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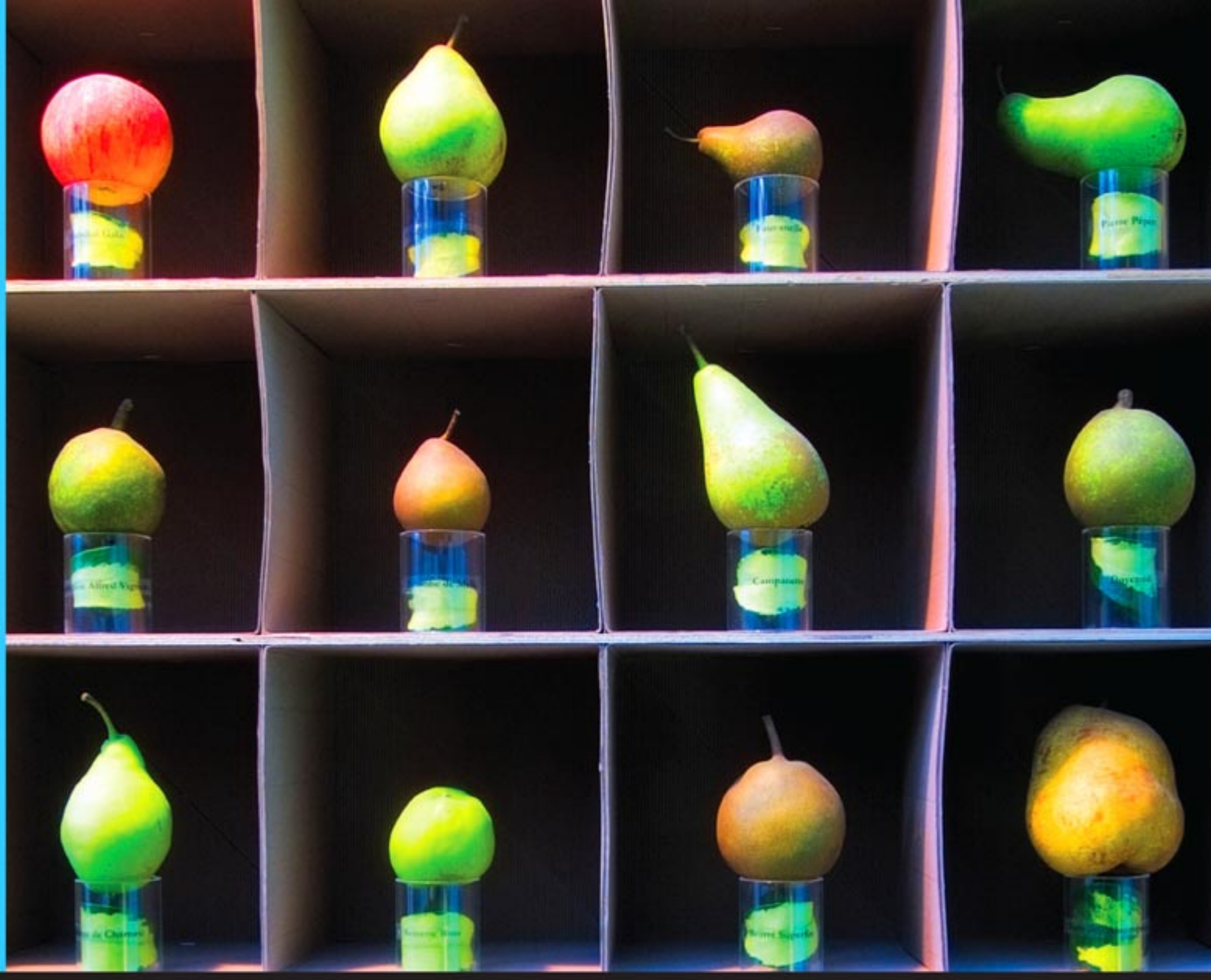

Key Concepts in Health Studies

CHRIS YUILL, IAIN CRINSON
AND EILIDH DUNCAN

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notes on the text

At the end of each entry, the initials of the author are shown:

Iain Crinson	I. C.
Eilidh Duncan	E. D.
Chris Yuill	C. Y.

Many concepts contain cross-references in bold guiding readers to related concepts.

notes on the authors

Chris Yuill is a lecturer in the sociology of health at Robert Gordon University, Aberdeen. He is the author of 'Understanding the Sociology of Health: A Sociological Introduction' (2008) London, SAGE, and his academic interests lie in the sociology of health inequalities.

Iain Crinson is senior lecturer in the sociology of health and health policy at St George's, University of London. He is the author of 'Health Policy; A Critical Perspective' (2009) London, SAGE, and his academic interests lie in the sociology of the healthcare professions, inequalities in health, and the impact of information technology within the NHS.

Eilidh Duncan is a lecturer in psychology at Robert Gordon University, Aberdeen. She graduated with a BSc (Hons) in Psychology from the University of Glasgow, and gained an MSc in Health Psychology from the University of Stirling. Eilidh is currently completing a PhD from Robert Gordon University investigating alcohol and nicotine use during pregnancy and is working towards chartership as a Health Psychologist.

Introduction

For most people, health is about what you eat and how much exercise you take, and if something goes wrong there's always the medical profession there to patch you up and get you back to what you were doing previously. Health Studies seeks to go beyond this narrow perception of health. Health Studies is animated by an understanding that health is much more than 'blood and bones', or only intelligible through the workings and ideas of mainstream medicine. The idea of 'health' emerges out of an array of diverse social processes and influences, many of these processes operating at levels beyond the physical body with which we experience life in all its states, good or bad. Culture, politics, ethics, emotions, our spiritual selves, and our social and individual perceptions of the world all contribute to what makes us healthy or not.

The great strength of Health Studies as a field of academic study is that it is built on the contributions of many disciplines. It draws on sociology, psychology, social policy, social epidemiology, ethics, anthropology and biology in an attempt to build the big picture of health. Each discipline possesses its particular strengths in contributing to an overall understanding of health. For example, sociology explores social processes and structures, and so aids an understanding of how our social class, our gender or our ethnicity influence and shape our health. Psychology investigates the psychological factors that may determine health, such as personality, stress and beliefs, and seeks to explain the thought processes that are fundamental to health behaviour. And social policy provides insights into how governments, charities and private companies structure their services and the thinking behind why they do so.

This textbook should be seen as part of the journey that you are now undertaking in exploring health in its fullest, richest and deepest sense. On offer here is a selection of key concepts that should ease that process. It will help you get to grips with a new way of thinking about the world by providing short summaries of the main concepts that you will encounter. Each entry on a key concept opens with a very brief definition of its main features before going on to outline the main issues and debates that the concept has generated. As such, you can build a firm basis on which to further discuss and read more on each concept.

This textbook book is not an end in itself. The outlines of the key assumptions of concepts widely utilized within Health Studies are presented, and some context for their application is also provided, However, applying these concepts to further understanding of real-world health issues also requires students to engage in more in-depth reading; hence the suggestions for further reading at the close of most entries. By pursuing these suggestions, your knowledge both of a concept and of Health Studies overall will be greatly enriched, allowing you to be more confident in your studies, in doing well in your assessments and possibly learning and understanding more about what shapes your health and the health of other people around you.

This book is structured into six parts, each of which deals with a specific issue within Health Studies, building from very general philosophical approaches before moving on to concepts that relate to practice and the structuring of health services.

Part 1 surveys on various concepts that attempt to capture and *define health*. Here, you can contrast different models of health that influence and inform how notions of health are constructed and maintained within society. Key here are the fundamentally different outlooks of the biomedical and social models of health. These tensions inform many of the other concepts described in the book, and are a central concern of Health Studies. This section provides an awareness of what makes Health Studies distinct from other approaches to an understanding of health and what insights Health Studies have to offer.

Part 2 centres on the *human life course* and outlines a range of concepts which relate to the 'transitions' and 'trajectories' that occur in everyone's lives. Evident here is how what may seem like an intrinsically biological process, that of growing from infancy to adulthood and on to old age before dying, is in practice bound up with a variety of social, cultural and psychological processes. From infancy on, through childhood and beyond, society and culture are always present, creating and conditioning everyday experiences, identity and health.

Part 3 turns to the notion of *health protection*. This is a term now widely used to describe national and international strategies to reduce threats to the health of populations (in the UK, for example, the Health Protection Agency is responsible for identifying and responding to all sorts of environmental threats and hazards, and improving our understanding and knowledge of these threats). This section looks at these issues in terms of health inequalities and global health risks, and the strategies deployed to counter these outcomes, such as public health interventions and health promotion initiatives.

In Part 4 we turn our attention to *health beliefs and health behaviour*. The concepts explored in this section seek to explain and contextualize the ways in which ordinary people perceive, understand and are motivated (or otherwise) about their health.

People actively interpret and filter messages and understandings of health through social, personal and cultural traditions and experiences. Again, this observation informs us about the subtleties of health and the rich variety of meanings attached to health in wider society. As human beings we remain bounded by our physical bodies, and to that extent our body both strongly shapes our self-identity and self-conceptions, and vice versa. The notion of the 'self', while being clearly different from the body, is nevertheless frequently experienced as one and the same thing. This interconnectivity between biology, the social and the psychological is explored in a variety of ways in this section.

In Part 5 we consider a vital aspect of *the lived experience of health and illness*. People experience being healthy or ill in a variety of ways. Research has identified that the functional medical aspects of being ill, attending a clinic, taking medication or following a treatment regimen, for example, are just one element of the experience of health and illness. How one maintains a sense of self and how one copes with the emotional tasks associated with pain and suffering can be just as important, if not more so, than medical concerns.

The book concludes with a final section exploring the forms of *health care provision* in all its aspects. Rightly or wrongly, most people perceive the health care system as the key tangible representation of health management within a society reflected in the support the public gives to these services and the continuing financial commitment of government. However, as has been observed many times, health care systems have little to do with health, rather, their function is to manage illness. These systems are explored in this section from the perspective of those who work within them, from the service users' perspective, and from the perspective of those who until recently have been ignored, excluded from or damaged by the health care system. Challenges to existing mechanisms of health care are also explored through the concepts of 'governance' and 'consumerism'.

We trust that you find the book useful and stimulating and that you come away after reading it knowing more about the subject that you are studying. If there is one overall message that this book is trying to communicate, it is that health exists in many interweaving dimensions, some obvious and apparent, others subtle and hidden. Health is about the body, the biological, but that is just one element of the many different relationships, processes and factors that ultimately constitute health.

Think too about the social, the psychological, the ethical, the spiritual, the cultural and many other elements that frame, influence, shape and make sense of health.

Chris Yuill, Iain Crinson and Eilidh Duncan

Part 1
Defining Health

The biomedical model of health

The medical, or as it has more properly become known, the 'biomedical' or 'scientific' model, draws upon biochemical explanations of ill health as the basis for treatment and intervention, as opposed to the focus of other forms of non-allopathic medicine (see **Alternative or complementary medicine**).

Many sociologists and others have for sometime argued that despite the undoubted achievements of biomedical interventions in the management of particular forms of illness (but also see **Medicalization**), and the very real effects of biological mechanisms in illness, the practice of biomedicine remains rooted in a knowledge base that is not as empirically-bound as biomedical scientists would have us believe. However, to the extent that biomedical knowledge is concerned to categorize and manipulate an understanding of biological mechanisms in order to contextualize the reality of the human illness, it is a process of knowledge construction which implicitly involves cultural and social assumptions as well as drawing upon a biological base of understanding (Lock, 1988).

The continuing dominance of the biomedical model or paradigm within modern health care systems is reflected in the day-to-day rational–scientific practices associated with the work of doctors in the hospital or clinic. For Foucault (1973) and those influenced by a relational conceptualization of power, these everyday clinical practices have contributed to the (social) construction and reproduction of what is termed the 'biomedical discourse'. A 'discourse' being the means through which we have come to know, understand and respond to aspects of our lives; in this case, our health and illness. Studies in the history of medicine have demonstrated the ways in which this biomedical discourse has been shaped not only by an emergent scientific understanding of the biological mechanisms of the human body, but also by other social, economic and cultural developments.

For example, Jewson's (1976) classic work on the development and production of medical knowledge identified a series of what he termed 'medical cosmologies', or ways of seeing the contribution of medicine to the diagnosis and treatment of the sick. Jewson drew on these 'cosmologies'

to describe the ways in which developments in medicine have historically been intimately linked with the sets of social relations and dominant ideas existing within society at the time. The *person-orientated* cosmology was seen as existing prior to industrialization and the 'Age of Enlightenment'. This approach to the practice of medicine required the physician to recognize the patient as a holistic entity, and where medical judgement was to be made in terms of the personal attributes of the sick person (if they were not, then the physician would lose the business!).

The early development of hospital-based medicine in the late eighteenth century is seen as being associated with the broader social changes occurring within British society at that time. The rise, that is, of capitalist forms of production, industrialization, the growth of towns and cities, and the increasing dominance of scientific knowledge and explanation. The emergence of a specialist scientific medical knowledge reflects the historical period in which the doctor–patient balance of power begins to change, and is described as an *object-orientated* cosmology. At this time the medical profession was becoming less dependent upon patronage of rich patients, and the control of medical knowledge began to pass from the patient to the clinician. Hospitals now became training centres for the new profession of medicine and sites for scientific research. The late nineteenth century witnessed the emergence of Jewson's third medical cosmology, that of *laboratory medicine*. Here, the patient as the object of medical practice moves out of the frame, and disease becomes a 'physio-chemical process'. This practice is characterized by the emergence of what Foucault (1973) termed the new 'clinical gaze', reflecting the changing social relationship of power between doctors and their patients.

The main methodological and philosophical assumptions of some of the key components of the biomedical model or 'discourse' are set out and explored below:

- A knowledge base that draws in large part upon a *positivist* methodology. Positivism is the philosophical position that science can only examine what is observable and measurable. Knowledge of anything beyond that is deemed to be impossible. It follows then that only observable signs and symptoms can lead to a medical 'diagnosis', all 'real' disease has to have measurable biological causal mechanisms. This approach has, in the past, frequently led to the marginalization and neglect of social and psychological factors in ill health.
- Health defined as the absence of any biological *abnormality* or change. Therefore 'disease' as its obverse is conceived as predominantly a

biological state associated with the malfunctioning of human biological systems. This is essentially a biologically reductionist view in that all forms of illness are seen as causally related to specific biochemical mechanisms.

- The (ontological) separation of the *mind and body*. This philosophical notion derives from the work of the seventeenth-century philosopher René Descartes, who distinguished between the *res cogitans* and the *res extensa*. The former referred to the soul or mind and was said to be essentially 'a thing which thinks', while the latter referred to the material stuff of the body. The latter is much more amenable to observation and measurement, and so enabled the emergence of modern bioscience and the practice of biomedicine (Bracken and Thomas, 2002). The legacy of this 'Cartesian split' within biomedicine has been a rejection of any possible connection between the mind or psyche and physicality. This distinction is now beginning to be addressed by more recent developments in neuroscience.
- The *reification* (i.e. to make an essentially abstract idea into something concrete or 'natural') of disease categories. The specific notion of disease that we all understand today (as a discrete set of pathological processes that can be isolated and located with body organs and tissues) first appeared with the emergence of modern medicine. The process of constructing diseases categories bundled together observed and measurable 'deviations' from the 'normal' functioning of the body (often distinguishing between those localized to specific organs and those deemed to be more general or systemic within the body), was crucial to the (social) construction of a body of clinical knowledge with which to train doctors and develop biomedical interventions. Drawing distinctions between the pathological effects of different diseases enabled a set of nosological (classificatory) tables to be drawn up. Yet, from the very beginning of modern medicine, the process of disease classification was not solely based on bioscientific knowledge of the 'natural' and the 'pathological'. There is an extensive literature which has documented, for example, the ways in which women were frequently 'diagnosed' as suffering from 'hysteria' when their behaviour appeared to fall outside particular social norms. This example and many others reflect the social, political and cultural assumptions surrounding the process of disease classification. The process of disease classification is ongoing, with the *International Classification of Diseases* (ICD) now in its 10th edition (for a history of the development of the ICD, see WHO, 2008). This history

demonstrates the contested and often uncertain nature of the practice of disease classification that the process of reifying disease would deny.

- The doctrine of *specific aetiology*. This is the oversimplified notion that draws on the positivist methodology (described above) that pathologies have single linear causality, i.e. a TB bacillus invades the 'host' (individual) bringing about the development of a particular form of tuberculosis (Comaroff, 1982). In practice, this doctrine has served to limit the understanding of the environmental factors that make individuals and social groups more susceptible to disease.

However, drawing attention to the biomedical 'discourse' does not constitute the case for arguing that the whole edifice of biomedicine is purely a social construction as some commentators would claim. What it does do is to question the claim to scientific rigour of all biomedical and clinical practice. Indeed, the practice of Medicine is sometime described as an 'Art' by clinicians themselves. What is being referred to here is the practice of making a diagnosis based on experience and the synthesis of a series of clinical 'facts' and 'data' about an individual patient from a variety of sources. The attempt is then made to connect this often incomplete and context-specific knowledge to a 'textbook' disease classification which is not always a systemic process; hence the notion of medical practice as an 'art' (Berg, 1992).

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The social model of health

The social model of health offers a distinctive and holistic definition and understanding of health that moves beyond the limitations and reductionism associated with the medical model of health. Health, according to the social model, is not a state of being solely under the domain of the medical profession, nor is health and disease only made intelligible by findings of medical science. Rather, a perspective of health is realized that embraces all aspects of human experience and places health fully in the dynamic interplay of social structures and embodied human agency. Such an approach in understanding health is crucial for Health Studies as it allows a wider understanding of health, one that accords with the multidisciplinary basis of the Health Studies approach and provides an excellent conceptual vantage point for the study of health.

The key elements of the social model of health are identified and outlined below. Many of the themes, such as the role of wider social and psychological elements, are encountered throughout this textbook and in many respects this entry provides a condensed overview of the ideas that animate Health Studies.

Individual health is enabled or inhibited by social context. A common lay perception of health, and one that is frequently found in media representations, is that what makes people healthy or ill is down to their own choices. People choose, for example, to eat the 'wrong' sort of high-fat sugary foods, or choose not to diet regularly or choose to engage in risk activities such as smoking. While the power and influence of human agency (ability to make decisions) cannot be ignored, only about a third of poor health can be explained by the choices people make. To further an understanding of health choices it is important to consider that people have to make sense of their lives as conditioned by the specific context in which they find themselves and in which they exercise that agency. Social distinctions such as class, gender and ethnicity also differentially shape the experience of these social contexts and it is to these that we must turn in order to have a fuller social conceptualization of health.