available at <www.foodfightmovie.com>

Food, Inc. (2008) 94 minutes.
A documentary critically examining the mass production of food in the US.

McLibel: Two Worlds Collide (1997) 58 minutes.
A documentary about the long-running legal dispute between McDonald's and two food campaigners.

Slow Food Revolution (2009) 52 minutes.
Examines the rise of the Slow Food movement.

Super Size Me (2004) 100 minutes.
A documentary that examines the role fast food plays in being obesity rates, as shown by film maker Morgan Spurlock. It's a diet of consuming only McDonald's food.



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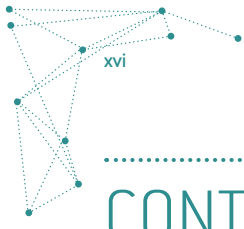
Thanks are also due to my publishers, firstly Jill Henry, Debra James, Katie Ridsdale, Rachel Saffer, and more recently Shari Serjeant and Estelle Tang. Thanks also to our copyeditor Natasha Broadstock for her excellent work, and to the designer, Ana Cosma.

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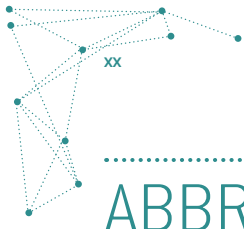
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ABBREVIATIONS

AA	Alcoholics Anonymous
ABS	Australian Bureau of Statistics
ACATs	Aged Care Assessment Teams
ACHA	Australian Community Health Association
ACQSHC	Australian Common on Quality and Safety in Health Care
AD[H]D	attention deficit [hyperactivity] disorder
AEI-NOOSR	Australian Education International—National Office of Overseas Skills Recognition
AFGC	Australian Food and Grocery Council
AGPS	Australian Government Publishing Service
AHPA	Allied Health Professions Australia
AHPRA	Australian Health Practitioner Regulation Agency
AIDS	acquired immune deficiency syndrome
AIHW	Australian Institute of Health and Welfare
ALP	Australian Labor Party
AMA	Australian Medical Association
ANJ	<i>Australasian Nurses' Journal</i>
ANPHA	Australian National Preventive Health Agency
ARIA	Accessibility/Remoteness Index of Australia
ASGC-RA	Australian Standard Geographical Classification—Remoteness Areas
ATSIC	Aboriginal and Torres Strait Islander Commission
BAC	blood alcohol concentration
BMA	British Medical Association
BMI	Body Mass Index
BRW	<i>Business Review Weekly</i>
BSE	bovine spongiform encephalopathy ('mad cow' disease)
CACPs	Community Aged Care Packages
CALD	culturally and linguistically diverse
CAM	complementary and alternative medicine
CDM	Chronic Disease Management
CHD	coronary heart disease or chronic diseases and health promotion or community health policy
CHP	Community Health Program
COAG	Council of Australian Governments
CSDH	Commission on the Social Determinants of Health

DAA	Dietitians Association of Australia
DHFS	Department of Health and Family Services
DIMA	Department of Immigration and Multicultural Affairs
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
DOHA	Department of Health and Ageing
DNA	deoxyribonucleic acid
DRS	Doctors Reform Society
DSM	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
DSM-IV	Fourth edition of <i>Diagnostic and Statistical Manual of Mental Disorders</i>
DSM-IV-TR	Fourth (Text revised) edition of <i>Diagnostic and Statistical Manual of Mental Disorders</i>
DSM-5	Fifth edition of <i>Diagnostic and Statistical Manual of Mental Disorders</i>
DTC	direct to consumer
DVA	Department of Veterans Affairs
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
EBH	evidence-based health care
EBM	evidence-based medicine
ELSI	ethical, legal, and social implications (of the Human Genome Project)
EPC	Enhanced Primary Care
FAO	Food and Agriculture Organization
FDA	Food and Drug Administration (US)
FSANZ	Food Standards Australia New Zealand
FSD	female sexual dysfunction
GDP	gross domestic product
GFC	global financial crisis
GIO	Government Insurance Office
GM	genetic modification/genetically modified
GNI	gross national income
GP	general practitioner
HACC	Home and Community Care program
HFA 2000	Health for All by the Year 2000
HGH	human growth hormone
HGP	Human Genome Project
HHSC	Hospitals and Health Services Commission
HIV	human immunodeficiency virus
HPCA	Health Profession Council of Australia
HREOC	Human Rights and Equal Opportunities Commission
HRT	hormone replacement therapy

IGAFFR	Intergovernmental Agreement on Federal Financial Relations
IHP	individualist health promotion
ILO	International Labour Organization
IMR	infant mortality rates
IPE	inter-professional education
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MAHS	More Allied Health Services
MDGs	Millennium Development Goals
MLs	Medicare Locals
MLS	Medicare Levy Surcharge
MSIC	medically supervised injection centre
NAAFA	National Association to Advance Fat Acceptance
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHOSN	National Allied Health Organisational Structures Network
NAHS	National Aboriginal Health Strategy
NAOMI	North American Opiate Medication Initiative
NASRHP	National Alliance of Self-Regulating Professions
NATSIHC	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NATSIHEC	National Aboriginal and Torres Strait Islander Health Equality Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDIS	National Disability Insurance Scheme
NESB	non-English-speaking background
NHA	National Health Agreement
NHHRC	National Health and Hospital Reform Commission
NHMRC	National Health and Medical Research Council
NHPAs	National Health Priority Areas
NHS	National Health Strategy (Australia) or National Health Survey (Australia) or National Health Service (UK)
NOHSC	National Occupational Health and Safety Commission
NPHT	National Preventive Health Taskforce
NRRAHAS	National Rural and Remote Allied Health Advisory Service
OECD	Organisation for Economic Co-operation and Development
ODA	official development assistance
OHS	occupational health and safety
OOS	occupational over-use syndrome
OPAL	Obesity Prevention and Lifestyles
PBS	Pharmaceutical Benefits Scheme
PCM	Prevention Community Model
PCPs	Primary Care Partnerships

PHC	primary health care
PHIAC	Private Health Insurance Administration Council
PKU	phenylketonuria
RACGP	Royal Australian College of General Practitioners
RCTs	randomised control trials
RPBS	Repatriation Pharmaceutical Benefits Scheme
RRMA	Rural, Remote and Metropolitan Areas
RSI	repetition strain injury
RUSC	Rural Undergraduate Support and Coordination
RVCN	Royal Victorian College of Nurses
SARRAH	Services for Australian Rural and Remote Allied Health
SCHIP	State Children’s Health Insurance Program
SCHP	structuralist–collectivist health promotion
SES	socio-economic status
SG	Superannuation Guarantee
SIDS	Sudden Infant Death Syndrome
TASA	The Australian Sociological Association
TCM	traditional Chinese medicine
TM	traditional medicine
U3A	University of the Third Age
UNA	United Nurses Association
VTNA	Victorian Trained Nurses’ Association
WASP	White Anglo-Saxon Protestant
WFS	World Food Summit
WHO	World Health Organization
WHS	workplace health and safety
WSRO	World Sugar Research Organization

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



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

IMAGINING HEALTH PROBLEMS AS SOCIAL ISSUES

John Germov

01



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?

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.

THE FOREST
THROUGH
THE TREES

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

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).

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’.

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.

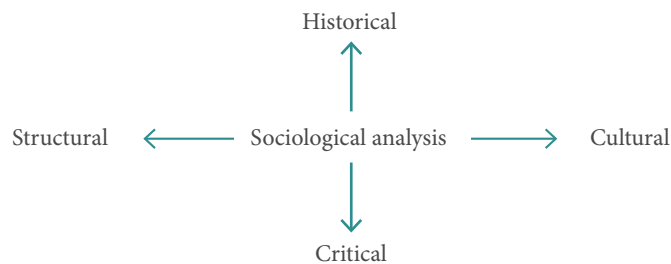
SOCIOLOGICAL IMAGINATION

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.

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.

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.

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).

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.

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.