Lesson Ten

Health

Aims

The aims of this lesson are to enable you to

- recognise that the concepts of health, illness and disability are both biologically and sociologically defined and constructed
- examine evidence of variations in health and illness by class, age, ethnicity, gender and locality
- be aware of sociological explanations of the distribution of health and illness
- examine variations in the provision of and access to health care
- consider the structure and development of public and private health care
- examine approaches to the issue of mental health and illness

Context

Health is one of the key topics for AQA AS Unit 2, and has obvious links with poverty and welfare. It is not particularly well covered in the standard textbooks (e.g. Haralambos) so it is tackled in some detail here.

Reading

David Bown et al: *AQA Sociology for A Level Book 1,* ch. 6.

Introduction

People perceive health in different ways, and most individuals don't think consciously about the normal functions of their bodies. It is only when people fall ill and being unwell disrupts their normal daily lives that 'health' and what it means to have a normally functioning body come into conscious awareness and becomes a focus.

The problem is that defining what is 'normal' in terms of health and well-being is difficult; this is therefore closely linked to people's perception of what is abnormal in terms of being ill. For example, when some people develop a cold they perceive it as nothing more than part of normal healthy life; it may be a minor inconvenience but doesn't affect their overall perception of well-being and good health. Other people who develop a cold may feel that their body is not functioning normally and the disruption to their lives means they are unhealthy. We may describe these as **lay** (= non-professional) **definitions** of health.

Many people with serious life-changing conditions will still perceive themselves as being healthy because they are basing their perceptions on what is 'normal' for them and not basing their perception on the total absence of disease. This demonstrates the difficulty sociologists have with understanding health abnormality, disability, illness and importantly how people in society perceive these concepts. Any statistical analysis of health is likely to be affected by these elements of subjectivity.

To compound this difficulty, other factors need to be considered such as cultural, age, class and gender differences. These differences will be revealed further within later discussion.

Medical Sociology

In recent years the importance of some of the questions raised by Sociologists to all aspects of life has been increasingly accepted by specialists in other fields. The subjects of medicine and illness form just one of several areas that have been *opened up* by and to sociological analysis, with previously unquestioned aspects of the process of becoming a patient, doctor-patient relationships, the social causes of disease, and the effects of medicine on the individual and society all coming under close scrutiny. Not everyone would agree that this has always been productive or constructive, and Ivan Illich's assertion that the *medical establishment has become a major threat to health* certainly stirred up controversy.

Even on the superficial level, however, Medical Sociology has provided a number of insights and de-bunked a number of myths.

Among many interesting observations reported by **David Tuckett** (left) in his introduction to *An Introduction to Medical Sociology (1976)* were the following:

1. Doctors and medicine are *as often concerned with the long-term management as they are with the immediate cure of disease*. In an analysis of the occupancy of hospital beds in 1972, he found that about 30% were taken up by people over the age of 75 and 5% over 65 years of age, pointing to illnesses of *the degenerative chronic type* rather than *the acute, life-threatening disease* of the past.

2. The average general practitioner spends the vast majority of time dealing with relatively minor ailments. Only between 6% and 17% of his or her time is spent on acutely serious life-threatening diseases as opposed to 51-77% on minor cases and between 8% and 30% managing chronic complaints. Indeed, only 1 or 2 cases of lung cancer, *the second most common form of death in the U.K.* are encountered by the average G.P. each year.

3. Social factors seem to influence the use of medical facilities, with the uneducated, lower classes, and ethnic minorities in the U.S.A., using them the least.

4. The relationship between doctor and patient can have an impact on the efficacy of treatment. Tuckett quotes Egbert's 1964 study in which it was revealed that the provision of extra information to patients on the quantity and quality of pain they were likely to experience led to a reduced need for pain-killers and earlier discharge from hospital.

5. Illness can be socially defined, with Jarman revealing that low blood-pressure is seen to require treatment in Germany, while in Britain it is seen as an asset in obtaining insurance cover. Szasz has similarly tried to show that what professionals may define as mental illness requiring psychiatric treatment may well be the product of living conditions that merit social or economic treatment.

Ivan Illich and 'Medical Nemesis'

Ivan Illich, using a Marxist analysis, basically sees modern society creating dependence of individuals on *experts* and technology. He argues that professionals are essentially self-interested groups, that

technology is impoverishing the individual, and that schools confuse *teaching* with *learning* and society should therefore be *de-schooled*. In such a framework, Illich makes a particularly virulent attack on medical professionals and medicine. He see *iatrogenic* or *treatment-caused* diseases now causing more suffering than the combination of traffic and industrial accidents, and by changing pain, illness and death into *technical problems* instead of being *personal challenges* human self-sufficiency is being removed. *By becoming unnecessary, pain has become unbearable*.

Illich (left) claims that he is not against the use of medicines or the development of new ones, but rather is opposed to the domination of professionals who *mystify* their skills, and he admits that there are special needs at various points in people's lives. The need is to give back to consumers their powers of self-determination, and by doing so health problems can be reduced: *A society which can reduce professional intervention to the minimum will provide the best conditions for health.*

A somewhat similar approach was taken in the series of Reith Lectures of 1980 by Ian Kennedy under the tile of *unmasking medicine*. Kennedy argues that *the nature of modern medicine makes it positively harmful to the health and well-being of the population*. He describes doctors as *new magicians and priests wrapped in the cloak of science and reason*, while he would prefer to view a doctor as *someone who can care*. Like Illich, Kennedy attacks medical science for concentrating on reaction and responses to ills rather than prevention of them, and he too point to the costs involved in terms of both finance and misplaced expectations. For Kennedy, the need is to use medical resources more effectively, *curb our predilection for medicine in the form of ever more complex technology*, improve the health education service, and pay particular attention to the disadvantaged groups at the bottom of the socio-economic ladder.

It is, of course, debatable as to how valid are the criticisms of Illich and the more moderate Kennedy. Nevertheless, it is interesting that medical science has come under increasing attack at a time when the scientific approach to Sociology is out of favour and environmentalists are pointing to the pollution and devastation caused by so-called scientific and technological advances.

Becoming a Patient

In Chapter 5 of his book, *Becoming a Patient*, **David Tuckett** points out that many self-reporting *patients* are judged by doctors and consultants to be suffering from *trivial* complaints, while many *with severe medical difficulties* make no effort to consult a doctor. Essentially what is at stake is the issue of whether *illness, symptoms,* and *trivia* are a matter of objective criteria or subjective judgment. This ties in with the view of Kennedy referred to above which were critical of the scientific image and aim of the medical

profession, seeing *caring* as much more important. As Tuckett points out, *individuals can experience enormous suffering from a condition which medically does not exist*, while many medically ill people accommodate themselves to a pattern of deterioration.

Wadsworth's 1971 study of the population of a London borough found that between 75 and 90% of the population over the age of 16 suffered, in any period of two weeks, at least one *painful and distressing symptom*. However, only about 20% of the total would have visited a doctor, less than 3% attended the out-patients department of a hospital, and 0.5% admitted as an in-patient. The general finding of such studies is that there is not a clear correlation between the seriousness of a symptom and the request for medical help.

Tuckett concludes that one factor involved is the level of tolerance that people have to pain. He quotes Beecher's study of battle-field patients that showed quite different quantities of morphine were required to relieve the pain from what were apparently similar wounds. Another factor identified by Tuckett is that alternative courses of action to consulting a doctor are available in the form of patent medicines, traditional remedies or other respected opinions. The decision may be based on such factors as fear, feelings of inevitability, and different definitions of symptoms and illness, with cultural factors influencing these.

Tuckett quotes the findings of many other studies and concludes that *Different social groups have different norms and values concerning the recognition of symptoms and what it is appropriate to do about them*. Added to this, however, is prior experience of medical services which constitutes what Kasl and Cobb call *the perceived value of action*; in other words, individuals weigh up the possible costs and benefits involved before using the medical services. Cartwright and others show that many decisions of dying people not the contact the doctor were realistic assessments of what could or could not be done for them.

One danger with the approach of Kasl and Cobb is stressed by Tuckett who argues that in their view the actor in question decides on a visit to the doctor solely on the basis of a rational consideration about health. However, many other factors can be influential in a particular case, and they might include pressures from friends and relations, or simply the desire to talk to someone. Indeed, several studies have shown that patients are often more anxious to talk about such matters as their families or jobs rather than the state of their health.

The decision not to consult a doctor may also be influenced, as Parsons suggested, by past experience of feeling dependent and helpless, and there is also low status in acquiring the position of *patient*. Financial loss, the effect on family relationships, and past

experience of relations with the particular doctor may also be influential.

The Doctor-Patient Relationship

The relationship between a doctor and a patient can be analysed in terms of power and subordination. Michel Foucault, for example, has compared the rôle of the doctor to that of a priest receiving a confession and granting an interpretation. During the Reith Lectures, Ian Kennedy quoted the example of an assembly line worker who is bored with the tedium of his job and wants a few days at home. He then has to *stake a claim* to illness, but it is the doctor who has the power to grant or refuse the sick-note. Kennedy points out that *health* is equated with *ability to work*, with the doctor in the roleof reinforcing *the prevailing social and political attitudes and values*.

Another aspect of the power of doctors is presented by Sudnow's study of American hospitals in which they had the power to decide who to treat and who to save when patients were brought in *Dead on Arrival*. They had the power to determine what revival efforts should be made, and Sudnow noted that such factors as age, social background and judgements on character were involved.

The more traditional view of doctor-patient relationship is one involving the former as an aid or resource to the latter. Tuckett quotes a vast array of studies which indicate the value of the relationship to the patient. Beecher, for example, has stressed the placebo effect of the patient's belief in professional help and treatment contributing heavily to its success. Balint stresses the importance of listening rather than asking questions to develop a diagnosis, with the human relationship being more successful than the scientific skill involved.

Such an approach can have problems, given the constraints on the doctor's time and energy. Doctors are forced into using their powers to select between the interests of various patients by the competing needs of those patients, and they must choose whether to allow a conversation to continue in the hope of ending or reducing the particular patient's problem, or to end it prematurely to enable other patients' problems to be aired and investigated.

Even with the advent of patient-centred care, self-management approaches, patient empowerment and expert patient programmes, these constraints are still largely in place because of the hierarchical structure of the doctor-patient relationship.

The Social Construction of Illness

Because of the power-inequalities between doctor and patient, as discussed above, interpretivist sociologists such as symbolic interactionists argue that health and illness are both social constructions. A social construction is a taken-for-granted concept that in reality has no clear, accepted definition. In other words, we are only 'ill' if the doctor says we are ill!

One very interesting study of the treatment of mental illness is offered by Rosenhan's article in Martin Bulmer's *Social Research Ethics*. In this study the researchers gained admission to mental hospitals by stating at an interview that they had heard voices saying *... empty, hollow, and thud*. Beyond falsifying their names and occupations they then proceeded to tell the truth when questions were raised about family relationships, friendships, etc. Each was admitted, and with one exception the diagnosis was *schizophrenia in remission* with the belief that the pseudo-patient was not sane and probably never had been.

One person was actually detained for 52 days and neither doctors nor nurses saw through the patients' guises. Other patients, however, did do so – *You're not crazy. You're a journalist, or a professor ... You're checking up on the hospital ....* This study indicates the vulnerability of alleged mental patients, because their behaviour patterns and answers to questions were all analysed in terms of them being mentally ill.

Using Becker's labeling theory, it can be argued that a person is only mentally ill if a 'professional' labels them as such. This could result in a self-fulfilling prophecy, whereby patients become institutionalised in hospitals and are unable to function in the 'real' world – in other words, they do actually become mentally ill.

Disability

Recalling the discussion earlier in the lesson on health perception and defining normality in this context, the topic of disability is equally challenging. Differentiation between a normal and abnormal body in terms of function, image and perception is based largely on a set of associated activities, social constructions and imposed societal impediments (Oliver, 1996 and Friedson, 1965).

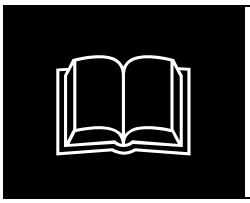
Stigma associated with disability still creates a negative attitude towards those who suffer from some kind of disabling condition (Goffman, 1963). According to Goffman there are different types of stigma, the first being discrediting which refers to obvious or outward signs of disability such as the person being in a wheelchair. This creates social difficulties as people experience awkwardness in

communicating with the person in a wheelchair, for example because they feel embarrassed.

Discreditable stigma refers to how a person feels if they have a serious illness and they are trying to conceal it for fear of how others may perceive them. For example, someone with HIV may act out of character in order to hide their diagnosis.

Green and Platt's research in 2004 into stigma and illness associated with HIV sufferers supported Goffman's findings.

Selective concealment of a condition occurs when the sufferer only tells a few trusted friends or family members about their disease; or they may completely cover up and tell nobody. Alternatively, the sufferer may 'medicalise' their behavior. Deciding not to conceal their illness, they choose instead to emphasise the medical aspects of it and so gain sympathy and a type of social acceptance. In some cases, people who have a stigmatizing condition may condemn the condemners and this means they engage those who have imposed the stigma and they may even engage in political action to address the stigmatization.



Now read David Bown et al: *AQA Sociology for A Level Book 1,* ch. 6, pp. 223-235.

Health, Social Class and Health Inequalities

The National Health Service inherited a pattern of unequal provision from the previous voluntary and municipal agencies, and as Noyce and others found in the early 1970s, the fewest resources still coincided with the areas with low average family income. Cartwright and O'Brien in an article in *Basic Reading in Medical Sociology* (edited by Tuckett and Kaufert) take this to be but one of many contributory factors to the differential use of health services by social classes. The additional factors are:

(a) ***Knowledge and Education:*** Studies showed the higher up the Registrar-General's scale (the official way of deciding a person's social class at that time) the greater the knowledge of the means of transmission of disease and of effective family planning methods.

(b) ***Attitudes and self-confidence:*** The higher up the scale the greater the expressed criticisms of the service provided. Professional class patients are more willing to ask questions, while the unskilled manual group *often waited to be told.*

(c) ***Vulnerability:*** Social conditions render working-class people more vulnerable to events that cause depression, i.e. loss of mother in childhood, large families, lack of confiding relationships and unemployment. Barbara Preston has noted that several diseases are *class-conscious*, with professional classes having only half the expected death rate from them, while unskilled manual workers have death rates at least 50% higher than expected. These include epilepsy, bronchitis, hernia, influenza, T.B., and pneumonia.

(d) ***Relations with the G.P.:*** Working-class patients found it more difficult to communicate their problems to what they saw as middle-class doctors, and so they required more consultations, but each lasted for a shorter period than those of their middle-class counterparts.

The expansion of private health services in recent years may be contributing to a widening of the gap in health care between the classes. Prominent in this development has been the agreement between the Electrical Contractors Association with the British United Provident Association (BUPA) to provide cover for 40,000 members of the Electricians' Union (EEPTU). This may be a reflection of the stratum mobility of certain groups of skilled workers as suggested by the *embourgeoisement thesis*, but the net result may be to further the relative deprivation of the semi- and unskilled groups. According to *Social Trends*, by 1984 the number covered by private insurance had risen to five million, and by 1987 to 5.3 million.

In a study of ante-natal care by **Ann Oakley** and **Alison MacFarlane** outlined in *New Society* in July 1980, the class factor in perinatal deaths was again stressed. They found that perinatal deaths occur disproportionately in babies born too small and those congenitally malformed, and *small babies are more commonly born to working class than middle class women.* The authors reject the view that lack of dietary advice or food supplements in pregnancy are responsible, concluding instead that it may well be *a woman's nutrition throughout her whole life* which is important.

Oakley and MacFarlane also point out that fatal congenital malformations *occur more often in the babies of working class than of middle class women*, and they suggest that some combination of environmental conditions and genetic factors is probably responsible. They suggest that stress resulting from environmental conditions can be very important, with smoking during pregnancy being a reflection of that stress. *Taking life easily may be medically recommended in pregnancy, but it is not necessarily what husbands want, what other children in the family need, or what financial circumstances permit.*

Several recent pieces of research have further stressed the link between both health and health treatment and social class. The so-called *Black Report* on *Inequalities in Health* published in August 1980 provided a great deal of evidence to this effect, with some important points being:

(i) A child born at the bottom of the social scale is twice as likely to die at birth or in the first few months of life as a professional class child.

(ii) For every boy from Class I who dies before his first birthday, there will be two from Class IIIb (skilled working class) and four from Class V (unskilled working class).

(iii) Of 38 causes of death for children aged between 1 and 14, twenty-two showed manual working class children more at risk than the professional classes, with only asthma showing the reverse.

(iv) For children under seven, the percentages not visiting the dentist and not being immunised against smallpox, polio, etc. rises the further down the scale. For example, the figures for smallpox immunisation were that only 6% in Class I had not been so immunised, as against 14% for Class II, 16% for IIIa, 25% IIIb, 29% IV, and 33% V.

(v) By 2003 the death rate amongst men of working age was approximately twice as high in Class 5 (unskilled) compared with those in Class 1 (professional)

Health and Other Dimensions of Inequality

In addition to the social class dimension, inequalities of health and health care have been identified on the basis of region, gender and race/ethnic group:

(a) **Region:** Following the publication of several articles on the basis of the findings of the *Black Report*, a bitter row broke out between Peter Townsend who had been a member of the working party, and the then Health Minister, Edwina Currie, over the interpretation of statistics of regional health disparities. Townsend argued that the shorter life expectancy and the greater vulnerability to heart disease and other health problems of people in the North reflected income and wealth disparities between the regions. Currie, on the other hand, placed the blame on the culture of Northerners who, she argued, took too little account of their diet by eating fatty foods and consuming too much alcohol.

Research by **Shaw et al** (1999) used all available statistics to highlight the worst areas and confirmed that geographical differences normally reflect differences in income and deprivation levels. However it was noted that poor people living in more affluent areas did tend to have a better standard of living whilst poor people living in deprived areas had an overall decreased standard of living and an associated poor standard of health.

Whichever explanation is favoured, the debate is essentially a reflection of the class issue, with the North having a higher proportion of working-class people than the South, and so comments on this dimension of inequality can be linked with those raised in the previous section.

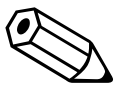
Activity 1

More recent studies continue to confirm the link between social class and health. One of the most important of these was conducted by Peter Phillimore, Alastair Beatie and Peter Townsend.

> Life expectancy for some groups in Britain has worsened for the first time in 50 years. Our study shows that mortality rate in the most deprived areas in the North of England are now as bad for some age groups as in the 1940s, and are four times higher than in the most wealthy areas. In the poorest areas mortality rates have risen in absolute terms in men under 45 and women aged 65 to 75, reversing previous improvements. The research into health inequalities show the poorest people in society have come adrift from the rest. The gap cannot be explained by differences in behaviour. Inequalities have been widening since at least the 1960's. What is new is that the widening has been quite dramatic. Health promotion campaigns are a diversion. The economic circumstances of inequality must be taken seriously.
>
> Commenting on this work Richard Wilkinson says that the widening of income differences and growth of poverty during the 1980s has been unprecedented. "If risks as great as these resulted from exposure to toxic materials then offices would be closed down and populations evacuated from contaminated areas."
>
> *Adapted from the British Medical Journal 1994*

The following extract may throw light on some of the reasons for high mortality rates in deprived areas

> The Conservative government has banned publication of a report made by the Health Education Authority showing that people living on low income cannot afford to eat healthily The study contradicts the Conservative government belief that lack of knowledge not lack of money results in poor people eating an unhealthy diet The banned report suggests that a good diet in 1986 cost £14 but very often people on low income had more than £10 to spend on food. Furthermore this report shows the cost of healthy food like green vegetables, fish, citrus fruit and wholemeal bread has risen faster in recent years than has less healthy food.



Poor people spent around half as much on food per week as rich people but this constitutes about a quarter of their income compared to about one sixth of a wealthy person income.

"People with low income buy food relatively efficiently within their resources. They get more for their money in terms of quantities of food and also most nutrients. Vitamin C is a notable exception to this. However they also get more fat and sugar, relatively cheap sources of calories" the report says. "People on income support may need to spend 40 to 50% of their disposable income on food if they are to eat a healthy diet."

Reviewing the impact of food poverty on health, it concludes "Of all the many nutritional factors associated with ill-health, the strongest inverse relationship between death rates and food consumption in the UK and other developed countries is the amount of fruit and vegetables eaten."

Adapted from A Ferriman: 'Poor's Unhealthy Diet Findings Blocked' in 'The Observer' 15th October 1989.

Question

1. If these two reports are accurate, what do you see as the cause of much ill-health and early death?

(b) **Gender:** A number of both feminist and non-feminist writers have focused on the relationship between women and the issues of health and health care. Jessie Bernard pointed to the effect of marriage on a woman's health and life-expectancy as being negative in both cases, while Oakley has pointed out that women more often visit the doctor than men. Oakley quotes a study by Balint which showed the importance of the mental element, with women being the consumers of 75% of psychotropic drugs. She attributes this to the higher rate of restriction of women to the home, leading to greater levels of psychological stress.

Annandale (1998) suggests that working women have better levels of health than their non-working counterparts. She also suggests that this has wide-ranging social impacts because working women have more independence and a much wider social network, therefore they have less stress and a better standard of health.

Such writers are also concerned with the fact that most medical specialists concerned with obstetrics and gynaecology are men, and so once again women are being subjected to male opinions as to how they should control their bodies.

(c) **Ethnic Group:** Various studies have indicated cultural differences in the way illness is perceived, vulnerability to particular diseases, and the treatment sought and provided. In his study of various ethnic groups in Boston, Zola found culture not only influenced perception of ill-health but also how it was presented and managed. In some societies, low blood pressure is seen as a threat to health while in others it isn't, and in her Polynesia studies Margaret Mead found that morning sickness was neither expected nor normally experienced during pregnancy.

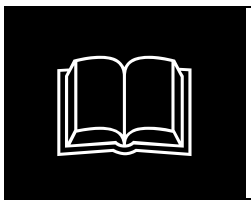
(d) In Britain certain ethnic groups seem vulnerable to particular diseases. Many of these can be explained by the different climatic and dietary situations in an immigrant's adopted country. One obvious example is illness among the Asian communities resulting from Vitamin B deficiencies due to consumption of polished rather than unpolished rice. It may also be that language and knowledge problems deter such people from requesting the medical care that it is required.

(e) **Global health inequalities** can be quite stark. For example:

The probability of premature death before the age of 65 varies greatly between different countries, for example in sub-Saharan Africa the figure is four times that of Japan.

Life expectancy is increasing globally except in Africa where the trend is totally opposite.

Cuban people have a better standard of health than USA citizens despite the Cubans being poorer.



Now read David Bown et al: *AQA Sociology for A Level Book 1,* ch. 6, pp. 236-258.

Mental Illness

The question of concern in this course is what, if any, contribution Sociologists have made to our understanding of mental illness. The obvious writer to discuss is **Thomas Szasz** (left).

Basically, Szasz (left) argues that mental illness was *discovered* in mid-nineteenth century when behaviour or *bodily function* was added to the study of *bodily structure* as the subject matter of medicine.

Persons who complained of pains when physically they seemed quite fit could now be described as suffering from *a functional illness*. The fundamental conclusions of Szasz are:

(i) Strictly speaking disease can only affect the body and not the mind.

(ii) Psychiatric diagnoses are stigmatizing labels phrased to resemble medical diagnoses and applied to people whose behaviour annoys or offends others.

(iii) Mental illness is not really something a person has but something he or she does or is, and therefore it cannot be subject to treatment or cure but might be changed.

(iv) The prestige and power of psychiatrists has been inflated by more and more phenomena being defined as within the scope of their discipline.

Szasz' work is certainly of importance in making us question what are now virtually taken-for-granted assumptions about *abnormal* behaviour, and making us focus on the psychiatrist as an official involved in a labelling process. It also makes us question what we take to be *abnormal* behaviour, and helps us to focus on the real personal and social problems people face in living. On the other hand, it is in danger of overstating the case and making us feel that nothing could be or should be done to mould the behaviour of people committing anti-social acts, and there are certainly many psychiatrists who would argue that Szasz is misrepresenting their profession.

Mental illness remains a regularly debated issue in sociology, not least in terms of trying to find a suitable definition and explain differences in the statistics for those who develop mental illness within a population. However, research is ongoing and for example, Busfield (1998) does put forward the idea that some groups in society are simply more predisposed to developing mental illness than others but that this could be more a difference in their behaviour, culture, gender, age or social class. For example, social minority groups will tend to suffer higher levels of stress and social exclusion, and therefore be more prone to developing mental illness.

Recent Developments

Studies of the lay (non-professional) view of health and illness can have some influence on the organisation or presentation of medical

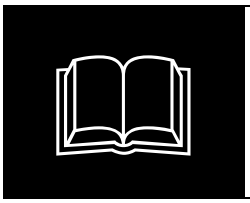
services. Following a recognition of the weaknesses of conventional health measures, there have been some attempts to take account of patients' experiences and to develop subjective health indicators — most notably that involved in the Nottingham Health Profile which has been utilised in a number of studies (described by Whitehead 1987).

In response to the growing number of people with chronic illness and the consequent emphasis on prolonging life and relieving suffering, there have also been attempts to develop measures of 'quality of life' for use both in clinical and administrative decision–making. 'Quality of life' measures seek to combine mortality and morbidity measures (Carr–Hill 1989).

According to Siegrist and Junge (1989), such measurements allow patients' own perceptions and definitions to be communicated to health care professionals in a regular and medically acceptable way. A 'quality of life' index is most useful in studies where different treatments are being compared or where routine decisions have to be made: like clinical practice or cost considerations.

Although in recent years morbidity rates have fallen and life expectancy has increased, there is still a discrepancy between how health is self-reported and the figures. This could be explained by a lack of acceptance that health is now better in terms of standard and decreased inequalities, or disbelief about 'good' health' (ONS, 2007).

Of course current problems that could see this figures change again include the obesity problem which is a significant risk factor for developing diabetes, heart disease and strokes (DoH, 2007).



Now read David Bown et al: *AQA Sociology for A Level Book 1,* ch. 6, pp. 259-266.

National Health Service (NHS) inequalities

In sociological terms, the NHS does not provide equitable service for all because some groups in society are less likely to demand services than others whilst some groups may be less able to access services than other groups.

Each region or area is allocated government funds to provide healthcare for its residents. However, successive modern governments have yet to address the challenges of making sure that

poorer areas have more financial resources. This is in part due to planning because services and therefore funding has to be planned ahead. But social poverty is changeable and therefore staying on top of regional needs in the present time is challenging because regions are always working with out-of-date statistics and therefore out-of-date budgetary provisions.

There are also influential groups such as politicians and the medical profession who have a significant voice with regards to the determination of where specialism will be based and funded.

Current problems with regard to excessive demands on NHS services have led to crises within some regions and therefore a non-demographic shortfall in care and service provision. In other words all groups in society are affected.

Private healthcare

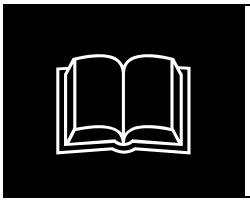
Those who can purchase private healthcare, either by private or insurance funding, create greater health inequalities. The reason for this is because those who can access private healthcare generally have a shorter waiting time to access services and a greater choice of treatments.

However, there are limitations in private healthcare plans for specific situations such as people with chronic conditions, where health insurers will not fund the cost of treatment; and once a condition has stabilized, insurers will rarely pay for ongoing management or regular follow-up treatments.

Complementary medicine and alternative therapy

With a reduction in conformity to traditional medicine, there is a rise in complementary medicine and alternative therapy. This can in part be linked with globalization and technological advancement which allows people to explore other avenues of treatment and access information about new therapies. In addition, because people are now 'consumers' of health provision and more motivated to take responsibility for their health, they are demanding a wider range of treatment options and integrated care with regards to using traditional medicine alongside complementary medicine and alternative therapy.

There is also disillusionment about many traditional therapies and treatments which drives people to seek help elsewhere and with a growing body of research associated with complementary medicine and alternative therapy; users are feeling more confident in trying different treatments.



Now read David Bown et al: *AQA Sociology for A Level Book 1,* ch. 6, pp. 267-282.

Self-Tuition Quiz

1. What is meant by 'iatrogenic disease'?

2. Who wrote *The Strategy of Equality?*

Summary

The study of health-related issues from a sociological perspective is a relatively new field, but it has been expanding rapidly. The whole variety of Sociology questions can be asked, ranging from organisational considerations to inter-personal relationships, and the various Sociological perspectives all have a contribution to make. The controversies that have raged in other areas of Sociological study are now brought to bear on the medical profession and medicine, and the image of *scientific autonomy* is called into question.

Self-Assessment Test (Lesson Ten)

1. What is the relationship between health and social class?

AQA Subject Content	The lessons in this pack of course materials are linked to the AQA sections on Health (3.2.2.3 and 4.2.3). If you select this option, you are required to study:
	• the social construction of health, illness, disability and the body, and models of health and illness • the unequal social distribution of health chances in the United Kingdom by social class, gender, ethnicity and region • inequalities in the provision of, and access to, health care in contemporary society • the nature and social distribution of mental illness • the role of medicine, the health professions and the globalised health industry.
	Use the points listed above as headings for a set of notes summarising the key points from the lessons and the textbook. These notes will help you to understand and remember the Information you have read and will be a valuable revision aid. An understanding of health issues also feeds into numerous other areas of sociology.

Answers to Self-Tuition Quiz

1. An 'iatrogenic disease' is one that is the product of medical treatment. This would include forms of drug-addiction or the side-effects of treatment that has been administered.

2. *The Strategy of Equality* was written by Julian le Grand.

Suggested Answer to Activity One

1. **Poverty**. Seen from this point of view, ill-health becomes a structural problem. Efforts to tackle ill-health may therefore need to involve the alleviation of social deprivation, for example, improvements in housing and nutrition.