CHAPTER 7

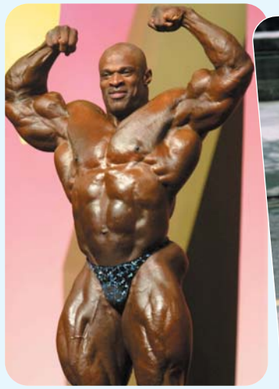
Health

AQA Specification	Topics	Pages
Candidates should examine:		
Health, illness, disability and the body as social and as biological constructs.	Covered in Topic 1	2–9
The unequal social distribution of health and illness in the United Kingdom by social class, age, gender, ethnicity and region, and internationally.	Covered in Topic 2	10–15
Inequalities in the provision of, and access to, health care in contemporary society.	Covered in Topic 3	16–21
The sociological study of the nature and social distribution of mental illness.	Covered in Topic 4	22–27
The role of medicine and the health professions.	Covered in Topic 5	28–33
The application of sociological research methods to the study of health.	Covered in every topic and the Exam Practice	

TOPIC 1

Defining health, illness and disability

Getting you thinking




Look at the four photos on this page and then answer the following questions.

1. **Which of these people are, in your opinion, 'abnormal' and which are 'normal'?**
2. **What suggestions can you make for helping 'abnormal' people make themselves 'normal'?**
3. **Next, indicate which of these people, if any, are 'ill'.**
4. **In small groups, compare your answers and explain how you made your decisions.**
5. **Do you think that health and illness and normal bodies have anything to do with society, or are they just natural, biological states?**

This topic investigates the ways in which **health**, **illness** and **disability** are defined in our society and the implications for people who are defined as ill or disabled. The majority of the population pass most their lives taking for granted the normal, routine state of their bodies, until this 'normality' is disrupted in some way. At this point, people often say they are 'ill'. However, it is very unclear just what illness is. Surely, such an important concept does not vary simply according to how each individual feels? Anyway, how does anyone know what is 'normal'?

A second, linked area is the notion of 'abnormality'. If there is such a thing as 'normality', then there must be something which is 'abnormal'. This category might include those suffering from chronic (long-term) illness, such as multiple sclerosis, those with a 'mental illness' or those with a physical 'disability'.

Sociologists also want to understand how terms such as 'abnormality' and 'disability' are constructed and what implications there are for the people so labelled.

We begin by looking at how health and illness are defined and the implications of these definitions for society. We then extend our analysis to issues of disability and mental illness, and their implications for people labelled with these terms.

Definitions of health and illness

At some time, most of us will have woken up in the morning not really feeling very well. Despite telling our parents this, it may have been difficult to persuade them that we really were too ill to go to school or college (particularly if there was an exam that day or a particular lesson they knew we loathed). Only when we produced some real evidence, such as vomiting or a rash, were we believed. Our parents may also be rather less than supportive when it turns out that we have been drinking pretty heavily the night before. Ill or just hung over? And anyway, why is being hung over not being ill – after all, we feel awful? The answer from disapproving parents might well be that being hung over is the price we pay for a night's drinking and that it therefore does not count as a 'real' illness.

This situation illustrates a number of issues. First, it is not clear exactly what we mean by being 'healthy' and being 'unwell'. It seems that these concepts may well have different meanings depending upon who is defining them. In this case, us and our parents. Furthermore, there is a 'moral' element involved. If feeling ill is a result of having drunk too much, then this may be classified as just a 'hangover' and hence our own fault.

Definitions of illness and their consequences (get the day off college or have to endure a miserable day attending) form the starting point for the sociology of medicine.

To unravel this complex issue, we will look first at how ordinary, or **lay**, people construct their definitions of health and illness. We will then move on to look at the competing models amongst health practitioners themselves.

Lay definitions of health and illness

If definitions of health and illness vary, then we need to know just what factors appear to influence the way in which individuals define their sense of being healthy or ill. Sociologists have suggested that culture, age, gender and social class are particularly important.

Cultural differences

Different social groups have differing ideas of what constitutes illness. For example, Krause (1989) studied Hindu and Sikh Punjabis living in Bedford, and in particular focused on their illness called 'sinking heart' (*dil ghirda hai*) which is characterized by physical chest pain. According to Krause, this illness is caused by a variety of emotional experiences – most importantly, public shame of some sort. No such illness exists in other mainstream cultures in Britain.

Age differences

Older people tend to accept as 'normal' a range of pains and physical limitations which younger people would define as symptoms of some illness or disability. As we age, we gradually redefine health and accept greater levels of physical discomfort. In Blaxter's (1990) national survey of health definitions, she found that young people tend to define health in terms of physical fitness, but gradually, as people age, health comes to be defined more in terms of being able to cope with everyday tasks. She found examples of older people with really serious arthritis, who nevertheless defined themselves as healthy, as they were still able to carry out a limited range of routine activities.

Gender differences

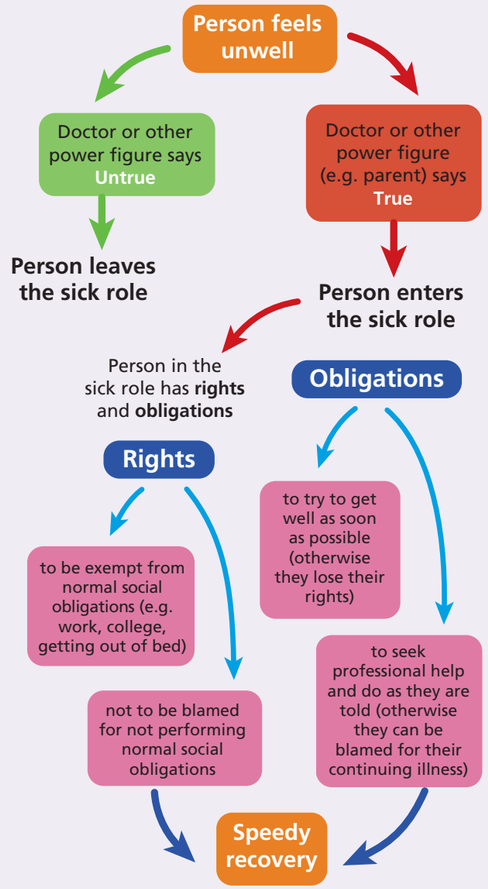
According to Hilary Graham (2002), men have fewer consultations with doctors than women and appear to have lower levels of illness. This is partly due to the greater number of complications associated with childbirth and menopause

Talcott Parsons

The sick role: sickness as deviance

According to Talcott Parsons (1975), being sick is a deviant act which can prevent a person undertaking their normal social functions. Society therefore controls this deviance through a device known as 'the sick role'. This is illustrated in Figure 7.1 below.

Figure 7.1 The sick role



1. **Think of examples of people you know who have 'unfairly' claimed the sick role. What do you think about them and their behaviour?**
2. **Are there some illnesses which, in your opinion, do not deserve the 'rights' of the sick role?**

which women face, but it is also partly due to the fact that men are less likely to define themselves as ill, or as needing medical attention. The idea of 'masculinity' includes the belief that a man should be tough and put off going to the doctor.

Despite the greater propensity of men to define themselves as healthy and to visit **GPs** less often, men have considerably higher mortality (death) rates than women.

Social class differences

Blaxter's research also showed that working-class people were far more likely to accept higher levels of 'illness' than middle-class people. Blaxter describes working-class people as 'fatalistic' – that is, they accepted poor health as 'one of those things'. As a result, people from lower social classes are less likely to consult a GP than middle-class people. This may be because they will accept a higher level of pain and discomfort before considering themselves ill enough to visit a doctor.

Medical definitions of health and illness

There is a distinction in most people's minds between those who think they are ill and those who really are ill. In contemporary society, the role of deciding whether the person is truly ill lies with doctors. If they decide that a person is ill, then a series of benefits flow, both formal (in the provision of medical help, or time off work or college) and informal (such as sympathy, release from household tasks and so on).

However, if they decide that you are not really ill, then you receive no benefits and may, in fact, be open to accusations of **malingering**.

Doctors use a particular 'scientific' measure of health and illness in order to decide whether someone really is ill or not. This model is known as the **biomedical model**, and it is the basis of all Western medicine. The elements of this model include the following:

- Illness is always caused by an identifiable (physical or mental) reason and cannot be the result of magic, religion or witchcraft.
- Illnesses and their causes can be identified, classified and measured using scientific methods.
- If there is a cure, then it will almost always be through the use of drugs or surgery, rather than in changing social relationships or people's spiritual lives.
- This is because the cause almost always lies in the actual physical body of the individual patient.

At its simplest, this model presents the human body as a type of machine and, just as with a machine, parts can go wrong and need repairing. Over time, the body 'wears out' just as a machine does and will eventually stop working completely. This is why the contemporary medical model is sometimes referred to as the 'bio-*mechanical*' model.

Illness and disease

What emerges from the discussion of health and illness is that individuals, using lay concepts of health, may define themselves as 'ill' or not, depending upon a range of social factors. On the other hand, doctors claim that they can scientifically determine, via medical tests, whether or not a person is ill. Eisenberg (1977) has therefore suggested that we should make a distinction between illness and disease. Illness is an individual's subjective experience of symptoms of ill health, whilst diseases are clinical conditions defined by medical professionals. It is therefore perfectly possible, as Blaxter has pointed out, to have an illness without a disease and a disease without an illness!

Traditional and non-Western definitions of health and illness

The biomedical model contrasts markedly with concepts of illness in traditional and non-Western societies, where illness is seen as the result of a wider range of factors than just the body itself.

In traditional societies, for example, these factors could include witchcraft – where the blame for the illness lies in the bad wishes of others, or possibly the 'will of God'. A more complex model of health exists in non-Western societies, where the body and the mind are seen as completely linked. Any understanding of the body must be linked with the person's mental state, and the two need to be treated together.

However, over the last two hundred years, the biomedical model of health has come to dominate healthcare and has excluded other approaches. This supremacy is linked to the wider development of science and scientific methods as the predominant form of knowledge in modern societies.

Complementary medicine

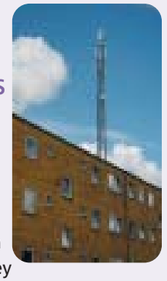
In recent years, there has been a major growth in alternative or **complementary** forms of health provision. These include therapies such as homeopathy, herbal medicines and acupuncture. Following the ideas of Giddens (1991) about the development of new ways of thinking and acting in contemporary society, which he characterizes as **late modernity** (see p. 32), Hardey (1998) has argued that in late modernity, there has been a decline in the uncritical acceptance of the authority of professionals, such as doctors. A second relevant feature of late modernity has been the growth in self-expression and individual choice. The idea that some people should give themselves completely into the power of doctors, and subject themselves to treatments which they may not even understand has therefore become increasingly questioned.

The result of this has been a partial rejection of the traditional biomedical model, in favour of seeking alternative therapies from the wide range available.

Research methods

Timotijevic & Barnett (2006)

Researching perceptions of the risks of mobile phones



Lada Timotijevic and Julie Barnett wanted to find out the sense of risk to their health that people felt when living near a mobile phone mast. They decided that they needed in-depth information and that the best method to use was that of focus groups. Timotijevic and Barnett organized nine focus groups in two areas: a London Borough and Brighton. They recognized that although focus groups allow issues to be discussed in depth, they also have drawbacks – in particular, that focus-group findings cannot be considered to be 'representative' in the same way as quantitative survey research is – people chosen for the focus group will almost certainly not form a statistically true cross section of the population. Also, the researcher leading the focus group has considerable influence on the course that a focus group discussion takes and, therefore, the views of the researcher may enter the discussion.

People were recruited through schools (to obtain the views of parents of young children) and through recruitment agencies in London. Participants were paid between £30 and £35 for attending the one-hour focus group. All the focus groups were recorded and then transcribed. Once this was done, they were analyzed using computer software to divide the discussion into various themes.

The authors concluded that people's perceptions of the risks of mobile phone masts were far more complex than generally thought, with most people having awareness of the possible dangers, although this did not influence their behaviour over much.

Source: Timotijevic, L. and Barnett, J. (2006) 'Managing the possible health risks of mobile telecommunications', *Health, Risk and Society,* June 8(2), pp. 143–64

1. **What is a focus group?**
2. **Name one advantage of a focus group.**
3. **Why is it considered a drawback that focus groups are not 'representative'?**
4. **When leading a focus group, why must researchers be careful?**
5. **What problem(s) can you think of which might result from paying people to join focus groups?**

Criticisms of the biomedical and complementary models of health

According to Coward (1989), both the biomedical and the complementary models of health tend to stress that health problems are individual, both in terms of the causes and the cures. Coward argues that this ignores the wider social factors which cause ill health, such as poverty, poor housing, job-related stress and pollution, amongst others.

The body

So far in this chapter, we have questioned common-sense ideas held about what is sickness and health and have raised some challenging questions about these ideas. However, we can go further and question a closely related concept upon which notions of illness are ultimately based: the concept of 'the body'.

All of us exist in 'bodies' that are *objectively* different shapes, heights, colours and physical abilities, and *subjectively valued* as attractive or ugly, young or old, short or tall, weak or strong.

Let us look first at the objective differences. The two most common explanations for objective differences between bodies are, first, that people's bodies vary according to genetic differences (height, weight, etc.) and, second, that bodies change as people age. However, sociologists point out that the shapes of people's bodies are often actually linked to diets, type of employment and general quality of life. A huge range of research indicates that poorer people are more likely to:

- eat 'unhealthy' foods and to smoke cigarettes
- be employed in repetitive, physically demanding work or the other extreme of boring, sedentary employment
- have worse housing conditions
- live in more deprived neighbourhoods.

All of these factors impact upon the condition of a person's body and health. We can see then that the physical shapes of bodies are strongly influenced by social factors.

If we look next at the differences in how bodies are subjectively valued, we can see that culture – and media – of different societies promote very different valuations of body shapes. What is considered as attractive or ugly, normal or abnormal has varied over time and society. Currently, for example, in affluent societies the idea of slimness is highly valued, yet historically in most societies the ideal body shape for a woman was a 'full figure' with a noticeable belly, while in middle-aged men, a large stomach indicated that they were financially successful in life – poor people looked thin and ill nourished.

Body shapes and appearance have never been neutral; they have always sent out social messages which others evaluate. However, in late modernity, the body has become an especially important 'site' for making statements about oneself. Giddens (1991) argues that in contemporary society our individual identity has come to be something which people 'work at', with everyone consciously constructing the image (personality, clothing, style of speech, ethnic affiliation) which they want to present to others as their real 'selves'. Giddens calls this

reflexive mobilization. One very important part of this is how we wish our body to be viewed by others and what message we wish it to give. Chris Shilling (2003), for example, has pointed out that, increasingly, bodies are coming to be seen as **unfinished products**, by which he means that bodies are decreasingly seen as something which people just 'have', to be accepted as they are. Increasingly, he argues, people wish to alter their bodies in order to express their individuality or to achieve some desired state. Shilling points to the growth of cosmetic surgery, tattoing, dieting and body building, all of which are undertaken by individuals to achieve a desired image of themselves.

Sociologists then are suggesting that we should not just view the body in biological terms, but also in social terms. The physical body and what we seek to do with it change over time and society. This has significant implications for medicine and ideas of health. Thus, the idea of people being 'obese' is *physically* related to excessive amounts of processed food, coupled with lack of exercise. However, *socially* it has become a medical problem as a result of people coming to define this particular body shape as 'wrong' and unhealthy. In many traditional African and Pacific island cultures, however, a large or (as we now call it) an obese body shape was a sign of success and a shape to be aimed at.

Defining disability

One particularly interesting area where ideas of health and body shapes overlap is the topic of disability. According to Friedson (1965), the common perception of disability is that disabled people have some impediment that prevents them from operating 'normally'. This perception starts from the assumption that there is a clear definition of the 'normal' body, and a 'normal' range of activities associated with it.

However, it has been pointed out by critics such as Michael Oliver (1996) that the impediments imposed by society are at least as great as those imposed by the physical impairment. In other words, disability is a social construction, rather than just a physical one.

Not everyone is able to do everything as well as others – for example, run, catch or throw a ball – yet we do not describe those who are less able as being 'disabled'. We just accept these differences as part of the normal range of human abilities. This range of normality could be extended to include those defined as 'disabled'. This could occur, it is argued, if physical facilities and social attitudes were adjusted to include those with disabilities – for example, by altering the way we construct buildings, and by regarding sport played by disabled people as equal to 'traditional' types of sport.

It is with this in mind that the World Health Organization has distinguished between impairment, disability and handicap:

- *Impairment* refers to the abnormality of, or loss of function of, a part of the body.
- *Handicap* refers to the physical limits imposed by the loss of function.
- *Disability* refers to the socially imposed restriction on people's abilities to perform tasks as a result of the behaviour of people in society.

According to this approach, disability has to be understood as much in social terms as physical ones; so, a person can have an impairment without being disabled.

The origins of disability

If disability is a socially constructed concept, how did it come about? According to Finkelstein (1980), the modern idea of the dependent disabled person is largely the result of industrialization and the introduction of machinery. People with impairments were excluded from this type of work and came to be viewed as a burden. The rise of the medical profession in the early 19th century led them to become labelled as sick and in need of care.

Oliver (1990) takes Finkelstein's analysis further, by suggesting that the medical profession not only imposed the label of sickness and abnormality on people with impairments, but also helped to construct a way of looking at disability which saw it as a **personal tragedy**.

This concept of personal tragedy stresses that the individual disabled person has to be 'helped' to come to terms with the physical and psychological problems which they face. According to Oliver, this draws attention away from the fact that impairment is turned into disability by the wider economic, physical and social environment which discriminates against disabled people.

Stigma, illness and disability

Stigma is an important term in helping us to understand how people with disabilities are excluded from social activities. The idea of 'stigma' does not just apply to disabled people, but also to those with certain illnesses, such as Aids. The concept was first used in sociology by Erving Goffman (1963), who suggested that certain groups of people are defined as 'discredited' because of characteristics that are seen as 'negative'.

Types of stigma

Goffman suggested that there are two types of stigma.

1. *Discrediting* – These are obvious types of stigma, such as being in a wheelchair. People find it awkward to have normal social relations with those who are 'discredited'. They may be embarrassed, avoid eye contact or ignore the 'obvious' disability.
2. *Discreditable* – Here, the stigma is one of potential, dependent on whether other people find out about the discreditable illness or disability. Examples of this might include HIV status or epilepsy. In this situation, the person with the illness may find it difficult to act 'normally' in case they are 'found out'.

The concept of 'master status'

When the discrediting or discreditable status becomes the main way in which people are seen by others, then Goffman calls this a 'master status'. The stigma then completely dominates the way the person is treated, and any other attributes are seen as less important. The person who is unable to walk unaided is seen simply as 'wheelchair-bound' (not as an intelligent, articulate woman, for example), and the happy family man is seen as an 'Aids victim'. Finally, Goffman points out that the individuals themselves may accept this master status and come to see themselves solely in terms of their stigmatized status.

However, Goffman's argument that the individuals with stigma may well accept this as a master status has been criticized by other sociologists. According to Scambler and Hopkins (1986), for example, people with stigma may react in a number of different ways, using different tactics to manage their stigma:

- *Selective concealment* – If the stigmatizing condition is not obvious, the person may only tell a few trusted friends and family.
- *Covering up* – The person may tell no one.
- *Medicalizing the behaviour* – If the person cannot hide (or does not choose to hide) the condition, they could emphasize the medical aspect of it, as opposed to the social or moral aspect, and thus make a bid for sympathy (a link to the sick role here – see p. 3).
- *Condemning the condemners* – This is where people with a stigmatized condition take on those who impose the stigma and engage in forms of political action to have the

Research methods

Green and Platt (2004)
Studying stigma and illness by 'mixed methods'

Gill Green and Stephen Platt wished to explore the experience of stigma by people who are HIV positive. Obtaining a sample of people with this condition was difficult and there were also a number of ethical issues involved.

As it was extremely difficult to obtain a random sample from the general population, Green and Platt used a theoretical or purposive sample – that is, they set out to recruit respondents in settings where they knew they could be sure of finding HIV+ people and then selected as broad a range of respondents as possible within these settings. The recruitment took place in outpatient clinics, prisons, drug rehabilitation centres, voluntary organisations and GP practices. How the respondents were approached depended upon what was permitted by these organisations. Usually, a member of the organisation arranged an interview after gaining permission from the HIV+ person. Initially, 61 people were interviewed; then, one year later in the follow-up interview, 40 of these people were interviewed. The drop in the number of interviewees was caused by deaths and by the refusal of some people to give a second interview. The researchers accept that this is a large 'rate of attrition', but they believed that the normal procedure of contacting respondents a number of times to urge them to be interviewed again was inappropriate in the situation of these people who were in considerable stress over their condition. Green and Platt were not willing to add to their stress.

The first interview used semi-structured questions and respondents were encouraged to elaborate their answers. They were also asked to rate their satisfaction of the services they had received from the NHS using a five-point scale (from very dissatisfied to very satisfied). The second interview asked a series of more factual questions (e.g. had any GP refused treatment?) and then the respondents were encouraged to talk openly about their experiences. The information obtained was therefore both quantitative and qualitative. The combined and integrated use of both these forms of methods is sometimes known as 'mixed-method research'.

All interviews were recorded and later transcribed. They were then analysed using special software which helped to analyse themes that emerged from the interview.

Green, G. and Platt, S. (2004) 'Fear and Loathing in healthcare settings reported by people with HIV', in E. Annandale, M.A. Elston and L. Prior (eds) *Medical Work, Medical Knowledge and healthcare*, Oxford: Blackwell

1. **Why would it have been extremely difficult to obtain a sample from the general population?**
2. **What is meant by a theoretical or purposive sample? Why was this method most appropriate?**
3. **Explain why there was such a large drop-out between the first and second interviews.**
4. **How could the research claim to be both quantitative and qualitative?**
5. **When studies explicitly set out to use both quantitative and qualitative methods together, what term is sometimes used?**

stigma reviewed. Examples of this include the activities of HIV/Aids pressure groups and of pressure groups set up by disabled people.

The origins of stigma

Goffman never explained the origins of stigma, that is, why some people are stigmatized and others not. His main interest was in the effect of stigma on people and their interactions with others. However, other writers have suggested reasons why certain categories of people come to be stigmatized.

Clarke (1992) conducted a content analysis survey of magazines over a 20-year period and concluded that certain illnesses are linked to leading the 'wrong' sorts of lifestyles. HIV/Aids is viewed as discreditable, as are lung cancer and **obesity**. However, heart disease had no negative image.

Oliver (1990), as discussed earlier, sees the role of the medical profession as being crucial in defining how certain conditions are viewed.

Key terms

Biomedical model of health the conventional Western model. It sees the body as very much like a biological machine, with each part of the body performing a function. The doctor's job is to restore the functions by solving the problem of what is wrong. Ideas about the environment or the spiritual health of the person are not relevant.

Complementary medicine alternative forms of health intervention, such as homeopathy.

Disability the socially imposed restriction on people's abilities to perform tasks as a result of the behaviour of people in society.

General practitioner (GP) a local doctor who deals with general health issues.

Health a person's perception of the state of their body's wellbeing.

Illness perception of feeling unacceptably worse than normal body state.

Late modernity a term used to describe contemporary society, where choice and individuality have become more important than conformity and group membership.

Lay definitions of health 'lay' refers to the majority of the public who are not medical practitioners and who therefore use common-sense ideas about health and illness.

Malingering pretending to be ill in order to avoid work or other responsibilities.

Obesity a medical term for being overweight.

Personal tragedy a term used by Oliver to describe the way disability is seen as a personal as opposed to a social problem.

Reflexive mobilization within late modernity the process of seeing oneself as others see you and using this to construct an individual identity.

Unfinished product (the body as) in late modernity, the human body is not regarded as a biological fact that one must accept, but as something that can be amended according to one's wishes.

Check your understanding

1. How does the public define health?
2. Identify and explain any three factors that affect the definition of health and illness.
3. Who 'sanctions' illness (officially approves it), and what are the benefits of being 'sanctioned' as ill?
4. Construct a table summarizing the three types of medical models: biomedical, traditional and complementary.
5. What do we mean when we say that, in late modernity, the body is something which is 'accomplished'?
6. What is the difference between 'impairment' and 'disability'?
7. Explain the difference between stigma and disability.
8. Why might certain types of people become stigmatized?

Activities

Research idea

Select a small sample of people, ideally from different generations, and ask them to rate their degree of sympathy on a scale of 1 to 5 for people with the following 'illnesses': hangover, headache (not caused by a hangover!), impotence, cirrhosis of the liver (caused by drinking too much alcohol), anorexia, heart disease, breast cancer, lung cancer caused by smoking, sexually transmitted disease.

Do your results show any different attitudes to illness and disease amongst people? What explanations can you suggest for your findings?

Web.task

Search online for information and advice on health – for example, *Men's Health Magazine* at www.menshealth.co.uk

Does the advice make an assumption about what is normal and abnormal in terms of body shape and styles of life?

An eye on the exam — Defining health, illness and disability

Item A

The Ndembu explain all persistent or severe health problems by reference to social causes, such as the secret malevolence of sorcerers or witches, or punishment by the spirits of ancestors. These spirits cause sickness in an individual if his or her family and kin are 'not living well together', and are involved in grudges or quarrelling.

The Ndembu traditional healer, the chimbuki, conducts a séance attended by the victim, their kin and neighbours. By questioning these people and by shrewd observation, he builds up a picture of the patient's social situation and its various tensions. The diviner calls all the relatives of the patient before a sacred shrine to the ancestors, and induces them 'to confess any grudges and hard feelings they may nourish against the patient'. By this process all the hidden social tensions of the group are publicly aired and gradually resolved.

Treatment involves rituals of exorcism to withdraw evil influences from the patient's body. It also includes the use of certain herbal and other medicines, manipulation and cupping and certain substances applied to the skin.

Adapted from Helman, C. (2000) *Culture, Health and Illness*, Oxford: Butterworth/Heinemann, pp. 197–8 (adapted)

Item B

In the biomedical model, information is gathered by means of indicators like X-rays, blood sugar levels, electroencephalograph readings or biopsies, which are thought to measure these biological processes directly.

This framework is closely associated with developments in Western science. Physicians can readily reach agreement on the functioning of the body by reference to well-defined criteria which are known to all members of the medical profession and which become progressively more precise with advances in scientific knowledge. The doctor will be able to use signs derived from these tests as objective indicators of biological malfunction or irregularity – regardless of whether the supposed patient actually feels ill.

Adapted from Dingwall, R. (1976) *Aspects of Illness,* Basingstoke: Palgrave

(a) Explain what is meant by 'disability'. (2 marks)

(b) Identify three characteristics of the traditional model of health, illness and medicine (Item A). (6 marks)

(c) Outline the main features of the biomedical model of health, illness and medicine (Item B). (12 marks)

(d) Using information from Items A and B and elsewhere, assess the view that health and illness are socially constructed. (20 marks)

Grade booster — Getting top marks in part (d)

Don't confuse the idea of social construction with social causes such as poverty, bad housing, poor diet, etc. Use examples from different cultures of the ways in which health and illness have been defined differently, or contrast lay and medical definitions. Use information from the Items to do this. Make sure you refer to health as well as illness. It's also legitimate to discuss how disability is socially constructed.

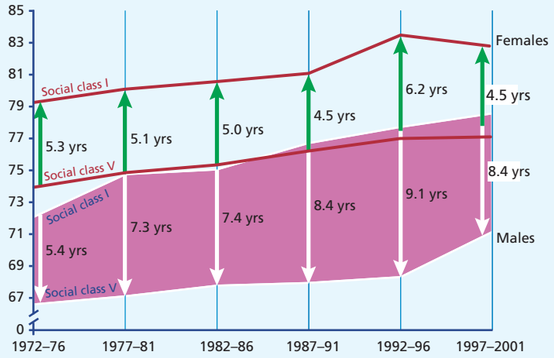
TOPIC 2
Health inequalities

Getting you thinking

Look at the graph on the right.

1. **Who is likely to live longer on average, men or women?**
2. **Approximately, what is the highest age that women could expect to live to in 2001 (the latest figures currently available) and what is the highest age for men?**
3. **What impact does social class have on age expectancy?**
4. **What explanations can you offer for these differences?**

Life expectancy at birth in years



Source: Department of Health (2005) *Tackling Health Inequalities,* London: DoH

Life expectancy, healthy life expectancy and disability-free life expectancy at birth: by gender (Great Britain)

	Years			
	Males		*Females*	
	1981	2002	1981	2002
Life expectancy	70.9	76.0	76.8	80.5
Healthy life expectancy	64.4	67.2	66.7	69.9
Years spent in poor health	6.4	8.8	10.1	10.6
Disability-free life expectancy	58.1	60.9	60.8	63.0
Years spent with disability	12.8	15.0	16.0	17.5

Source: Social Trends 37, 2007

Look at the table on the left.

5. **Although people live longer nowadays, what does the table tell us about the health of older people? What implications might this have for women in particular?**
6. **In your opinion, is it a curse or a blessing to live longer (on the basis of these statistics)?**

If ever anyone sought proof that social factors have a significant impact upon people's lives, then they only have to look at the relationship between a person's life experiences and their chances of illness and early death. The chances of an early death, of a serious long-term illness and of a disability are closely related to social class, income, gender, area of residence and ethnic group.

But why should this be? Health, illness and disability are generally thought of as linked to the luck of our genes – that is, they are biologically caused. Yet sociologists argue that the evidence from research indicates that it is the interaction of our social experiences with our biological make-up that determines our health. If pressed, they might well argue that the more important of the two sets of factors is actually the social rather than the biological. In the following discussion, we will explore the major social determinants of our health: geography, social class, gender and ethnicity. We will look at each area in turn.

Geographical differences

The simplest way of finding out the impact of place of residence on health is to compare the health differences between **parliamentary constituencies** in Britain. Mary Shaw and a group of researchers (1999) used the available statistics to compare the health of one million people living in the constituencies that had the very worst health records with the one million people living in the constituencies that had the very best health records. The gap between these groups surprised even the researchers themselves.

The comparison showed that, in the worst health areas:

- children under the age of 1 are twice as likely to die
- there are ten times more women under the age of 65 who are permanently sick (including those who are disabled)
- adults are almost three times as likely to state that they have a serious 'chronic' (long-term) illness or disability
- adults have a 70 per cent greater chance of dying before the age of 65.

These geographical differences generally reflect differences in income and levels of deprivation. However, they are not simply a reflection of these, because poorer people living in the richer areas tend to have higher standards of health. It seems that quality of life in poorer areas is generally lower and, as a result, health standards are worse.

Social class

Mortality

Over the last 25 years, **life expectancy** has risen for both men and women, in all social classes. But overall they have risen more for those in the higher social classes, so that the difference between those in the higher and those in the lower social classes has actually grown. For example, in the 1970s, the **death rate** among men of working age was almost twice as high for those in class V (unskilled) as for those in class I (professional). By 2003, it was almost two and a half times as high. Men in social class I can expect to live for almost eight and a half years longer than men from social class V, while women in social class I can expect to live four and a half years longer than their social class V counterparts.

Deaths from heart disease and lung cancer (the two most common causes of death for people aged 35 to 64) are twice as high in people from manual backgrounds as non-manual backgrounds.

Morbidity

Although death rates have fallen and life expectancy has increased, there is little evidence that the population is experiencing better health than 20 years ago. In fact, there has actually been a small increase in **self-reported** long-standing illness, and differences between the social classes are still quite clear. However, as we saw in Topic 1, what is defined as 'health' changes over time. So it may be that people are actually in better health but don't believe it. Bearing this in mind, among the 45 to 64 age group, 18 per cent of people from 'managerial or professional backgrounds' reported a limiting long-standing illness, compared to over 32 per cent of people from 'routine or manual backgrounds' (ONS 2007).

In adulthood, being overweight is a measure of possible ill health, with obesity a risk factor for many chronic diseases. There is a noticeable social-class gradient in obesity, which is greater for women than men. According to the Department of Health (2007), about 32 per cent of women in the poorest fifth of the population are obese, compared to 16 per cent of women in the richest fifth of the population.

Explanations for differences in health between social classes

Different ways of explaining class differences in **mortality** and **morbidity** have been suggested.

The artefact approach

An **artefact** is something observed in a scientific investigation that is not naturally present, but occurs as a result of the investigative procedure. Perhaps the link between class and health is not real but a statistical illusion. Illsley (1986) argues that the statistical connection between social class and illness exaggerates the situation. For example, he points out that the number of people in social class V has declined so much over the last 30 years that the membership is just too small to be used as the basis for comparisons with other social classes.

However, the recent 'Independent Inquiry into Inequalities in Health' showed that, even when the classes were regrouped to include classes IV and V together, significant differences remained. For example, in the late 1970s, death rates were 53 per cent higher among men in classes IV and V, compared with those in classes I and II.

Social selection

This approach claims that social class does not cause ill health, but that ill health may be a significant cause of social class. For example, if a person is chronically ill (i.e. has a long-term illness) or disabled in some way, it is usually difficult for them to obtain a secure, well-paid job. The fit and healthy are more likely to be successful in life and upwardly mobile in terms of social class.

The problem with this approach is that studies of health differences indicate that poor health is a result of poverty rather than a cause of it.

Cultural explanations

The **cultural explanations** approach stresses that differences in health are best understood as the result of cultural choices made by individuals or groups in the population.

- *Diet* – Manual workers consume twice as much white bread as professionals, and have higher sugar consumption and eat less fresh fruit.
- *Cigarette smoking* – Over 40 per cent of males and 35 per cent of females in social classes IV and V regularly smoke, whereas only about 12 per cent of males and females in social class I smoke.
- *Leisure and lifestyle* – Middle-class people are more likely to take exercise and have a wider range of social activities than the working classes. These reduce levels of stress and help maintain a higher standard of health.
- *Alcohol* – Alcohol consumption is directly related to social class, with much higher consumption amongst the 'lower' social classes.

The cultural approach, however, fails to ask why these groups have poor diets and high alcohol and cigarette consumption. Critics point out that there may be reasons why people are 'forced' into an unhealthy lifestyle. These critics have put forward an alternative **material explanation**.

Material explanations

Some analysts see a direct relationship between differences in health and the unequal nature of British society. Supporters of this approach accept the behavioural differences pointed to earlier, but claim that this behaviour has to be seen within a broader context of inequality. So, poor health is the result of 'hazards to which some people have no choice but to be exposed given the present distribution of income and opportunity' (Shaw *et al.* 1999).

- *Poverty* – This key factor links a range of health risks. Poorer people have worse diets and worse housing conditions. They are more likely to be unemployed and generally to have a more highly stressed, lower quality of life. According to the British Regional Heart Survey (cited in Shaw *et al.* 1999) – a study of 8000 middle-aged men – over half of those who did not own a car or a home were reported to be in poor health, compared to a tenth of those who owned both.
- *Position at work* – Workers with little power or control over their work are likely to experience worse health than those given more responsibility. Research on civil servants (Davey Smith *et al.* 1990) has shown that routine clerical workers are much more likely to die young than workers in higher grades. If the lowest and highest grades are compared, those in the lowest grades are actually three times more likely to die before reaching the age of 65.
- *Unemployment* – According to Moser's long-term study of the relationship between income and wealth (Moser *et al.* 1990), unemployed men and their wives are likely to die younger than those in employment.
- *Types of industry* – industries vary in how dangerous they are to their employees. For example, respiratory diseases are common amongst those working in road and building construction, as a result of the dust inhaled, while various forms of cancer are associated with chemical industries.

The material approach has the advantage of explaining why there are cultural differences in behaviour between various groups in society. The argument advanced by those who support this approach is that people may make choices about their behaviour, but that the circumstances within which they make their choices are strongly affected by the extent of inequality existing in Britain.

Gender and health

Women live longer than men, but are more likely to visit their GPs for treatment. They also have higher levels of mental illness. This apparently contradictory pattern – higher morbidity combined with a longer life span – has led some observers to argue that it is not that women are more likely to be ill than men, but that they are more willing to visit the doctor. Yet MacIntyre (1993) shows that women are, in fact, no more likely than men to report symptoms. The answer lies perhaps in a combination of biological factors and social roles.

Explanations for the link between gender and health

Biology

There is some evidence to suggest that women are biologically stronger than men (for instance, female foetuses are less likely to die than male foetuses) and they have a greater biological possibility of living longer. However, this does not mean that they are less immune to illness. In addition, they can suffer from a range of health problems associated with reproduction and the menopause.

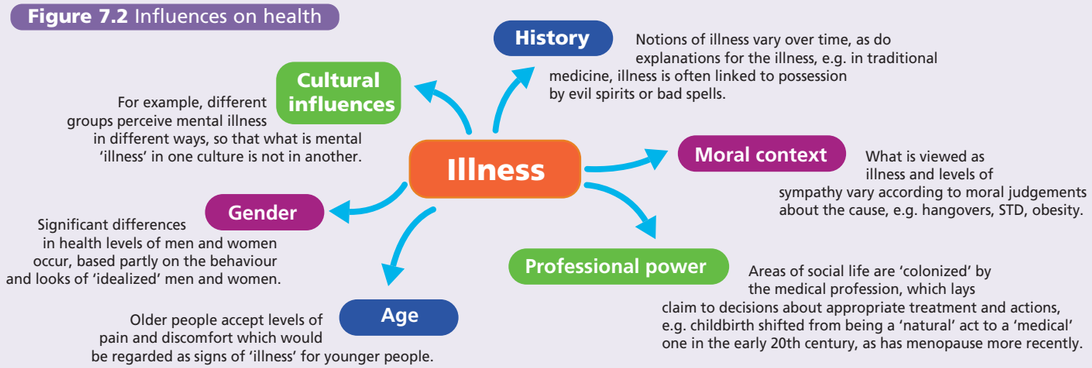
Social role

Women may also live longer because their social role tends to prevent them from taking risks. Their social role discourages them from violence, fast driving and excess alcohol consumption. Women are also less likely to smoke than men. However, the social role that limits their activities also places considerable stress upon women, by restricting opportunities in employment and in life in general. Furthermore, women are more likely than men to be living in poverty. They are also more likely to be lone parents. Both place considerable burdens upon their health.

Work

According to Ellen Annandale (1998), women who go out to work have better levels of health than those who do not. Annandale argues that this is not just because of the financial benefits, but also because work gives women a sense of independence and a wider social network. Both of these have the effect of lowering stress levels – and stress is closely related to standards of health.

Figure 7.2 Influences on health



Ethnicity and health

Surprisingly, there is only limited information available on ethnicity and illness. This is partly because of the complex make-up of ethnic groups in the UK and the difficulty of making generalizations across these groupings. However, some specific health problems can be linked with particular groups – for example, those of Afro-Caribbean origin are much more likely to suffer from sickle cell disease.

The research that has been done (mainly by the Health Education Authority) shows that members of minority ethnic groups are more likely to define themselves as having poor health than the majority population. For example, just under 50 per cent of ethnic minority members described themselves as having fair or poor health. This compared with just under 30 per cent of the majority population.

As for mortality, all ethnic minority groups have a shorter life expectancy than the majority population. Patterns in the causes of death do seem to vary, with groups from the **Indian subcontinent** having the highest levels of coronary heart disease of the whole population, while those from the **Caribbean commonwealth** have the lowest levels of death from this cause. Although, overall, health levels are worse and life expectancy is lower, one striking difference is that all of the ethnic minority groups have lower rates of deaths from cancers than the majority population.

Explanations for the link between ethnicity and health

'Race' and inequality

We saw earlier the profound effects of inequality in helping to explain different levels of health. Minority ethnic groups have some of the lowest incomes, worst housing and highest unemployment rates in Britain. Even without any specific explanations related to 'race', the higher levels of morbidity and higher early mortality rates could largely be explained by their relative social deprivation.

'Race' as a specific factor

Some analysts have gone further than this, however, and have argued that 'race' is important by itself. First, much of the poverty and exclusion is actually caused by racism. Second, the experience of living in a racist society can place great stress upon people and this may impact upon health levels.

Research methods

English Longitudinal Study of Ageing

In order to ensure that government policies are working effectively and to find out the needs of the British population, the government is constantly carrying out surveys of various kinds. One of these, known as the English Longitudinal Study of Ageing (ELSA), obtains information on the health of approximately 8500 people over the age of 50. The research takes place every two years and follows one nationally representative sample of people aged 50 or more. It is drawn from households and is intended to be a longitudinal survey. The first phase of the survey took place in 2002/3 and the second in 2004/5. The statistics are so complex that it takes two years before the reports can be published.

The sampling was conducted by a random sample of postcode selected from the Postcode Address File. These were then 'stratified' to ensure that a range of health authorities and a true cross section of social class groups were represented. Addresses were then selected 'systematically' from each sector.

Each selected household was sent a letter explaining the research and asking if they would agree to be interviewed and to complete a questionnaire. They achieved a response rate of 84%, which is extremely high. This may have been because it was an official piece of research or because people are likely to be interested in their health and prepared to answer questions about it.

First, there was an interview which covered a wide range of subjects including the demographics of the household, the health of the people living there, their income and their activities. Each chosen person was left a questionnaire to complete, covering such things as life satisfaction, views of ageing, social networks and alcohol consumption.

Finally, the respondents were examined by a nurse to collect data on their physical health. The result is extremely detailed information on a wide range of factors that impact on a person's health and longevity.

Source: Banks, J., Breeze, E., Lessof, C. and Nazroo, J. (2007) *Retirement, Health and Relationships of the Older Population in England: The 2004 English Longitudinal Study of Ageing* (Wave 2)

1. What do we mean by a 'longitudinal survey'?
2. How can it be argued that 8500 people represent an accurate image of health and ageing in Britain?
3. How was the sample obtained?
4. What is meant by the 'postcode address file'?
5. The results of surveys often take years to be published. Why might this be?
6. This survey has a very high response rate – what factors might influence these response rates?
7. Why do you think that some information was obtained by interview and some by questionnaire?

Culture and ethnicity

The final approach argues that cultural differences, in terms of diet and lifestyle, may influence health. For example, diets using large amounts of 'ghee' (clarified butter) can help cause heart disease amongst those of South Asian origin. Asian diets also tend to lack vitamin D. Long work hours and relatively little physical leisure activity may also lower the health levels of some minority ethnic groups.

Health inequalities in an international perspective

Although inequalities in health are quite marked within the UK, the differences between the richer and poorer countries of the world make quite stark reading.

The obvious reasons for the differences in life expectation and levels of illness lie in the extremes of poverty that exist in the less developed nations as well as in their lack of health systems. However, perhaps more surprising were the findings of Richard Wilkinson (1996), who compared the health and economic data for 23 different countries. He found very strong evidence to link the overall health of the population with the degree of economic inequality. Once a certain basic level of overall economic wealth had been attained by a country, then the greater the economic inequality which existed, the wider the health differentials. Interestingly, no matter how high the general standard of living became, as long as there were economic inequalities, there was no increase in the general standards of health. This meant that a country with a high standard of living, but considerable economic inequality, actually had lower standards of health for the majority of the population than a poorer country with greater social equality. Cuba, for example, despite being much poorer than the USA, has better standards of health and expectation of life overall than the USA.

Wilkinson's conclusions were that societies with low levels of inequality had high levels of 'social capital' – that is a sense of belonging and place in a society. This sense of belonging had the effect of increasing the sense of wellbeing, which in turn improved standards of health.

Key terms

Artefact approach an approach that believes that the statistics about class and health exaggerate the real situation.

Caribbean commonwealth parts of the West Indies that are in the Commonwealth, such as Barbados.

Cultural explanations explanations that emphasize lifestyle and behaviour.

Death rate the number dying per 1000 of a population per year.

Indian subcontinent the section of south Asia consisting of India, Pakistan and Bangladesh.

Life expectancy the average length of life of individuals in a population.

Material explanations explanations that focus on the make-up of society: for example, on inequalities of income and wealth.

Morbidity refers to statistics about illness.

Mortality refers to statistics of death.

Parliamentary constituency an area that elects one MP. The country is divided into over 600 constituencies.

Self-reported the result of asking people themselves.

Check your understanding

1 **Identify four factors that are closely linked to health.**

2 **Why might some areas of Britain have worse health than others?**

3 **Give one example of health differences between the social classes.**

4 **What explanations have been suggested for health differences between the social classes?**

5 **Explain, in your own words, the meaning of the 'artefact approach'.**

6 **Do biological factors alone explain the differences in health between men and women?**

7 **What three explanations have been given for the differences in health between the various ethnic minorities and the majority of the population?**

Activities

Research idea

Ask a sample of 20 people how much fresh fruit they eat each day. You might wish to divide the sample by gender or by age or even by parental occupation. Do any differences emerge?

Web.task

Go to the Department of Health's Community Health Profiles website at:

www.communityhealthprofiles.info/index.php

Here you can look up your own area and obtain a full health profile.

An eye on the exam — Health inequalities

Item A

Percentage of people in England and Wales reporting long-term illness or disability that restricts daily activities: data from Census 2001

Great Britain	*Males (%)*	*Females (%)*
White British	15.9	15.3
White Irish	17.7	15.7
Mixed	18.3	17.8
Indian	16.5	19.8
Pakistani	22.1	25.4
Bangladeshi	23.6	24.9
Other Asian	16.7	18.6
Black Caribbean	17.9	19.3
Black African	14.1	16.7
Other Black	18.8	19.9
Chinese	11.4	12.1
All ethnic groups	16.0	15.4

Source: ONS www.statistics.gov.uk/cci/nugget.asp?id=464
www.empho.org.uk/products/ethnicity/inequalities.htm

Item B

<< Alongside these material and behavioural determinants, research is uncovering the psychosocial [social and psychological] costs of living in an unequal society. For example, perceiving oneself to be worse off relative to others may carry a health penalty, in terms of increased stress and risk-taking behaviour. Attention has also focused on the health effects of the work environment and particularly on the control that individuals exercise over the pace and content of work.

Material, behavioural and psychosocial factors cluster together: those in lower socio-economic groups are likely to be exposed to risks in all three domains. Health-damaging factors also accumulate together: children born into poorer circumstances clock up more by way of material, behavioural and psychosocial risks as they grow up and grow older. For example, girls and boys born into social classes IV and V are more likely than those in higher social classes to grow up in overcrowded homes, to develop health-damaging habits like smoking and to be exposed to stressful life-events and work environments.>>

Graham, H. (ed.) (2000) *Understanding Health Inequalities*, Buckingham: Open University Press

(a) Explain what sociologists mean by 'behavioural factors' (Item B). (2 marks)

(b) Using Item A, identify the ethnic group with:

(i) the highest level of female long-term illness

(ii) the lowest level of female long-term illness

(iii) the biggest gap between male and female levels of long-term illness. (6 marks)

(c) Outline some of the causes of gender inequalities in health. (12 marks)

(d) Using information from the Items and elsewhere, assess the view that inequalities in health are the result of material factors. (20 marks)

Grade booster — Getting top marks in part (d)

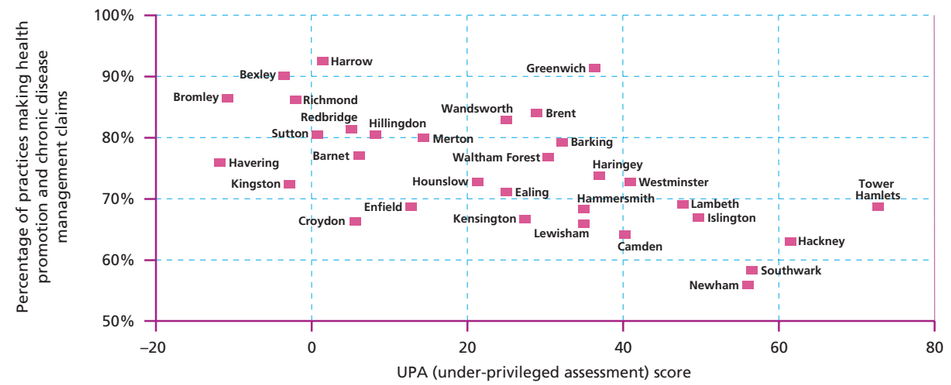
Be clear what 'material factors' means and what kinds of health inequalities they might cause. Discuss how different material factors, such as low income, unemployment, poor housing, etc., affect health. Make sure you use information from the Items. Use other explanations, such as cultural/behavioural, artefact and social selection, to assess the materialist view. How far can material and behavioural factors be linked? Most of your answer can be about class inequalities, but mention other types too, e.g. gender, ethnic, age or regional.

TOPIC 3

Inequalities in the health service

Getting you thinking

GP Health promotion claims, by Jarman (UPA) score of health authority, London Boroughs, October 1995



Source: www.archive.official-documents.co.uk/document/doh/ih/fig17.gif

The graph above shows the amount of preventative health work done by GPs in London boroughs in relation to the extent of deprivation in those boroughs. The higher the borough on the vertical axis, the more preventative work it is doing. The more deprived the borough is, the further to the right it is along the horizontal axis.

Is the day of rationing the US healthcare services on the basis of age close at hand?

The fastest growing age group is the population aged 80 and over – the very segment of the population that tends to require expensive and intensive medical care. The projected demands from a growing elderly population on the healthcare system have led to troubling questions about society's ability to meet future healthcare demands.

Daniel Callahan has proposed that the US government refuse to pay for life-extending medical care for individuals beyond the age of 70 or 80, and only pay for routine care aimed at relieving their pain. While the health of the young can be ensured by relatively cheap preventive measures such as exercise programs and health education, the medical conditions of the elderly are often complicated, requiring the use of expensive technologies and treatments. In short, the costs that are incurred to prolong the life of one elderly person might be more productively directed toward the treatment of a far greater number of younger persons.

Source: Andre, C. and Velasquez, M. (1990) 'Aged-based healthcare rationing: challenges for an aging society', *Issues in Ethics*, 3(3)

1. **Look at the chart above. Identify the two boroughs in the graph where the lowest levels of health prevention are carried out. What other social characteristic do they share?**
2. **'If more money is spent on health in poorer areas then more affluent areas are deprived.' Do you agree with this statement? Give your reasons.**
3. **In small groups discuss the position put forward by Callahan regarding older people – do you agree with his argument?**
4. **Do you think there are some (other) groups in society whose access to healthcare should be restricted?**

Despite the National Health Service (NHS) being free to users, and despite taxpayers spending over £115 million *each day* on paying for the NHS, it is a fact that some groups in the population are more likely to receive medical help than others. This contradicts the fundamental notion of 'equity' – the principle that provision of services is based solely upon need. According to this principle, the health services serving disadvantaged populations should not be of poorer quality or less accessible than those serving the more affluent groups in society. Furthermore, it implies that more resources should be allocated to the poorer groups in society, as they have worse levels of health. However, sociologists argue that there is not actually equity in the NHS, for two reasons:

1. The NHS fails to provide equal services for all in relation to their relative needs.
2. Certain groups are less likely to demand services than others.

Issues of provision

The NHS is the main provider of healthcare for the population and it needs to plan how best to provide this care. Provision is influenced by several factors, discussed below.

Geographical and social inequalities

Each area is allocated a certain amount of money by the government to provide healthcare for its residents. The amount of money given to each **health authority** is based on the principle of giving more money to poorer areas and less to richer areas. Unfortunately, this has never worked out as planned, and the poorer areas have never received adequate funding. Reasons for this include:

- *Foundation trust hospitals* – These are usually located in the richer areas of the country and have traditionally been given considerably higher levels of funding than other hospitals.
- *Political pressures* – Certain areas, such as London, have historically received more money than other regions. Over time, the reasons for this extra funding have disappeared – with shifts in population, for example. Each time plans have been put forward to reallocate money to other areas, the politicians have blocked them for fear of losing votes.

An example of this is provided by the Healthcare Commission, an official government body set up to oversee equity in healthcare. Easington in County Durham, a very deprived area, should be receiving an additional £26.5 million a year in funding, while Kensington and Chelsea, one of the richest places in Britain, is receiving £30.3 million a year, more than the official government funding formula requires.

The Healthcare Commission also found variations between England and Wales, with patients more likely to wait longer for hospital appointments in Wales than in England. In March 2004, 50 people were waiting more than nine months for an operation in England, yet in Wales, 8457 patients had been waiting longer than 12 months, of whom over 1000 had been waiting longer than 18 months.

The medical professions

The medical professions are extremely influential in determining how the different areas or specialisms of healthcare are funded. There are some specialisms that are seen as much more important and prestigious, whilst others are viewed as less important or less attractive. In general, chronic illness (that is, long-term illnesses for which there is no cure), mental health and geriatric (elderly people's) healthcare are seen as much less attractive areas than surgery, pharmaceuticals and high-technology medicine.

Hospital and primary care trust quality

Different hospitals and **primary care trusts** appear to be organized in very different ways, which results in great differences in the chances of survival from serious operations, and in the chances of catching some form of infection in hospital (known as **iatrogenesis**). In a study of all English hospitals in 2000, the researchers found that 17 people were likely to die in the worst hospitals for every 10 in the best. For instance, the death rate from cancer is 60 per cent higher in Liverpool than in east Dorset.

Private healthcare

Although there is much evidence of inequalities within the NHS, greater inequalities in access to healthcare exist between those who rely upon the NHS and those who use the private sector.

Private healthcare is used by those who pay directly for medical services or who have private health insurance. The total spending on private healthcare in Britain is about £2.5 billion each year, and those doctors who provide private healthcare earn about £550 million each year.

Private healthcare increases inequalities in healthcare by:

- allowing those who can pay to have treatment without waiting, whereas NHS patients have to join a waiting list
- giving private patients access to a range of medical services that may not be available on the NHS
- limiting the number of hours worked by some consultants (senior specialists) in the NHS, who prefer to earn more money in the private sector
- employing nurses and other specialists who have been trained by the NHS – thus contributing to the shortage of trained staff.

Issues of demand

Social class variations

Although the health of the population as a whole has improved, there is no evidence to show that inequalities between the social classes have decreased. As we saw in Topic 2, despite the fact that members of the working class are more likely to be ill and to have accidents, they are actually less likely to attend doctors' surgeries. They are also less likely to take part in any form of **screening programme** that can

discover disease (such as certain forms of cancer) at an early stage. They are, however, more likely to use accident and emergency services – often because conditions that have not been attended to have become acute.

The reasons for this are not that they care less about illness, but that there are more barriers to them accessing healthcare. They are less likely to be able to:

- afford to take time off work
- travel a considerable distance to a GP's surgery – this is a particular problem because there are far fewer GPs in poorer areas, in proportion to the population, than in more affluent areas
- notice signs of health problems.

Gender

Women live approximately seven years longer than men, but they do not necessarily do so in good health. In fact, on average, they have only two extra years of healthy life without significant chronic illness. During their lifetimes, too, women appear to have higher levels of illness and higher rates of attendance at doctors' surgeries. However, this needs to be set against women's needs. Women give birth, and also take on the main childcare role, both of which put great strain upon their bodies.

Feminist sociologists argue that women actually under-use the health services, if their use is compared to their actual needs. They argue that, instead, the health services spend much of their resources on controlling women, by turning many 'normal' physical activities, such as giving birth, into medical ones. This takes power away from women and hands it to men, who form the majority of doctors.

As a result of these concerns, a national screening programme for breast cancer was introduced in 1988, and for cervical cancer in 1995. However, within these programmes, considerable differences in attendance have occurred, related to social class and ethnicity. Overall, the take-up rates have been approximately 75 per cent, but the poorer the social group, the less likely women are to attend. Similarly, the attendance rates for those of Bangladeshi and Pakistani origin are particularly low.

Ethnicity

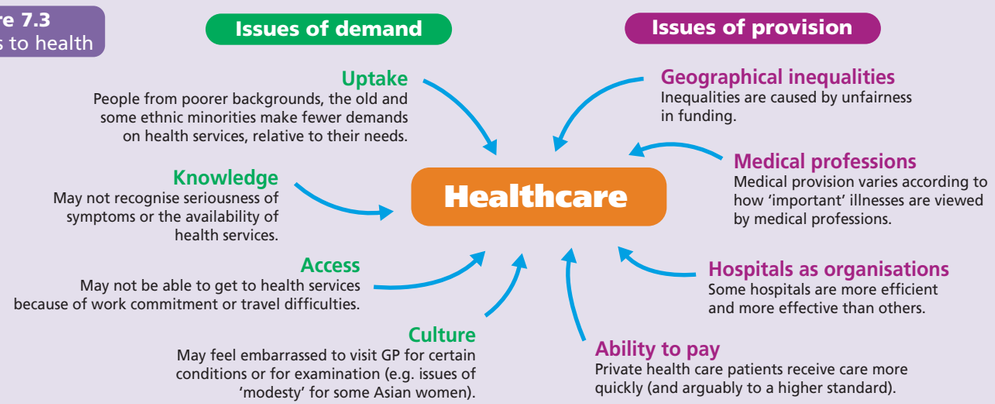
There is a lower use of medical services by certain ethnic minority groups. Several reasons have been suggested for this:

- *Language barriers* – Until recently, there was little attempt to provide translation facilities or to publicize the NHS in minority languages.
- *Cultural differences* – The traditional acceptance of male doctors has been challenged by many women from ethnic minorities, whose ideas of modesty have meant that many are unwilling to be seen by male doctors.
- *Poverty* – Ethnic minorities contain some of the lowest-income families in Britain, and so the factors that limit working-class use of health services (time off work and public transport difficulties) apply equally to them.

Age

Older people's approach to healthcare provision is different from that of middle-aged and younger people. Although they are the age group who are most in need of health services and who use them most, they tend to under-use them relative to their needs. Older people see themselves as 'wasting the doctor's time' if they consider that they may be consulting the doctor unnecessarily. What is more, geriatric medicine (the care of older people) is seen by doctors and nurses as an area of low prestige, and staffing and funding levels are extremely low. Therefore, both in terms of demand and provision, older people do particularly badly. However, stratification by class and geography also cuts across age lines – for example, the proportion of older people in the population receiving flu vaccinations varies from 49 per cent to 78 per cent across England.

Figure 7.3 Access to health



Research methods

Meershoek *et al.* (2007)
Doctors' power of judgement

The Netherlands and the UK operate a similar system whereby people applying for long-term state benefits on the grounds of disability will be assessed by a specialist doctor. Because of the difficulty in deciding precisely what 'disabled' means, a great deal of discretion is given to the doctors. Meershoek and colleagues set out to uncover the grounds on which the doctors made their judgements about whether a person was truly disabled or not and hence about their entitlement to state benefits.

Meershoek and colleagues undertook an ethnographic study of the specialist doctors employed to do this work in The Netherlands. This involved observing over 500 consultations between clients and 20 different doctors, in different phases of the sick leave, including final judgments for long-term disability pension. They made field notes of the consultations and of the doctors' comments beforehand and afterwards. They also interviewed the 20 physicians about their decision-making processes. In order to have a background understanding, they also followed the doctors in their contacts and meetings with other experts and employers, but did not make any detailed notes.

They made notes of all the consultations and then agreed between them on certain themes and patterns which emerged on the basis of 'grounded theory' (that is, not making any assumptions before gathering data and then building up a theory as the information becomes available). They then re-analysed their notes to look at the specific responses of doctors to the replies of people claiming disability benefit whom the doctors considered 'problematic'.

Source: Meershoek, A., Krumeich, A. and Vos, R. (2007) *Judging without Criteria? Sickness certification in Dutch disability schemes*, ••Place: Publisher••

1 **What is meant by an ethnographic approach?**
2 **The researchers made notes of the meetings, but did not make any (electronic) recordings. Do you think this might present some problems?**
3 **The researchers did not make detailed notes of their interviews with the experts and employers. Do you think making detailed notes would have been useful?**
4 **Grounded theory is commonly used in ethnographic research – how does this compare with more positivistic approaches?**

Theoretical approaches

So far, we have seen how patterns of inequalities in the usage of the NHS can best be grasped in terms of provision of services on the one hand and demand for healthcare on the other. However, some writers have suggested that these explanations can also be included within wider theoretical perspectives. In particular, Ham (1999) has suggested that Marxism, pluralism and structuralism are the best ways of understanding the inequalities in health provision.

Marxist approaches to inequalities in health provision

Marxist writers on health, such as Doyal (1979) and O'Connor (1973), argue that the health service exists for two reasons. First, it has a 'legitimation' role, in that it persuades the bulk of the population that capitalism 'cares' for them. In this role, it acts to limit class conflict and social unrest by creating a sense of harmony. The health service therefore legitimates capitalism and is a subtle form of social control. However, the second role of health services helps the capitalist economy more directly. The health service maintains a healthy and hardworking – and therefore productive – workforce. Workers who are ill or injured are returned to work and therefore continue to make profits for the owners of capital.

Using this approach, inequalities in health provision are directly related to how productive people are. This explains why there are low levels of expenditure on people with mental illness, people with learning difficulties and the oldest and frailest members of society. The low levels of expenditure on the working class is explained by the presence of social-class divisions throughout society, whereby working-class people consistently receive worse treatment across the range of services in housing, education and health.

There are a number of problems with the Marxist analysis. It could equally be argued that, rather than being a form of social control, the National Health Service provides a very powerful alternative message to that of capitalism. The NHS is based on the socialist principle of giving to people in need, irrespective of income. Capitalism is based on people choosing to buy services, which depends upon their levels of income.

Also, some of the largest areas of NHS expenditure are actually with groups who are not 'productive'. For example, the largest group of users of the NHS are older, retired people.

Pluralist approaches

This approach suggests that the best way to understand any society (or large organization) is to examine the way that power is distributed within it. More powerful groups will be more likely to gain benefits compared to less powerful groups. This differs

from the Marxist model in a number of ways, but, most importantly, pluralism argues that no one group has all the power – instead, there are numerous ('plural') competing groups who need to accommodate each other. The resulting social inequalities will be much more complex and fragmented than in the ruling-class/working-class division in Marxist theory.

Applying pluralist theory to inequalities in health service provision, we can understand these inequalities (both of provision and demand) in terms of the differences in power between the various groups. In terms of the provision of services, there is the interplay between the various professional groups (surgeons, dentists, nurses, pediatricians, geriatricians) and between managers and, finally, political interests. Demand for services consists of competing demands from the various 'illness categories' (mentally ill, children, older people, cancer patients, etc.) and from groups stratified according to ethnicity, age, gender and class.

The outcome in terms of provision and use will constantly vary according to shifts in power between these groups.

Structuralist approaches

Alford (1975) has suggested that both the Marxist and the pluralist approaches are useful, but that combining elements of both produces a better theory.

According to Alford there are three groups of interested parties in the health service: dominant, challenging and repressed. These groups operate on different levels and there is conflict both *between* them and *within* them. The dominant group consists of the established medical professions who vie with each other for dominance. Whatever the outcome of their struggles, the winners will have greater power over decision-making than the next 'challenging' group – which consists of senior health managers and health-service policy planners. The third group, the 'repressed' consists of patients and other consumer groups. Different categories of patients compete for their health needs to be addressed, but they do so within the framework set out by the dominant and challenging groups.

This may seem rather complex, but Alford is essentially arguing that the competing interest groups in the health service can be grouped together in terms of the power they hold. In doing so, Alford presents a modified version of pluralism. The elements of Marxism incorporated into his theory include the point that the dominant and challenging groups draw their power from established social hierarchies and so the divisions in the health-service provision reflect the divisions in the wider capitalist society.

Key terms

Health authorities the National Health Service is actually a system of local health services. Health authorities are the bodies responsible for ensuring that local people get adequate health services by overseeing the local healthcare trusts which actually provide the health services.

Iatrogenesis illness caused by the medical professions (e.g. as a result of poor care or inaccurate diagnosis).

Primary care trusts the NHS organizations responsible for local health- and social-care services (including GPs).

Private healthcare healthcare that is not provided by the NHS, but which people pay for themselves.

Screening programmes programmes where particular sections of the population are tested to see if they have signs of a particular disease.

Check your understanding

1 **What do we mean by 'issues of provision and demand' when discussing inequalities in access to healthcare?**
2 **What impact can doctors and hospitals have on inequalities of provision?**
3 **What three factors help to restrict the use of health services by ethnic minorities?**
4 **How does the medical profession view geriatric medicine?**
5 **Explain what impact private medicine may have on health inequalities?**
6 **Explain the structuralist explanation of inequalities in healthcare provision, using examples from the main text where appropriate.**

Activities

Research idea

Interview a sample of older people (over the age of 60) and ask them:

- whether they get their 'flu jab' each autumn and why they do or don't
- whether they think older people are treated any differently by the NHS than younger people.

Compare your answers in class.

Web.task

Go to the site of the Healthcare Commission at www.healthcarecommission.org.uk/homepage.cfm

Find out what the Commission does and look up how well your local healthcare trust is performing.

- How does your area compare with others?
- Do links appear to exist between the richer areas and 'better performance'?
- How useful do you think these tables are?

An eye on the exam — Inequalities in the health service

Item A

Julian Tudor-Hart has argued that there exists an 'inverse care law' in healthcare, in which those groups and neighbourhoods most in need of good healthcare in fact have least access to it. For example, in working-class neighbourhoods, there are fewer GPs, dentists and so on than in more affluent middle-class areas. It has been suggested that one reason for this may be because the medical professionals are middle-class themselves.

More recently, Gordon *et al.* (1999) have argued that there now exists a large body of evidence to support what they describe as the 'Inverse Prevention Law' in front-line healthcare. By this, they mean that those social groups who are in greatest need of preventive care – that is, the ones whose risk of ill health is greatest, such as manual workers, the unemployed and many ethnic minorities – are least likely to have access to preventive services such as health promotion, dental check-ups, immunisation, cancer screening and so on.

By contrast, the middle classes are more aware of such services and make greater use of them.

Item B

<< The way that [health] services are organized and offered is based on indigenous British culture and is often inflexible so that members of ethnic minority groups may find vital provision irrelevant, offensive, unhelpful or threatening.

Aspects of racism that are implicated here include the failure to provide health information in appropriate languages, the failure to make knowledge of religious, dietary and cultural imperatives basic to health professional training, and the failure to provide amenities to support cultural beliefs in the importance of running water for washing, death rites, prayer in hospital, visiting times, food in hospital, etc., as an automatic inclusion in health service budgets.>>

Culley, L. and Dyson, D. (1993) '"Race", inequality and health', *Sociology Review*, 3(1)

(a) Explain what sociologists mean by 'iatrogenesis'. (2 marks)

(b) Identify three reasons for gender differences in use of health services. (6 marks)

(c) Outline some of the causes of ethnic differences in access to healthcare. (12 marks)

(d) Using information from Item A and elsewhere, assess the reasons for class differences in use of health services. (20 marks)

Grade booster — Getting top marks in part (d)

You need to focus on differences in healthcare rather than in health chances, but make sure you stick to social class differences (not ethnicity, gender, etc). Make use of the information in Item A. You should discuss a range of class differences, e.g. in uptake of different types of services, the inverse care law and the inverse prevention law (both in Item A), and a range of reasons, e.g. cultural factors and knowledge of services, material factors (e.g. being able to afford private care), labelling by professionals, and so on.

Mental health and mental illness

Getting you thinking

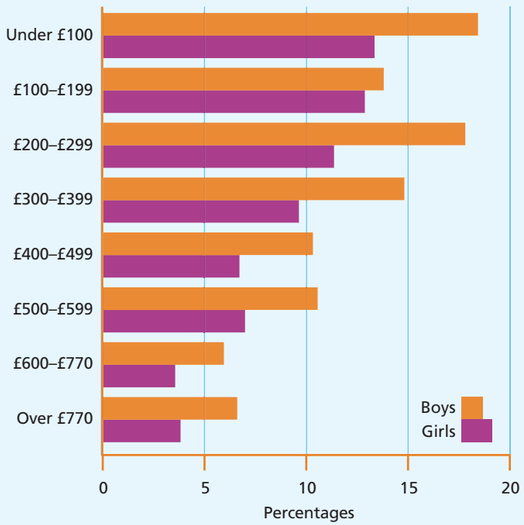
'Normal children given drugs'

*By **David Derbyshire** and **Roger Highfield** at the British Association science festival The Daily Telegraph (filed: 09 September 2004)*

THE RISE OF attention deficit hyperactivity disorder has led to concerns that doctors and drugs companies are turning unpleasant, but essentially normal, human behaviour into medical conditions. Its most serious form, known as hyperkinetic disorder, affects 1.4 per cent of children. Sufferers are unable to concentrate, forgetful, disorganized and easily distracted. At school they are disruptive, find it almost impossible to learn ...

While the most serious cases are generally recognized as psychiatric disorders, diagnosis of milder forms of ADHD, is more controversial. One person's ADHD victim is another's naughty child. Some researchers are concerned that drugs such as Ritalin, the "chemical cosh", are used to suppress essentially normal but disruptive behaviour. In the UK, only 0.3 per cent of all children receive medication for ADHD, compared with six per cent in America.

Prevalence of mental disorders among children: by gender and gross weekly household income, Great Britain, 2004



Source: Office for National Statistics, *Mental Health of Children and Young People Survey*

1. **Provide a short summary of what the chart above tells you about the relationship between mental illness and (a) gender (b) family income.**
2. **Can you suggest any explanations for these links?**
3. **There is considerable debate concerning the very existence of ADHD. Some people argue that it is simply a way of labelling bad behaviour as mental illness and therefore taking the blame away from parents and the children. What is your view?**
4. **Do you think that it is right to use drugs to alter the behaviour of children?**
5. **Look at the photo of the anorexic/very thin young women. Is anorexia a mental illness in your opinion?**
6. **What conclusions can you draw about how we define mental illness and who decides whether it exists or not?**

Mental illness has been the forgotten twin to physical illness, in terms of the attention paid to it and the funding provided by the NHS. The issue only comes to the fore when a particularly spectacular event hits the headlines. However, mental health is a major problem in society, with about one in seven of the population claiming to have mental health problems at some point in their lives. But mental health is dogged with debates over definitions and over the differences in the extent of mental health problems across different groups in society.

According to the government publication *Social Trends 2007* (Self and Zealey 2007), about one in six British people aged 16 to 74 reported experiencing a neurotic disorder (self-diagnosed), such as depression, anxiety or a phobia, in the seven days before a national survey on mental health. A higher proportion of women (19 per cent) than men (14 per cent) experienced such a disorder.

Defining mental illness

Sociology is split between two different approaches regarding how to define mental illness. The two approaches are **social realism** and **social constructionism**.

Social realism

Social realism is a general term used to describe the approaches of sociologists who, broadly speaking, accept that there are distinctive sets of abnormal behaviour which cause distress to individuals and to those around them. These forms of abnormal behaviour are classified as mental illness. Social realists such as Pilgrim and Rogers (1999) accept that, at different times and in different cultures, there are variations in what is considered as mental illness. Nevertheless, they argue that, although mental illness may have different names and may or may not be recognized in different cultures, it does actually exist as a real condition.

Social constructionism

Social constructionist perspectives have been very influential in sociological approaches to mental illness and start from the argument that what is considered normal varies over time and from society to society. For example, over the last two hundred years in Britain, alcohol consumption has been seen variously as normal, as morally wrong or even illegal, as a sign of being mentally ill and as a central part of a religious ritual. In fact, most of these different attitudes to alcohol can still be found in Britain today!

Even greater extremes of behaviour have been seen as normal in some societies and as evidence of madness in others. For example, saying that you are possessed by the spirit of your ancestor would suggest madness in contemporary Britain, but for native Americans, or in some West African religions, it would be a perfectly reasonable statement which most people would believe was true.

Mental illness: real or culturally created?

All sociologists agree that there are forms of behaviour that cause considerable stress to the individual involved, and which prevent them from engaging in any meaningful participation in society. They also recognize that how it comes to be defined depends upon cultural differences. Where the difference between realist and constructionist perspectives emerges is more in the stress they place on how far the cultural context determines the levels and types of mental illness.

The best way to understand the sociology of mental health is to see it as a continuum, with those who argue for the overwhelming importance of culture at one extreme and those who argue for the existence of common illnesses (which might go under different names, but are essentially the same) at the other extreme.

Mental illness: the labelling perspective

The degree of flexibility about what constitutes normal and abnormal behaviour has been taken furthest by so-called 'labelling theorists'. Labelling theory (as we saw in Chapter 1, p. 22) examines how labelling occurs in the first place and what effects it has on those who are labelled. Thomas Szasz (1973), for example, argues that the label 'mental illness' is simply a convenient way to deal with behaviour that people find disruptive. Labelling theory rests firmly upon a social constructionist definition of mental illness.

The effects of labelling

According to Scheff (1966), whether someone becomes labelled or not is determined by the benefits that others might gain by labelling the person 'mentally ill'. So, those people who become a nuisance, or who prevent others from doing something they want to do, are far more likely to be defined as being mentally ill than those who pose no threat or inconvenience, and may be ignored.

Once labelled, there are a number of negative consequences for the person, because it is then assumed that all their behaviour is evidence of their mental state. A famous study by Rosenhan (1973) illustrates this. In the early 1970s in the USA, Rosenhan asked eight perfectly 'normal' researchers to enter a number of psychiatric institutions after phoning up and complaining that they were 'hearing voices'. Once the researchers had been admitted into the institutions, doctors and staff regarded them as truly mentally ill and reinterpreted all their behaviour as proof of this. However, the researchers were under strict instructions to behave completely normally at all times.

In a later study, new staff in a psychiatric hospital were told that this experiment was to be repeated in their institution, and they were asked to uncover these researchers who were just

pretending to be ill. In this study, staff routinely judged people who were 'genuinely ill' as merely pretending. It would seem, therefore, that there is some confusion as to how even experts can decide who is actually mentally ill.

Erving Goffman (1961) followed the **careers** of people who were genuinely defined as being mentally ill. He suggested that, once in an institution, people are stripped of their **presenting culture** – by which he means the image that we all choose to present to the world as 'us'. This may include a style of haircut, make-up, or the requirement that people address us as 'Mr' or 'Mrs' rather than 'Michael' or 'Sarah'. The 'patient' may also lose their right to make decisions about their life and may be required to take medication which can disorientate them.

Quickly, the self-image that a patient has – perhaps of being a respectable, witty, middle-aged person – is stripped away, leaving them bewildered, vulnerable and ready to accept a new role. In this powerless situation, any attempts to reject the label of mental illness can actually be interpreted as further signs of illness, and perhaps as indicating a need for increased medication or counselling. In fact, accepting the role of being mentally ill is seen as the first sign of recovery.

Criticisms of the labelling perspective

The labelling perspective on mental illness has not gone unchallenged. Gove (1982) suggests that the vast majority of people who receive treatment for mental illness actually have serious problems before they are treated and so the argument that the label causes the problem is wrong. Furthermore, he argues that labelling theory provides no adequate explanation for why some people start to show symptoms in the first place.

According to Gove, labelling may help explain some of the responses of others to the mentally ill, but it cannot explain the causes of the illness.

Foucault's perspective on mental illness

A second, very distinctive version of social constructionist theory emerges in the work of the French sociologist, Foucault (1965). He explains the growth in the concept of mental illness by placing it in the context of the changing ways of thinking and acting which developed in the early 18th century. According to Foucault, during the **Enlightenment**, more traditional ways of thinking, based on religious beliefs and on emotions, were gradually replaced by more rational, intellectually disciplined ways of thinking and acting. These eventually led to the significant scientific and engineering developments which formed the basis of the 'industrial revolution'. Foucault argues that as rationality developed into the normal way of thinking, irrationality began to be perceived as deviant.

This shift away from the irrational and towards the rational was illustrated, according to Foucault, by the growth in asylums for those considered mad. Foucault suggests that having mad people in asylums, both symbolically and literally, isolated mad people away from the majority of the population. The asylums symbolized the fact that madness or irrationality was marked out as behaviour that was no longer acceptable.

Although Foucault's writing is very dense and complicated, the essential message is that madness, as we understand it, is a relatively modern invention which emerged from the development of modern 'rational' ways of thinking and acting.

Structuralist perspectives on mental health

Structuralist perspectives on mental health are closely tied to the social realist definition of mental illness. These approaches accept the reality of mental illness and set out to discover what factors in society might cause the illness. As a result of research by sociologists working within this tradition, evidence of clear mental health differences between social groups has emerged. Some of these are discussed next.

Mental illness and ethnicity

Members of ethnic minorities have significantly different chances of mental illness compared to the majority white population. According to Nazroo (2001) people of 'South Asian origin' have very low rates of mental illness, whilst those of African Caribbean origins have particularly high levels of **schizophrenia**, with levels between three and five times higher than the population as a whole. Writers within the structuralist perspective, such as Virdee (1997), explain this by arguing that the sorts of pressures and stresses that can cause people to develop mental illness are more likely to be experienced by members of ethnic minorities because they encounter racism and disadvantage throughout their lives.

However, labelling theorists have argued that some of the behaviour of Afro-Caribbean adults, in particular, has been seen as inappropriate in British society, and has therefore been labelled as a symptom of mental illness. Nazroo points out that people of Bangladeshi origin, who are amongst the most deprived groups in the British population and are also recipients of racism, actually have lower levels of mental illness than the general population. They therefore argue that it cannot just be racism and deprivation.

Mental illness and gender

Women are more likely than men to exhibit behaviour defined as mental illness. Overall, women have rates about one third higher than men, but in some specific forms of mental illness the figures are much higher. For example, women are at least three times more likely to suffer from depression. Structuralists, such as Brown *et al.* (1995), argue that women are more likely to lead stressful lives – combining careers and the responsibility for childcare, for example, and being more likely to experience poverty and poor housing conditions.

However, labelling theorists and feminist sociologists, such as Chesler (1972), go further and argue that the behaviour of women is more likely to be defined as evidence of mental illness because the defining is done by a male-dominated profession. Rather than looking for the real reasons – which are most likely to be stress and poverty – psychiatrists are more interested in defining the problem in terms of an individual's mental state.

Busfield (1988) has suggested that the structuralist position and the labelling approach are not irreconcilable and that women are under pressure in their lives, which leads to higher levels of mental illness, but are also more likely to have their problems defined as mental illness by psychiatrists.

Inequality, social class and mental illness

Overall, when looking at which group is most likely to suffer from high rates of mental illness, the poorest and most excluded are massively overrepresented.

Link and Phelan (1995) reviewed all the evidence over a period of 40 years of connections between social class and mental illness, concluding that all the research clearly pointed to the close relationship between deprivation and low levels of mental health. A government study (Office for National Statistics Study 2004) found that children from the poorest backgrounds were three times more likely to have conduct disorders than those whose parents were in professional occupations. Structuralist writers, such as Myers (1975), have

Research methods

Emma Rich (2006)
Research into how women manage anorexia

Emma Rich set out to explore the ways in which young women 'manage' the difficulties associated with having an anorexic identity, the stigma attached to it, and the relationships they develop with fellow sufferers.

The style of the research was complex and used a number of methods. First, the researcher undertook semi-structured interviews with young women who were experiencing anorexia or bulimia. These interviews were with young women (all under the age of 16) who were attending a special school for the treatment of eating disorders. The aim of the interviews was to collect 'narratives' of the young women's experiences in previous schools as well as their current views and feelings.

As well as this, an academic researcher in her early twenties engaged in an ethnographic study of the young girls at the school. Rich developed her ideas by using the field notes of this researcher, but she restricted her research to the interviews only. This researcher was, according to Rich, of 'slim build' and she stayed at the centre interviewing and interacting with the girls during their daily routines. This allowed her to share some of the experiences and interact in greater depth with the young women. However, she was still always an outsider. Rich describes the researcher's relationship to the young women as follows: the researcher reports being 'invited into' this subculture, with a number of intimate experiences and practices shared, against which the ethnographer reports having to renegotiate relationships and taken-for-granted assumptions about anorexia.

Conversely, there are other occasions where these young people remain protective of certain social spaces.

A third element of Rich's research was her use of the internet to enter support networks and chatrooms – even websites which support anorexia.

Finally, she conducted a full literature review of academic sources.

Rich states that her research was conducted from a clear feminist standpoint and that her interpretation of the research results was conducted through this perspective.

Rich, E. (2006) 'Anorexic dis(connection): managing anorexia as an illness and an identity', *Sociology of Health and Illness*, 28(3), pp. 284–305

1. **How many methods did Emma Rich use?**
2. **Which part of the work was undertaken by another researcher? Can you see any difficulties this might create for (a) Rich's research process and (b) the analysis of the results?**
3. **What are the strengths and weaknesses which she identified of the ethnographic element of her research?**
4. **What perspective guided her research? What views do you have of an explicit 'political' perspective being applied to the research process and analysis?**

suggested a '**life-course**' model, which explains the higher levels of mental illness as a result of poorer people consistently encountering higher levels of social problems over their lifetimes, but having limited educational, social and economic resources to continue overcoming the problems. They argue that, eventually, the stress of coping emerges and is expressed through mental illness.

A second form of structuralist explanation is that of **social capital**. The concept of social capital derives from the writings of Putnam (2000) who argues that people who have social networks of friends and relatives are more likely to be happy, to have lower levels of stress and to feel they 'belong' to their local community. The result of this is that they are less likely to suffer from mental illness.

Pilgrim and Rogers (1999), however, point to the arguments of labelling and feminist theorists, who note that within the most deprived groups, there are also higher levels of women suffering from mental illness compared to men and they would suggest that women are more likely to have their problems defined in terms of mental illness.

Mental illness: conclusion

Mental illness is a highly contested issue in sociology. There are arguments over the very definition of the term and how to explain the differences in mental illness rates in the population. However, the approaches are not entirely irreconcilable and Busfield's approach is one that has received much support. She argues that it is probably true that some groups are much more likely to find their behaviour defined as mental illness, compared to the behaviour of other groups. However, it is also true that these very same groups – ethnic minorities, women and the socially excluded – all suffer high levels of stress and so one would expect them to have higher levels of illness. Both processes reinforce each other.

Check your understanding

1. Identify the two sociological approaches to defining mental illness.
2. Explain the key differences between the two approaches you have identified.
3. How does the idea of 'labelling' help us to understand mental illness?
4. What is meant by a structural explanation for mental illness?
5. How does Busfield suggest that the structuralist and labelling approaches can be combined?
6. Why are people from certain ethnic minorities more likely to be defined as suffering from mental illness?
7. What argument do feminist writers use to explain why women are more likely to be defined as suffering from mental illness?

Key terms

Career refers, in this context, to the gradual changes in people as a response to a label (for example, 'mental patient').

Enlightenment a period of intellectual change in the late 17th to the late 18th centuries.

Life-course model suggests that the accumulation of social events experienced over a whole lifetime, not just individual important events, influence people and their mental state.

Presenting culture a term used by Goffman to refer to how people like to portray themselves to others.

Schizophrenia a form of mental illness where people are unable to distinguish their own feelings and perceptions from reality.

Social capital refers to a network of social contacts.

Social constructionism the approach which suggests that mental illness (and all other social phenomena) exists because people believe it does.

Social realism a sociological approach which suggests that mental illness does really exist.

Activities

Research idea

Conduct a small-scale survey. Ask 20 people:

1. what the first words are that pop into their minds when you say the words 'mental illness'
2. to suggest the two main reasons for people being mentally ill.

Collate your answers – what do they suggest about people's views of mental illness. Do the sociological ideas contained in the topic ring true?

Web.tasks

1. Find the website of the mental health charity MIND at www.mind.org.uk. Use the 'links' section to explore the work of some of the organizations connected with mental health issues. Make a list of all the mental health issues covered. How important an issue is mental health in the UK today?
2. Key the words 'mentally ill people' into Google and then list the themes that emerge.

An eye on the exam — Mental health and mental illness

Item A

<<It affects your mind. If you feel depressed that you are not treated as other people are, or they look down on you, you will feel mentally ill, won't you? It will depress you that you are not treated well racially, it will affect your health in some way. It will cause you depression, and that depression will cause the illness.>>

Quoted in Annandale, E. (1998) *The Sociology of Health and Medicine*, Cambridge: Polity Press, p. 187

Item B

People of African-Caribbean origin are far more likely to reach the mental health system via the police, the courts and prisons, and to experience the more harsh and invasive forms of treatment (such as electro-convulsive therapy), than other groups.

Recorded rates of schizophrenia are considerably higher for people of African Caribbean origin than for other groups. However, it is not clear how far this is due to a greater willingness of psychiatrists to diagnose the condition in this group. Littlemore and Lipsedge argue that schizophrenia among black patients is simply misdiagnosed paranoia resulting from the racism they have encountered in British society.

With regard to mental illness, for all diagnoses combined, women's rate of admission to hospitals in England and Wales was 29 per cent above the rate for men.

Adapted from Annandale, E. (1998) *The Sociology of Health and Medicine*, Cambridge: Polity Press, pp. 143 & 186

Item C

Katz examined the process of psychiatric diagnosis among both British and American psychiatrists. Groups of British and American psychiatrists were shown films of interviews with patients and asked to note down all the pathological symptoms and make a diagnosis. Marked disagreements in diagnosis between the two groups were found. The British saw less evidence of mental illness generally. For example, one patient was diagnosed as 'schizophrenic' by one-third of the Americans, but by none of the British.

Adapted from Helman, C. (2000) *Culture, Health and Illness*, Oxford: Butterworth/Heinemann, p. 80

(a) Suggest two reasons why the British and American psychiatrists in Item C may have diagnosed the same individual differently. (4 marks)

(b) Using material from Items A and B, suggest two reasons for ethnic differences in mental health. (4 marks)

(c) Outline the reasons for gender differences in the patterns of mental illness. (12 marks)

(d) Using information from the Items and elsewhere, assess the usefulness of labelling theory in understanding mental illness. (20 marks)

Grade booster — **Getting top marks in part (d)**

Outline the labelling theory, linking it to the idea that mental illness is socially constructed (a product of social definition). Use 'realist' approaches (i.e. that mental illness is a real illness, not merely a label) to criticize it. These can include structuralist views that see mental illness as resulting from society's unequal structure. Make sure you use relevant information both from the Items and from studies of mental illness, e.g. of class, ethnic or gender differences in rates of mental illness.

TOPIC 5

The medical professions in society

Getting you thinking

Trust me, doctors are paid too much

By ***Nick Britten***

A JUNIOR DOCTOR yesterday called for doctors' pay to be reduced into line with that of nurses and other public sector workers, saying that his senior colleagues enjoyed an 'opulent' way of life while other hospital staff had to get by on a 'piffling' amount.

Mark Jopling, a first-year pre-registration house officer, said doctors allowed themselves to be placed on a 'golden pedestal' and were happy to be regarded as 'awesome life savers', earning large amounts of money, driving luxury cars and living in grand houses.

The British Medical Association said Dr Jopling's views were 'not widely held' among doctors, but he won support from the Royal College of Nursing for 'helping expose nurses' poor pay'.

Dr Jopling, 24, yesterday accepted that his comments might well upset his senior colleagues. He said: 'If I became a consultant, the taxpayer would be sending me home with about £90,000. Were I to prefer a nine-to-five job as a GP, I would be raking in a fat £100,000 – even more, if I played the system well.'

Doctors, Dr Jopling said, were 'quick to justify' their salaries 'with a series of compelling arguments: we work hard, we have big responsibilities, we are also well qualified and have to endure a protracted training'. But he added: 'Teachers, social workers and other professionals in the public sector work long hours too, however, some of these at home and unrecognised.

It is unfair that our salaries dwarf theirs. In medicine there has been a long-standing acknowledgment that nurses work hard and are underpaid. A nurse starts on a relatively modest £16,000 and regularly works nights and weekends. It is usually nurses who give patients most support during their stay in hospital.'

A spokesman for the BMA said: 'This is one doctor's point of view. Unsurprisingly, it isn't widely held in the medical profession. The facts support the case for paying doctors more, not less. The new GP contract pays doctors for raising the quality of patient care they provide.'

Source: nbritten@telegraph.co.uk

Nurses fear for futures as morale plummets

By ***Nicole Martin***

MORALE AMONG NURSES has reached an all-time low, according to a survey that paints a picture of a profession in crisis.

A poll of 9,000 nurses found that despite the Government pouring billions of pounds into the health service many still feel overworked, undervalued and fear for their futures.

More than half – 55 per cent – said they were too busy to deliver the level of care they would like, and 30 per cent said they would quit the profession if they could.

Source: www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/07/16/nnurse116.xml

1. **Why are doctors paid higher salaries than nurses or teachers?**
2. **Do you think that only outstanding people can become doctors?**
3. **Break into small groups and decide whether, as a group, you agree with Dr. Jopling's arguments or those of the BMA.**
4. **Which occupational group, if any, do you trust more than doctors?**

Members of the medical profession are among the most prestigious and well-paid groups in society. But how did they get this superior status? Was it really through their greater abilities, as they would have us believe? Sociologists are always suspicious of the claims groups make about themselves and, as you might expect, their views are not always totally supportive of the caring, dedicated image the medical professions like to present. In this topic, we are going to explore the reasons that sociologists suggest provide the basis for the power, prestige and affluence of the medical professions. This exploration of the medical professions is useful in its own right, helping us to understand the nature of medical provision in Britain, but it is also a helpful model for understanding how other occupational groups have arrived in their particular position. Some of these, such as the legal profession, have been successful in obtaining prestige and financial rewards, while others, such as the teaching profession, have been much less successful.

There are five main sociological approaches to understanding the position and role of the medical professions. These are:

- *the functionalist argument* – that the medical profession benefits society
- *the Weberian approach* – that the medical profession is just an occupational strategy to get higher income and status
- *the Marxist view* – that the medical profession acts to control the majority of the population and is rewarded for this by the ruling class
- *Foucault's suggestion* – that the power of the medical profession has emerged as a result of their ability to define what is prestigious knowledge
- *the feminist approach* – that the medical profession can best be understood by seeing how it has controlled and marginalized women.

The functionalist approach: professions as a benefit to society

The first approach to understanding the role of the professions developed from the functionalist school of sociology (see Chapter 1, p. 12), associated with the writing of Talcott Parsons, which seeks to show what functions the various parts of society play in helping society to exist.

Barber (1963) argued that professions, especially the medical professions, are very important for society because they deal with people when they are in particularly vulnerable positions. It is, therefore, in the interests of society to have the very best people, who maintain the highest standards, to provide medical care. These people must not only be competent but they must also be totally trustworthy. According to functionalists, true professions can be recognized by the fact that they share a number of 'traits'. These are as follows:

- They have a *theoretical basis* to their knowledge – Doctors have a full understanding of medical theories about the body. This allows them to make independent decisions about the cause of illness and the best cure.
- They are *fully trained* to the highest possible standards – Only the most intelligent can enter and succeed.
- Competence is *tested by examination* – There is no favouritism and doctors are in their position as a result of their ability alone.
- The profession has a *strict code of* '**ethics**' – Doctors deal with people at their most vulnerable and the code of ethics ensures that no patient is exploited.
- They are *regulated and controlled* through an organization (in the case of doctors it is the General Medical Council) which decides who can enter the profession and has the power to punish and exclude for any misconduct.

Critics of the functionalist approach, such as Waitzkin (1979), while agreeing that high standards and trust are all needed, argue that these 'traits', rather than simply justifying the high status of doctors, are used by the medical profession as barriers to prevent others from entering. This criticism was for a long time supported by the fact that entry to medicine remained largely the preserve of males from higher social-class backgrounds. Only in the last 20 years has there been a significant inflow of women and ethnic minorities into the medical profession. This inflow has largely coincided with an acceptance of the criticisms of the functionalist approach.

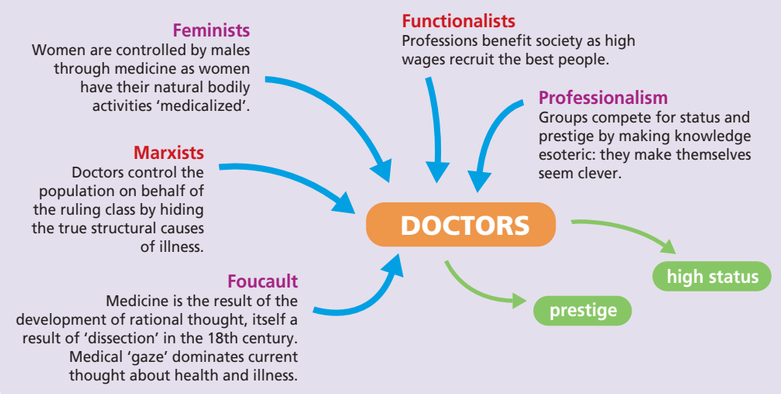
The Weberian approach: professionalization as a strategy

The second approach to understanding the power of the medical professions is that, rather than being constructed for the good of the community, they are, in fact, constructed for the good of the medical professions themselves. This argument has developed from the original writings of Max Weber, an early 20th-century sociologist who argued that all occupational groups are constantly vying with one another to improve their prestige and financial bargaining power. There are a number of different techniques used, but the two main ones are the creation of trades unions (which has traditionally been used by the working class) and the construction of professions (which has been used by the middle class).

Overall, **professionalization** of an occupational group has actually been a more effective method to gain status and financial rewards. It is for this reason that many other groups, such as teachers and social workers, have tried to gain professional status. The process of professionalization has four important dimensions:

1. *The production of a body of* **esoteric** *knowledge* – This means creating an apparently complex body of knowledge which must be placed in the hands of experts.
2. *Educational barriers* – Professionals construct a series of specialist educational courses and qualifications in order to limit the numbers of entrants.

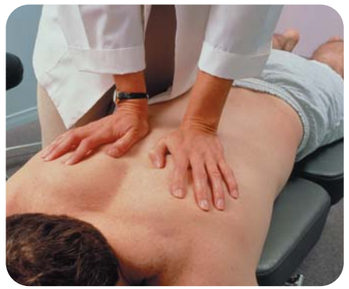
Figure 7.4 The social position of the medical profession



3 *Exclusion of competition* – The profession must wipe out any possible competitors, such as faith healers, homeopaths and herbalists. They do this by claiming that only scientific medicine and surgery are effective.
4 *Maintenance of privilege* – The professional group will fight all attempts to have others impose any control over them. So, doctors will demand '**clinical freedom**' – the right to do what they think best – and they will fight any attempts to hand over part of their work to others, such as allowing nurses to prescribe medicines.

These four methods of professionalizing are very similar to the traits suggested by functionalist writers. From a Weberian perspective, therefore, the medical profession is looking after its own interests as well as those of the patients.

A good example of the Weberian approach is provided by Cant and Sharma (2002), who studied the relationship between the medical profession and the practitioners of chiropractic. (Chiropractic is the manipulation of the spine, joints and muscles in order to realign them.) For over 60 years, chiropractors campaigned to gain legal recognition, which was finally granted in an act of parliament in 1994. But Cant and Sharma point out that in order to get this recognition, chiropractors effectively had to subordinate themselves to doctors.



Marxist approaches

Marxists, such as Navarro (1977), argue that in capitalist societies such as Britain, a small ruling class exploits society for its own benefit. In order to hide this exploitation from people and to maintain its power, the ruling class employs a number of mechanisms which involve distorting 'reality', so that people come to accept exploitation as 'natural'.

The medical profession plays an important role in this by misleading the population as to the real cause of their illnesses. The medical profession explains health and illness in terms of individuals' actions and genetics – they point the finger away from the poor working conditions, poverty, poor housing and inequalities in society, which are the true, underlying causes of ill health, according to Marxist writers (see Chapter 1, pp. 17–18, for more details on Marx). But what doctors do succeed in doing for the health of the population is to keep them fit enough to work.

Marxists also point out that health and illness in a capitalist society are carefully linked to being able or not able to work. Doctors play a key role in deciding who is fit to work and who is sick enough to be eligible for state disability and sickness benefits.

Critics have pointed out that this perspective ignores the genuinely beneficial work that doctors do, and that to characterize their work as only misleading and controlling the population is inaccurate. Doctors do work very much within the framework of looking at individual problems, but stress in the workplace and the role of poverty are well known and recognized by doctors.

Foucault's approach

There is an old saying, 'knowledge is power', and in Foucault's analysis of society this is literally true. According to Foucault (1976), in every society, groups are 'battling' to look after their own interests. The best way of doing this is to get control of what is regarded as 'truth' or 'knowledge'. If other people believe that what you say is 'true' and what others say is 'false', then you have a high chance of getting them to do what you want. So you seek to create an overall framework of thought and ideas, within which all the more specific debates (what Foucault calls '**discourses**') are conducted. This argument is similar in some ways to the Marxist argument we saw earlier.

Foucault argues that, over time, doctors have led the way in helping to construct an idea of 'science', through their activities in dissecting bodies and demonstrating to people the ways in which bodies are constructed in the form of a 'biological machine'. This has resulted in a society where rational scientific thought is prized above all else, where other forms of thought are regarded as inferior, and where doctors have significant prestige and power.

So, medicine has played a major part in constructing the way we think and act in contemporary society. In the process, the medical professions have gained considerable benefits in terms of prestige and financial rewards.

Feminist approaches

Feminist sociologists, such as Oakley (1986) and Witz (1992), suggest that the activities of doctors contribute to the social control of women, both as patients and as medical practitioners. They point out that medicine has traditionally been a male occupation, with women excluded or marginalized into junior roles. This simply reinforces the subordinate position of women in society. (However, in the last 15 years, roughly equal numbers of men and women have been training to be doctors.)

Historically, women had always held a key role in healing and traditional healthcare. For example, the women whom we now refer to as 'witches' were very often herbal healers who were eagerly sought out in rural areas. There had always been a degree of competition between male and female healthcare practitioners and it was not until 1885 that a law was passed which legally recognized a closed medical profession. Although women were not legally prevented from entering the medical profession, the values of Victorian Britain and the nature of the educational system, which generally excluded women from higher education, meant that the outcome of the act was effectively to prevent women from becoming doctors.

Techniques to exclude women from the medical profession

According to Witz, the male-dominated medical profession was successful in excluding females for over half a century by using two techniques – exclusion and demarcation:

- *Exclusion* involves creating barriers so that it is virtually impossible for other groups (in this case females) to enter the profession.
- *Demarcation* involves creating a restricted area of competence and then allowing people to enter this area. At the same time, this area of competence is still controlled by the medical profession. Examples of this include nursing and radiography.

Witz further argues that to combat these techniques, women have used two strategies – inclusion and dual closure:

- *Inclusion* involves using any possible method of gaining entry through, for example, political and legal action.
- The aim of *dual closure* is to accept, in part, a restricted area of competence, but then to close this off to others and to seek to turn it into a profession. It is exactly this process that is happening to nursing.

The 'medicalization' process

Feminist sociologists, such as Lupton (1994), also claim that the male-dominated profession of medicine has successfully 'medicalized' a number of female activities or problems. By this, they mean that normal or natural activities of women (such as childbirth and menopause), or problems faced more often by women (such as depression), have been taken over by the medical profession and turned into medical issues. So, for example, women are expected to give birth in the manner and in the place determined by 'the experts'. For Lupton, this means that male doctors can use this as a means of controlling how women ought to act. According to Lupton, through this process 'women are placed in a position of compliance with expert advice throughout their pregnancy and delivery, and their personal needs and wishes tend to be ignored' (Lupton 1994, p. 148).

When it comes to an 'illness' such as depression – which feminists argue is partly a result of the restricted role of women

Research methods

Lorelei Jones and Judith Green (2006)
The attitudes of younger GPs

Lorelei Jones and Judith Green wanted to find out whether newly qualified GPs had different views from older GPs about the nature of professionalism. Traditionally, GPs have perceived their jobs as a vocation, in which they had a duty to their patients and society. Their motivation was as much moral as financial. Jones and Green wished to know if, in late modernity, this vocational attitude to being a GP was still dominant. They discovered that the traditional vocational approach had been replaced by one in which younger GPs seek nice work, by which they meant good pay, pleasant surroundings, interesting and varied work and decent patients.

A purposive sampling strategy was used to select interviewees who were working in general practice from across England, Wales and Scotland in a range of rural and urban locations. In total, 20 GPs, aged 32–37 (14 women, 6 men) were included in the study, reflecting the gender composition of the total cohort study participants who had become GPs.

Interviews, lasting about an hour, were audio-taped and transcribed. In all interviews, participants were prompted for reasons for choosing general practice, career histories, descriptions of their work, satisfactions and dissatisfactions with the job and plans for the future. Participants were encouraged to elaborate when they raised other topics. The results were transcribed and formed the basis of a second interview.

Follow-up interviews took place some months later and participants were asked to reflect on questions arising from analysis of the earlier replies. These second replies were also transcribed.

The research was based on 'grounded theory', in which the theoretical ideas emerge during the research in the process of discussion and analysis. The researchers used computer software which can be used to generate 'themes'. The analysis of the transcripts showed the key theme of 'nice work'.

Before the research, the interviewees were assured that they would remain anonymous and all the interviewees were given pseudonyms in the published academic article.

Jones, L. and Green, J. (2006) 'Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom', *Sociology of Health and Illness*, 28(7), pp. 927–50

1 **What sort of sampling technique was used?**
2 **The researchers interviewed a total of 20 GPs. Do you think that it is possible to make generalizations for all younger GPs based upon this number?**
3 **What do we mean by grounded theory? How does this differ from traditional positivistic research methods?**
4 **Why was it important to the accuracy of the research that the GP's remained anonymous?**

in society – the medical profession turns it into a medical problem that can be solved by prescribing medicines. This shifts the issue away from the position of women in general, to the particular medical condition of a single woman. One example of the creation of female illness and resulting medical treatment, according to Wertz and Wertz (1981), was the treatment of upper-class women in Victorian Britain. Links were made between the female reproductive and sexual organs and a whole range of illnesses including headaches, sore throats, indigestion and 'inappropriate libido'. This resulted in 'routine' hysterectomies, removals of ovaries and clitorectomies.

The rise of complementary medicine

The traditional male-dominated medical profession's monopoly of healthcare has been strongly challenged over the last 20 years. Within the profession, there has been an influx of ethnic minorities and women, and from outside the profession the claim to sole expertise on health matters has been challenged by a wide range of groups. Perhaps the biggest external challenge has come from complementary or alternative medicines, which include homeopathy, herbal remedies, acupuncture and a range of other techniques.

Giddens (1991) has argued that this is the result of the development of late modern society. Two particularly relevant characteristics of late modernity are:

1 decline in conformity, with a greater stress on individual desire and choice
2 disillusionment with the claims of professionals and experts in general to have a monopoly of knowledge. The particular result for healthcare and medicine has been a decline in the acceptance that 'doctor knows best' and an increased demand for choice in what 'cures' and interventions the ill person should undergo.

A third, less significant element of late modernity, which is particularly relevant to mental illness, is that a much wider range of behaviour is tolerated. This makes the distinction between deviant or marginally tolerated behaviour and mental illness far less clear.

Key terms

Clinical freedom the right of doctors to do what they think is best without other people having a say.

Discourse a way of thinking about issues.

Esoteric obscure and accessible only to a few.

Ethics a code of behaviour.

Professionalization tactic used by occupational groups to gain prestige and financial rewards.

Check your understanding

1 **Give two examples of the 'traits' of a profession, according to functionalists.**
2 **According to the 'professionalization' approach, how do professions exclude other competing occupational groups?**
3 **How do the actions of doctors, in explaining why we are ill and then prescribing medicines, help capitalism?**
4 **Give one example of how doctors have 'medicalized' a normal activity of women?**
5 **According to Foucault, what is the relationship between knowledge and power over people?**

Activities

Research ideas

1 Ask a small sample of people to identify five characteristics they associate with doctors. Do your results support the points made in the topic?
2 Identify a small sample of people who have actually used some form of 'alternative' healing. Conduct unstructured interviews to uncover their motives in seeking the treatment and the meaning they gave to their experiences.

Web.tasks

1 Visit the Royal College of Nursing website at www.rcn.org.uk
What aspects of the discussion in this topic are illustrated here? You will find useful to look at the section on the RCN's 'mission'.
2 Visit the General Medical Council website at www.gmc-uk.org
What points in this topic does this website illustrate (and also perhaps challenge!)?
3 Visit the Institute for Complementary Medicine website at www.icmedicine.co.uk
What ideas about 'the body' and healing lie behind these therapies and treatments? To what extent are they similar to, or different from, the conventional Western 'biomedical model'?

An eye on the exam — The medical professions in society

Item A

<<It is commonly held that nursing, since becoming a profession (the first register was set up in 1919), has progressed to become a higher-status, centrally recognized healthcare profession. Yet the crucial distinction between nursing and medicine remains: that of curing versus caring. Nursing's professional bodies are caught in a double-bind: in order to be of high status, the profession must lay claim to clinical and curative skills, but in order to remain as 'nursing', the practice must be centred on caring for, not curing, patients.

This dilemma has been addressed in part by the conscious formation of a body of theoretical knowledge, the nursing process, which is particular to nursing and distinct from medicine. To some extent, this has also been the rationale behind the most recent developments in nurse education, for example, the creation of the new Project 2000 and the possibility of a degree in nursing, which superseded the old apprentice-style ward-based training of 'pupil' nurses.>>

Marsh, I. (2000) *Sociology: Making Sense of Society*, Harlow: Prentice Hall

Item B

Professional bodies (such as the General Medical Council) are charged with supervising the profession. But, being members of that profession, they usually whitewash or ignore cases of incompetence, etc. Final sanctions, like striking a doctor off the medical register, are used only rarely and then more often for sexual misconduct than for gross incompetence.

The medical profession also do a bad job. Their drug prescriptions often cause bad side effects and sometimes dependency. Their diagnostic tests sometimes do more harm than good. Women in particular suffer at their hands. Many iatrogenic (doctor-caused) diseases affect women only, for example those stemming from using contraceptive pills and devices, and from hysterectomies. Doctors medicalise pregnancy and birth, taking control away from women and treating them merely as 'cases'.

Adapted from: Trowler, P. (1996) *Investigating Health, Welfare and Poverty*, London: Collins Educational

Item C

<<For functionalist sociologists the higher professions such as medicine are virtually beyond reproach. Professionals are seen as selfless individuals working for the good of the community, often making great personal sacrifices. They need to be of the highest intelligence and skill, have to undergo years of training and in their early careers earn very little. High levels of reward later, then, are necessary to attract, retain and motivate the best people into the professions.>>

Trowler, P. (1996) *Investigating Health, Welfare and Poverty*, London: Collins Education

(a) Explain what is meant by a 'professional body'. (2 marks)
(b) Identify three features that functionalists see as typical of professions. (6 marks)
(c) Using information from Item A and elsewhere, outline some of the ways in which doctors and nurses have tried to raise their power and status. (12 marks)
(d) Using information from Items B and C and elsewhere, assess the view that the medical profession enjoys high status and rewards because of its contribution to society. (20 marks)

Grade booster **Getting top marks in part (d)**

You could begin with Barber's functionalist view, linking it to Item C. You need to evaluate this view in the light of other theories, such as Marxist, Weberian and feminist approaches to the medical profession's status and rewards. Consider who the medical profession serves – is it their patients, themselves, capitalism, or patriarchy? – and link this to the different theories. Use Cant and Sharma or Items A and B when examining the Weberian approach that professionalization is a strategy.

Exam Practice

1 Read **Item A** below and answer and answer parts (a) to (d) that follow.

Item A

Of the population of England and Wales, those people born in the Indian sub-continent have higher than average rates of tuberculosis, heart disease and diabetes, but lower rates of certain cancers. Those born in Africa or the Caribbean have higher rates of strokes, diabetes and high blood pressure. About a third of all male deaths in the UK are from circulatory diseases (such as heart attacks and strokes), but this rises to about a half among men under 50 from the Indian sub-continent, while Indian men in their 20s have over three times the national death rate from heart disease. Those born in Africa, the Caribbean and the Indian sub-continent are also more likely to suffer death from accidents.

There are also important differences in the birth weight of babies born to different ethnic groups. The average birth weight of babies born to mothers from India, Bangladesh and East Africa is about 300 grams lower than for babies of women who were born in the UK. These differences in some ways minor social class differences; for example, babies born to working-class mothers have a lower average birth weight than those born to middle-class mothers.

(a) Explain what is meant by 'morbidity'. *(2 marks)*

0/2

The term 'morbidity' means death. The morbidity rate is the death rate.

(b) Suggest **three** reasons why women on average live longer than men in modern society. *(6 marks)*

Firstly, women live longer than men because they don't smoke as much as men, so they don't get lung cancer etc as much.

Secondly, they go to the doctor's more often than men, e.g. to take the children when they are sick, so they can get early medical attention themselves at the same time and this can sometimes save their lives.

4/6

Thirdly, women are biologically different from men and this accounts for their longer life expectancy.

(c) Outline some of the reasons for class differences in healthcare. *(12 marks)*

Health statistics show that the working class have a shorter life expectancy than the middle class and that they are more likely to be ill. Sociologists have found many reasons for this.

One explanation is the cultural and behavioural explanation. This states that the class differences are due to different behaviour, for example manual workers smoke and drink more, eat less healthy foods and don't go to the doctor's for check-ups and screening.

However, other sociologists argue that class differences in healthcare are due to material factors, e.g. not being able to afford healthy foods. Also, working class people are less likely to get paid time off work to go to the doctor's compared to, say, a businessman who can take time off whenever he likes.

Another reason for the differences is the fact that in working-class neighbourhoods there are not as many doctors' surgeries, so it is harder to get treatment than in middle-class neighbourhoods. This may be because doctors are middle-class and prefer to work in these areas. Working-class people may also have to rely on public transport to get to the surgery because they can't afford private transport.

This is related to poverty, because the working-class earn less and this can cause further health problems. Lack of money makes life stressful and causes mental health problems. Doctors are more likely to treat working-class patients with drugs rather than psychotherapy, perhaps because they are not so good at communicating with middle-class doctors.

6/12

An examiner comments

Wrong – morbidity means sickness. Death is 'mortality', not morbidity.

The first two reasons are fine, but the third one isn't. It needs to say at least which biological differences are important or how they may prolong women's lives. A better approach is to suggest other aspects of women's lifestyle or social role, e.g. they drink less, drive less, work in less dangerous jobs, and so on.

Needs to focus on healthcare rather than health *chances*.

Still too much on health chances. Begins to touch on care via check-ups and screening – but needs to explain reasons.

Again, it's the last part that scores by giving a reason for differences in take-up of healthcare.

Good focus on care here, but should mention the inverse care law.

Overall, this is a reasonable answer, but it needs to be clearer about the difference between chances and care, and to focus on the latter. It could mention differences in consultation times, referrals and preventative treatment. It's also rather descriptive and should say more about reasons, such as speech codes, cultural capital or the inverse care law.

Drifts into health chances at first but comes back to focus on mental healthcare. Good point about communication – could mention speech codes here.

(d) Using information from **Item A** and elsewhere, assess sociological explanations of differences in the health chances of different ethnic groups. *(20 marks)*

As Item A shows, different ethnic groups have different health chances, and ethnic minorities tend to have worse health than the white majority in Britain. There are various reasons for this difference, which sociologists have tried to identify.

Genetic causes can play a part. For example, black people are more likely to get inherited diseases like sickle cell anaemia, which is very rare in white people.

Cultural factors can also be important. For example, if a group has a particular norm which requires women to marry very young and not to go out to work, but to stay at home, and the religion of the group forbids them to use contraception, then it is likely that there will be a high birth rate and the risk of worse health for both mother and children. Some groups also practise female circumcision (also known as genital mutilation), which can harm women's health.

Another example of how a group's culture can affect the health of ethnic minorities is in the fact that Asian children have higher rates of rickets (a bone deformity) as a result of their diet, which lacks vitamin D. Another source of vitamin D is sunlight and some sociologists have argued that rickets is also due to wearing clothes which cover up so much of the skin and prevent sunlight reaching it.

Language is an important aspect of culture. If a person's first language is not English, they may not be able to communicate with doctors, nurses etc., so they may fail to get the treatment they need. They may also be unable to understand health education campaigns, so this will worsen their health chances. However, many minorities speak English, e.g. people of Caribbean origin, plus most second-generation immigrants, so language is not always a factor.

Housing can also be a cause of ill health. Ethnic minority groups are more likely to live in substandard housing. Marxists would argue that this is the result of discrimination against ethnic minorities, so that they get pushed into the worst housing, with overcrowding, damp etc., and this in turn leads to health problems for the family members.

Although ethnic minorities generally have worse health than the majority of the population, it can be difficult to explain, partly because we don't have proper figures, e.g. in Item A it only tells us about people who were born in India, Africa and the Caribbean, but a lot of the ethnic minorities were born in the UK so they wouldn't appear in the figures.

12/20

An examiner comments

A good way to approach this question would be to identify different types of explanation. These could be, for instance, cultural, structural, biological and labelling.

You could then organise the answer into sections on each, with an account of the explanation plus some evidence for and against it. This answer has a good account of some cultural factors but much less on other approaches – a little on genetic factors and a mention of Marxism.

There's a brief reference to Item A, but it should be used much more, e.g. by linking low birth weight to poverty among minorities (who are more likely to be working class). You could also ask why minorities are at greater risk of accidental death (e.g. link to poorer working conditions, housing, etc.). Does racism and discrimination cause stress and affect high blood pressure and strokes?

Look at mental as well as physical health. Some studies indicate that black people are more likely to be labelled schizophrenic, given harsher treatment and be 'sectioned' against their will. Is this because of institutional racism, more stressful lives, or both?

The answer needs more theory and debate between views – e.g. a better account of Marxism, plus a functionalist view. You could link the latter to cultural differences, e.g. the idea that some minorities may not share the mainstream 'modern' culture and so may engage in practices harmful to health - and you can criticise this view as ethnocentric and as neglecting material factors as well as the effects of racism.

One for you to try

This question requires you to **apply** your knowledge and understanding of sociological research methods to the study of this **particular** issue in health.

2 Read **Item B** and answer the question that follows.

Item B

One way of studying mental illness is to see it as a type of labelling. This is strikingly illustrated by Rosenhan's (1973) pseudo-patient study, entitled 'On being sane in insane places'. A team of researchers presented themselves at a number of different hospitals in California claiming, falsely, to have been hearing voices. Once admitted, they behaved normally. Yet, having been diagnosed as schizophrenic, all their subsequent behaviour was interpreted by staff in terms of this label. Interestingly, though, some of the other patients suspected that the pseudo-patients were not genuinely ill.

Using information from **Item B** and elsewhere, assess the strengths and limitations of **one** of the following methods for the study of mental illness:

(a) participant observation
(b) questionnaires. *(20 marks)*

An examiner comments

Remember that you need to know what the main features are of the method that you choose to write about, and you need to be able both to outline and to evaluate the method's advantages and disadvantages. These include practical, theoretical and ethical factors, such as time, cost, reliability, validity, etc. You need to apply these to the study of mental illness. For example, Rosenhan's participant observation study might be seen as valid yet unethical, because it involved covert observation. By contrast, questionnaires might be both a cheap and reliable method, but how would you gain access to a mental hospital to give them out?

Answers to the 'One for you to try' will be available **free** on **www.collinseducation.com/sociologyweb**

Chapter summary