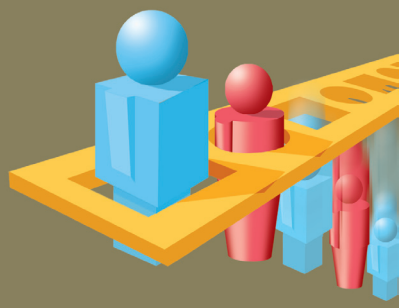
Chapter 11

Sociology of health



By the end of this chapter you will be able to:

- understand the concepts of health, illness, sickness, morbidity and mortality
- examine and evaluate biomedical and social models of health
- understand how health and illness are socially constructed
- understand the social process of becoming a patient
- identify patterns of ill health by class, gender and ethnicity
- explain and evaluate artefact, social selection, cultural and structural explanations for patterns of ill health
- identify definitions, diagnosis and trends in mental illness by class, gender and ethnicity
- explain and evaluate structural and interactionist explanations for mental illness
- explain and evaluate medical and social models of disability
- explain and evaluate functionalist, Marxist, Weberian and feminist explanations for the role of health professionals in society
- evaluate the extent to which alternative medicines complement or challenge conventional medical models of health and illness

Key concepts and the social construction of health and illness

Health

Health is a staple topic of conversation for most of us — we're interested in both our own health and that of others. We often check our **health status** — we like to enjoy 'good health', and 'being ill' is something to avoid. We enquire after the health of others, even complete strangers. We worry about 'becoming ill' and plan **health regimes** (regular

physical exercise, healthy eating, detoxification) that we hope will promote good health. We take pills and potions designed to keep us healthy and ward off illness, or, if we do succumb, to aid our recovery to a state of healthiness.

An awareness of 'being healthy' is one thing, but it's another to actually define 'health'. Does it involve the **presence** of qualities that make us healthy, or the **absence** of qualities that make us unhealthy? Gadamer (1996) calls this the 'enigma of health' — the idea that the absence of something (ill health) can be a quality of the presence of something else (good health).

These two broad types of definition underlie what Blaxter (1990) calls two models of health: positive state models and negative state models.

Positive state models

In positive state models, health involves the **presence** of something. An example is the World Health Organization's (1948) definition of health as 'a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity'. In this definition, health is:

- **multidimensional** — covering physical, psychological and wider social elements
- **objective** — relating to physical and social states that can be measured
- **positive** — more than the absence of something (such as illness)
- **subjective** — involving our feelings about our state

WHO definition

Multidimensional
Objective
Positive
Subjective

Saracci (1997) argues that positive state definitions suggest health is not simply a 'medical problem'; physical health can't be separated from how we *feel* or what we *believe* about our health. A definition of this kind, however, involves a range of **problems**:

- **Generalisation**: It takes no account of health *gradations*; most people probably exist in a state somewhere between 'complete health' and 'complete illness'.
- **Undifferentiated**: It makes no distinction between different aspects of health — every positive aspect of our lives somehow contributes equally to our health.
- **Measurement**: There is no objective way to measure health. More importantly, perhaps, we could argue that what is being defined is not 'health', but something even more elusive — 'wellness'.
- **Perfection**: Very few people could ever be said to exist in 'a state of *complete* physical, social and mental well-being'.

Problems

Generalised
Undifferentiated
Measurement
Perfection

Negative state models

In negative state models, health involves the **absence** of something. As Blaxter (1990) suggests, an alternative way to see health is to define it negatively — as 'not ill'. Health, in other words, is simply the absence of illness. This definition has some significant **advantages**:

- **Measurement**: A disease or condition (such as a heart attack) can be measured and quantified in terms of its severity (unlike health or wellness).
- **Objectivity**: Health is not a subjective interpretation or state of mind. It can be objectively established (as the absence of illness) through scientific testing.
- **Detection**: Detection relies less on patient reporting (based on an awareness that something is wrong) and more on the ability of medical professionals to diagnose health problems.
- **Scaling**: While the positive model sees health as an 'either/or' condition (either you're healthy or you're not), the negative model allows for grades of illness (such as chronic, life-threatening or temporary). This, in turn, suggests a sliding scale of health.

Advantages

M easurement
O bjectivity
D etection
S caling

? Identify and explain one difference between positive and negative state definitions of health.

However we define health, the idea of being unwell looms large in any definition. We can consider this in terms of three related ideas: disorder, disease and disability.

Disorder refers to anything that upsets the normal functioning of the human body, for example through disease.

Disease is an *abnormal* condition that can be medically diagnosed (different diseases are associated with different symptoms and signs). Medically, diseases can have an *external* cause, such as a virus, or an *internal* cause, such as some kind of body malfunction. More generally, 'disease' refers to any medical condition involving pain, discomfort, distress or even death.

Disability is a specific form of 'disorder', physical or mental, explored in more detail in a later section.

Illness

We tend to see disease and illness as being much the same thing. However, Morris (2000) argues that while disease is an *objective* disorder (something you *have*), illness is more *subjective* (something you *feel*). Illness, in this respect, can be defined in a range of ways.

First, illness can be defined as the actual experience of pain, treatment and so forth. An individual with an infectious disease, for example, has very different experiences from someone without the disease.

Second, illness can be defined in terms of how different people respond to it. Someone can, for example, be objectively ill (for example, in having a disease with no outward symptoms), but show no signs of illness (they live their 'normal' life). On the other hand, someone can be ill without being diseased, through **hypochondria** (a belief you are ill without having any definable medical condition) or the belief that a perfectly normal experience is a symptom of a wider illness.

Third, illness can be defined in terms of the ways others react to an individual's sense of illness. Our reaction to someone vomiting will be different depending on the social context of their behaviour.

For example, someone who drinks 10 pints of lager and vomits the next morning is not considered ill. Similarly, pregnant women frequently display symptoms and signs we normally associate with illness (vomiting, loss of appetite, skin changes and so forth) without being considered ill. On the other hand, someone who contracts food poisoning (even after drinking 10 pints of lager) is considered ill.

We should also note that concepts of illness are related to different *historical and cultural contexts*. Ideas about the causes of physical and mental illness in contemporary Britain, for example, are very different from those of 500 years ago. An example of cross-cultural contrast is **obesity**: this is considered a disease in contemporary Britain, whereas in some societies it is a symbol of wealth — of having more than enough food to eat.

Sickness

If disease is what you *have* and illness is what you *feel* about what you have, then sickness is what you *are* — it reflects people's expectations about how to behave when 'sick'. If health is defined as 'normal', illness is seen as 'abnormal' and, more importantly, **deviant**.

However, this is a special kind of **non-culpable deviance** — something for which the sick can't be blamed. It needs to be managed differently from culpable forms of deviance (such as theft, where the deviant is to blame and for which they can expect punishment). This is achieved, according to Parsons (1951), through the **sick role** — 'a temporary, medically sanctioned form of deviance'.

In this functionalist explanation, the person playing the 'sick role':

- **manages** their deviant status by cooperating with the people around them (doctor, parent, partner, etc.) to resolve their deviance by being nursed back to health
- **negotiates** certain *rights* (such as not having to go to work or school) in return for taking on particular *obligations* (such as resting, taking prescribed medicine and so forth)

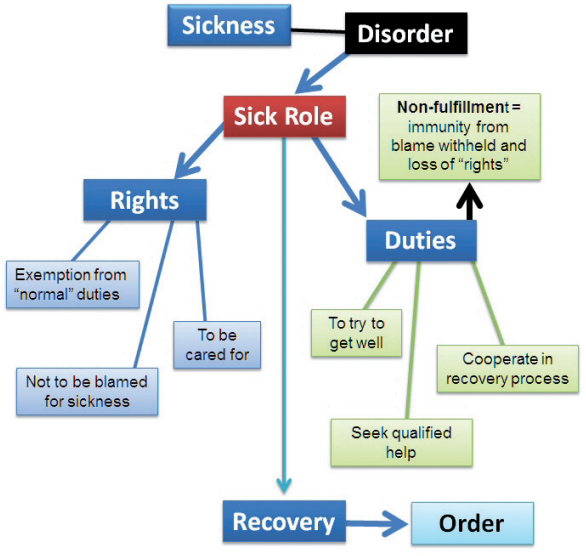


Figure 11.1 The sick role
Source: Parsons 1951

As with any other social role, the sick role is **policed** (by doctors or other interested adults, such as parents or partners).

Evaluation

The idea of a sick role accurately describes a familiar and recognisable process many people experience, in terms of less serious forms of sickness (such as influenza or minor surgery). By defining sickness as 'non-culpable deviance', Parsons highlights the way health is constructed as a normal aspect of social order. The concept does, however, have a number of weaknesses:

- **Stigma**: The patient may reject the sick role, especially in cases where an illness or condition is stigmatised. Some patients may similarly reject the 'illness' label.
- **Blame**: In some situations the patient is held responsible for their illness. Chalfont and Kurtz (1971) argue that, with stigmatised illnesses such as alcoholism, the patient does not qualify for the *rights* normally associated with the sick role.
- **Expectations**: For many forms of **chronic illness** there is no expectation of recovery and, therefore, no possibility of 'restoring order' through the sick role. Such patients are not, however, treated as deviant and do not have their rights removed.
- **Roles**: Although Parsons separates the roles of 'patient' and 'carer', in some instances the roles are confused. For example, in **Munchausen's syndrome by proxy**, the 'carer' deliberately makes their patient ill in order to nurse them. In this case, a mother deliberately making her child ill seems to be playing the carer role (policing deviance) when in fact she is the one who is ill; her child, on the other hand, cannot successfully play the sick role because they can never really 'get better'.

? Suggest one reason for seeing 'sickness' as deviance.

Approaches to health and illness

While the ability to define concepts like health, disease and illness is important, these definitions also reflect different approaches to understanding health and illness. To show this, we will look at two different models: **biomedical** and **social**.

The biomedical model

Most of us will be reasonably familiar with the biomedical approach because it has been the dominant medical **discourse** in our society for 200 years or more. It has strongly shaped our thinking about **causes** of ill health and **treatment** of illness.

Sociologically, we can outline the model in terms of its underlying **assumptions**, the social **relationships** that devolve from these assumptions, and its general **strengths** and **weaknesses**.

Assumptions

Health is defined as a **negative state** — the absence of disorder (such as disease).

In terms of **causality**, Blaxter (2004) argues that this model is shaped by the 'doctrine of specific aetiology': every disorder has a *single observable cause* that can be identified,

isolated and (once we have sufficient scientific knowledge) treated. Ill health is seen as the result of two medical processes:

- **External** processes: The normal, healthy body is 'invaded' by viruses, bacteria and so forth that cause particular types of disorder.
- **Internal** processes: The normal functioning of the body breaks down because of physical changes or because of genetic disorders and predispositions.

As a result, this approach is sometimes characterised as a **mechanical model** of order. Just as a machine like a car has a 'normal state' where the parts work as they should, so too does the body. When a machine breaks down — through normal wear-and-tear or because something has caused it to malfunction — the cause can be established, the problem fixed and normal functionality returned. Similarly, the cause of 'mechanical breakdown' in the body can be established and treated, such that the body returns to its normal, ordered state. Malfunctions, therefore, are **engineering problems** capable of resolution by skilled technicians.

If ill health has clear, definable causes, it follows that a **scientific approach** to understanding causality must be based on **objectivity**. Our understanding and treatment of ill health are based on clear and incontestable *rules of evidence* that have to be followed if treatment is to be successful. The **subjective beliefs** about disease that may be held by those who treat it (such as a doctor) or those who seek treatment (the patient) are largely irrelevant — health cannot be restored on the basis of things like prayer, faith, charms or rituals.

A further aspect of objectivity is the idea that disorders are largely *random events* — disease doesn't strike people because they are 'evil' or 'sinful', or because someone has worked a 'magic spell'.

Relationships

These assumptions shape the social relationships surrounding health and illness in a range of ways, in terms of **roles** and **power**.

Roles

The *objective* view of disease leads to an *objective* relationship between a doctor (someone medically qualified to diagnose and treat illness) and their patient (the person who is treated). This relationship has the following qualities:

- **Formal**: While the patient's role is to describe their symptoms, the doctor's role is to correctly interpret and treat those symptoms.
- **Distant**: While the doctor–patient relationship can be friendly, how they interact socially is largely irrelevant in terms of diagnosis and treatment. The objective nature of the process means that a treatment will work regardless of the relationship between those involved.
- **Instrumental**: The relationship is based on what each individual needs and can provide in return. The patient needs treatment and expects the doctor to provide it;

the doctor needs the patient to cooperate in their diagnosis and, in return, suggests a treatment for their disorder.

Power

There is a clear power difference between doctor and patient based on differences in knowledge (about the cause of illness) and skills (in treating a disorder). Health, in this respect, is something medical professionals:

- define — on the basis of scientific observation
- police — to ensure that only those properly qualified can make diagnoses
- measure — in order to determine effective treatments

Evaluation

The biomedical model has a number of strengths and weaknesses.

Strengths

- Health is simple to define and measure.
- The model is **evidence-based**. In basic terms, *it works*; it has what Keat and Urry (1975) call **instrumental utility** — it works successfully even though a patient may not know exactly how or why a cure works. **Cause-and-effect** relationships can be **reliably** tested and established — for example, we know that malaria is caused by a parasite passed on to humans through a mosquito bite.
- Knowledge of causality leads to knowledge about **prevention**. For example, one of the greatest life-savers of the twentieth century was clean water — and we understood why clean water was important because of our scientific knowledge of deadly bacteria.

Weaknesses

- A simple cause-and-effect analysis, whereby exposure to a particular virus causes a particular disorder, for example, doesn't always hold true. Two people exposed to the same influenza virus don't always both fall ill — which suggests that health and illness sometimes have a **complex causality** which is not simply and easily established.
- Modern medicine is centred on **technology** rather than the patient. In other words, it has become focused on finding more and better 'cures' rather than seeking to prevent disease occurring in the first place. While this has made the medical profession powerful and produced huge profits for private transnational pharmaceutical companies, the overall health of the population has not greatly improved beyond a certain minimum level.
- The focus on technology (more and better medical machines) and drug-based cures has made medicine increasingly **expensive**. In private health systems even basic forms of medical care have been priced beyond the reach of many citizens; Smith et al. (2011), for example, note that in 2009 around a quarter (26%) of all American citizens 'experienced at least 1 month without health insurance coverage'. In the UK,

where the National Health Service is funded from taxation, the cost has increasingly risen each year.

- Another issue is **iatrogenesis** — illness caused by the medical profession. According to Illich (1976), there is a general assumption (advanced by an increasingly powerful medical profession) that medicine represents an inevitable progression from ignorance about disease to enlightenment about the nature and causes of illness, but this assumption ignores the fact that people can be 'made ill' by the medical profession in three main ways:
  - **Clinical iatrogenesis** refers to the use of ineffective, toxic and unsafe treatments.
  - **Social iatrogenesis** refers to the way social life is increasingly 'medicalised': a wide range of 'disorders', from children misbehaving to adult criminality, are seen as having a medical cause, and requiring a medical response (such as the application of new drugs). This process also leads to an increasing rate of 'discovery' of new conditions (especially, but not exclusively, those of the mind) that can be 'cured' using drug-based technology.
  - **Cultural iatrogenesis** refers to the hegemonic (or leadership) role of the medical profession: alternative forms of treatment or ways of dealing with pain, illness and so forth are marginalised or brought under the control and oversight of the medical profession.

  Richardson and Peacock (2003) concluded that an increase in the number of doctors resulted in increased mortality rates: 'The hypothesis that iatrogenic effects may more than off-set the direct beneficial effects of additional, and largely unregulated, medical services must be contemplated seriously. Maybe Ivan Illich got it right!'

? Identify and explain one strength and one weakness of the biomedical model of health.

The social model

The social model is an **oppositional discourse** on the nature of health and illness — one that challenges the biomedical assumptions concerning the way to promote health (and well-being) and the doctor–patient relationship.

Assumptions

Health is a **positive state** that, for Seedhouse (1988), involves something more than the 'absence of illness': 'health' is given a much wider interpretation, based around the idea of '**human potentials**'. In this view, healthy individuals are those able to fully participate in the groups, communities and societies to which they belong. The (**functional**) emphasis, Wolinsky (1980) notes, is on the individual's ability to perform particular roles and tasks in their everyday life.

Seedhouse argues that health is determined by certain central conditions:

- **material conditions** such as food, shelter, warmth and peace — the basic **prerequisites** for health

- **non-material conditions** that include access to information about health and disease and the ability to understand and use such information to promote a healthy lifestyle

Relationships

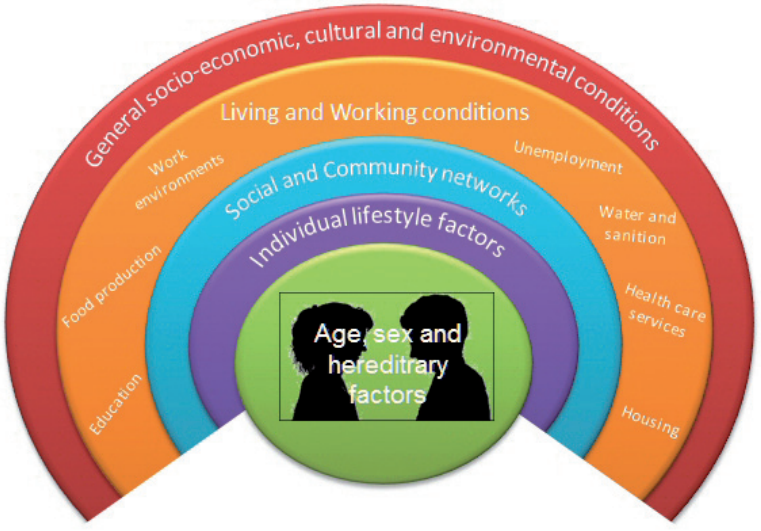
The social model assumes that health and illness have *multiple causalities*, ranging from individual factors (such as age and genetic inheritance) through group factors (such as lifestyles) to wider community factors (such as the quality of water and air supplies). It also assumes that health involves a combination of individual and wider social relationships.

Healthcare is a matter not simply for individuals, based around a doctor–patient relationship, but for societies as a whole. A range of individual, social and environmental factors and relationships combine to create healthy or unhealthy individuals. As an extreme example, people living in a war-zone without access to clean water, food and shelter will have demonstrably worse health than people living peacefully with access to the basic necessities.

The focus of this model, therefore, is not professionals and their patients (although these roles may be part of the overall health equation) but rather **demographic factors** — how, in basic terms, individuals and groups interact with their natural and social environment.

The biomedical model sees health as primarily a **private** concern — the health of the individual normally plays no part in the health of the community (except in the case of highly contagious diseases). In contrast, the social model sees health as mainly a **public** concern — the health of the community goes a long way towards determining the health of the individual.

Figure 11.2 The social model



Source: Dahlgren and Whitehead (1991)

Dahlgren and Whitehead (1991) represent the relationship between the individual, their social environment and health in terms of **layers of influence** (Figure 11.2). These layers capture the relationship between two types of asset: **fixed** and **modifiable**. At the bottom of the diagram are the fixed assets: those that can't be changed, including personal factors such as age and genetics. (Consider, for example, the greater vulnerability to illness of the very young and the very old, and the effect of hereditary diseases.) Above the fixed assets, the diagram shows several levels of modifiable assets. These are assets that can be changed and include the following:

- **lifestyle choices** (such as heavy alcohol use) that impact directly on the health of the individual
- **social and community influences** determining the levels of mutual support that contribute to, or minimise the likelihood of, ill health
- **living and working conditions** (e.g. the condition of people's housing and the nature of their work environments)
- **general social and economic conditions** which affect a whole society (e.g. the wealth or poverty of a society, whether it is peaceful or war-torn, levels of medical knowledge)

Evaluation

The social model has a number of strengths and weaknesses.

Strengths

- **Responsibility**: The responsibility for a population's health is shared throughout a community; illness is a 'collective problem' related to a range of social and economic conditions, some of which are the individual's responsibility (such as smoking and drinking), while others relate to community responsibilities (such as waste disposal, safe working conditions and the like). The model also highlights how large-scale **social inequalities** (such as extremes of wealth and poverty) contribute to individual health problems.
- **Community**: Government behaviour impacts on individual health. The provision of proper sanitation or adequate housing are factors beyond individual control that have significant impacts on individual health. Governments also have a role in ensuring that drugs and medical services known to injure health are controlled.
- **Diminishing costs**: The general health of a population improves as social and economic conditions improve (e.g. through the provision of clean water and air, or the banning of unsafe working conditions). Health is not based on constant technological developments in medicine.
- **Causality**: This approach focuses on the '*causes of the causes*' of ill health: the social conditions (poverty, malnutrition, unsanitary conditions and so forth) that *cause* disease which, in turn, *causes* individual ill health.

Weaknesses

- **Responsibilities**: Where health is seen as a collective problem, the question arises as to who is ultimately responsible for ill health — the individual? the community? some combination of both? It's not clear from the model where responsibility ultimately lies.
- **Entrenched interests**: Where a medical system is based on private profit, there is little incentive for health prevention because profits mainly lie in curing illness (through expensive individual treatments).
- **Victim blaming**: Where health is conceptualised as a community problem, it ironically becomes easier — once certain 'community responsibilities' have been met, such as the provision of clean water — to attribute ill health to the individual and their personal lifestyle choices.

? Identify and explain one strength and one weakness of the social model of health.

Morbidity and mortality rates

Whatever the actual model of healthcare in any society, we need some way of measuring its general effectiveness and we can do this using rates of **morbidity** (ill health) and **mortality** (death). For the moment we can simply define these concepts and note some general problems with them, as preparation for examining patterns and explanations for ill health in a later section.

Morbidity rates

These focus on the proportion of a population (such as the number per thousand) suffering ill health over a given period (such as a year) and are usually expressed in two ways:

- **General morbidity rates** provide a comprehensive picture of the health of a population, although they often aggregate a small range of important disorders rather than every form of ill health in a society. (Sweet (2011) notes that the three most common groups of disorder in Britain are cancer, circulatory diseases and respiratory diseases.)
- **Specific morbidity rates** examine the occurrence of specific diseases in a society or particular locality. They can be used to measure the effect of relatively minor illnesses (such as influenza) on a population.

Marshall (1998) notes two main ways in which morbidity data are collected:

- **official statistics** that 'provide data on persons who have had some contact with the health services — so-called "treated" cases'
- **community surveys** that involve asking people to self-report instances of ill health

Problems

Although official statistics may be consistently produced (all visits to a doctor or hospital, for example, are likely to be accurately recorded), there are a couple of major problems with **reliability**:

- One is the **iceberg effect**: the number reporting medical conditions is just the small, visible tip of the morbidity iceberg. Not everyone who develops an illness, for example, reports it to a doctor.
- People with the *same* symptoms or illnesses may or may not choose to report these to a doctor, making statistical comparisons difficult.

Marshall (1998) argues that the **validity** of official morbidity statistics is limited by 'illness behaviour'. This is affected by several factors:

- One is people's willingness to use health services. They may choose not to do so because they don't see their illness as particularly serious, or because they prefer to self-medicate or even use alternative medical treatments.
- Another factor concerns the ease of access to health services. For example, the time and effort involved in accessing services may outweigh any perceived benefits.

Self-report studies overcome these **methodological problems** to some extent because they provide information on illnesses unreported to the health service:

- They have greater **validity** because they include relatively minor illnesses that go unreported in official statistics.
- **Reliability** is more problematic since, as Marshall (1998) argues, the meaning of 'illness' varies from person to person (does 'feeling under the weather' count as ill?) and everyday (or 'lay') definitions of illness are often different from clinical definitions. If an individual 'feels ill' this will be included in self-report statistics even though their 'illness' wouldn't be diagnosed as such by a doctor. This may lead to an over-estimation of 'ill health' in a society.

Mortality rates

Mortality rates measure the proportion of people in a given population who die during a particular time period (such as yearly). Marshall (1998) suggests that if we know when and why people die, this gives an indication of their 'life-time health'. Mortality data are **reliable** and **valid** — every death in our society must be officially recorded. In addition, **death certificates** contribute to the reliability and validity of other statistics (such as average life expectancy) by recording a range of information about the deceased:

- cause of death
- age
- residence
- gender
- occupation

Death certificates

C ause
A ge
R esidence
G ender
O ccupation

Problems

- **Ageing populations**: These may have higher mortality rates, even though the *general health* of a society may be high because more people live longer.
- **Reliability**: It can be difficult to reliably compare mortality rates **historically** and **cross-culturally** because population differences, class, age and gender all affect such rates.

? Briefly explain the difference between morbidity and mortality.

Social construction of health and illness

Social construction, in this context, refers to the way different societies develop different ideas about concepts like health and illness. In other words, these concepts are socially constructed:

- There is no fixed, universal, agreement about their meaning.
- Their meaning changes over time and between groups.

Conrad and Barker (2010) suggest some ways in which health and illness are socially constructed:

- **Health**: There is no general agreement on how health should be defined.
- **Illness**: There are differences in what counts as illness and in how this state is seen by others. In some societies obesity is an illness, while in others it demonstrates health.
- **Knowledge of medicine**: This changes over time. What was once an accepted medical truth (e.g. smoking isn't bad for you) is often revealed to be mistaken.
- **Experience of illness**: People experience illness — even the same disorder — in different ways depending on a range of cultural factors (age, gender, class and so forth).
- **Sickness**: Some people conform to the **sick role**, others reject it and those who are chronically ill cannot play it.

Social construction
Health
Illness
Knowledge
Experience
Sickness

The meanings of concepts like health and illness are, therefore, relative in both time and space; interpretations change over time, across different societies and in different contexts. We can explore these ideas further in the context of cultural relativity and 'lay' definitions.

? Identify and explain one way illness is socially constructed.

Cultural relativity

The meaning of health and illness differs within the **same society** over time. The way we currently perceive mental illness is very different from how our society perceived it

400 years ago. As Foucault (1961) notes, 'the mad' in the seventeenth century were seen as being in touch with 'mysterious forces of cosmic tragedy'.

Similarly, there are arguments about the origin and nature of mental illness. On one side it is seen as having a physical reality that can be treated using medications. On the other, Foucault (1961) sees 'mental illness' as a category with no objective validity — it is whatever the powerful (in this case medical professionals) define it as being.

Meanings also differ **between cultures**, which again points to their social construction:

- **Homosexuality**, for example, is probably seen by most people in Britain as something that's socially acceptable, largely unremarkable and part of the normal sexual landscape. However, it has been classified in some cultures as a mental illness (it was listed as a 'mental disorder' by the American Psychiatric Association in 1952, although this classification was quickly revoked). Recent debates have focused around whether homosexuality has a *genetic origin*. Some Christian fundamentalist groups argue that it is a 'disordered state'. Whitehead and Whitehead (1999) argue that homosexuality is 'abnormal, unnatural' and can be changed (or cured) by therapy.
- **Symbolism**: Some cultures (in parts of China and India, for example) understand health in terms of the symbolic power of different foods ('hot' and 'cold') — health and illness involve the balance between these two types.
- **Prophetic medicine**: In Morocco, Martinson (2011) argues, medicine is based around a range of 'spiritual, psychological and socio-cultural' ideas that, while not totally rejecting biomedical models, see the treatment of patients in holistic terms; they locate health and illness in a context that considers biological, social and spiritual factors (with the latter involving aspects of 'faith healing').

Lay definitions

While 'official' definitions of health and illness are clearly important, individual or subjective definitions are also significant because they affect the way people react to things like illness. Lay definitions involve explanations of health and illness that are not always consistent with official definitions.

Lay definitions generally focus on **well-being**. Walters (2000) suggests that this is a

> broadly defined and positive state…a deliberate statement that the medical model is an inadequate description of health. The presence or absence of health is determined by the subjective assessment of the individual concerned, not by the objective assessment of others.

Walters notes that lay definitions generally involve a wider range of ideas about health and its (self-)assessment, based around notions like fitness, strength, 'energy,

vitality and psychosocial wellbeing'. People may 'define themselves as healthy despite having a disease'.

However, we shouldn't assume that lay definitions are somehow 'wrong' or 'ignorant of medical realities'; rather, we need to understand them as part of a complex process whereby people construct concepts of health and illness in ways that draw on different social, psychological and physical experiences. As Blaxter (1990) suggests, lay definitions involve a combination of two dimensions.

First, they involve an understanding of certain **attributes**, such as physical indicators of health and illness based on conventional biological notions. When we catch a cold, for example, there are a range of physical indicators, or biological attributes, that tell us we are 'ill' — a blocked nose, sneezing, headache and so forth.

WARREN GOLDSWAIN/FOTOLIA

Lay definitions of health often focus on vitality and well-being

Second, there is a **relational** dimension to lay definitions, based on how we react to biological attributes. Our perception of illness is conditioned by social factors, such as our class, age and gender. For example, different people react differently to catching a cold: a young woman might carry on with her busy life as if the cold is nothing more than a minor hindrance, while an older man might retire to his bed for a couple of days. To develop this point, we will look at a range of less stereotypical examples of the relational dimension to lay definitions. We will consider age, gender, education and social class.

Age

Blaxter (1990) argues that our society generally thinks in terms of **health capital** — we are born with certain hereditary health attributes (the most negative being inherited genetic disorders, the most positive being good health) that are progressively modified and diminished by social factors, such as those associated with age.

Blaxter found that the elderly reported more problems with mobility, eyesight and hearing than the young. These were seen as evidence of diminished health capital — as something that was to be expected and part of a **natural process**. The elderly 'lived with' experiences of pain and restriction that, in younger people, were more likely to be interpreted as evidence of disorder or illness. Lay definitions here see health as functioning — if you can look after yourself and carry out routine tasks, you are healthy.

Gender

The Office for National Statistics (2010) suggests that women are more likely to believe they are in poor health, but less likely to die over the following 5 years. Women are also more likely than men to visit their GP, although this is partly explained by **health routines**: women tend to visit their doctor for routine healthcare (such as gynaecological examinations and pregnancy health checks) and are also more likely to take their children for health checks. Men are more likely to see a visit to the doctor as something non-routine.

Education

Sen (2002) argues that higher levels of education are associated with higher levels of reported illness. For example, he found a greater willingness to report ill health in America than in India, even though mortality rates were lower and life expectancy higher in America. This finding is partly explained by the idea that greater knowledge of 'health problems' led to higher levels of reporting.

Social class

Blaxter (1990) found greater acceptance of ill health among the working class than the middle class. This was partly explained by their differing types of work experience (manual labour, for example, causing more 'natural wear and tear') and partly by their different attitudes to health; the working class showed a greater acceptance of pain and discomfort and a greater reluctance to visit the doctor for 'minor complaints'.

Calnan (1987) found that working-class and upper/middle-class definitions of health differed considerably. While the former defined it in terms of 'getting through the day' and 'never being ill', the latter saw it in terms of 'being active', 'feeling fit and strong', and as a 'state of mind'.

More recently, Beale et al. (2010) found that those in the lowest council tax valuation bands (who are most likely to be working class, although the fit is by no means perfect) were more likely to 'take their children to a doctor for everyday symptoms'. Although this seems to contradict Blaxter's findings, it fits with the idea of '**health capital**' and class — working-class parents are more likely to take steps to protect initial health capital in light of their experience of how it diminishes over time.

Lay definitions

W ell-being
A ge
G ender
E ducation
S ocial class

An overall view

In terms of an overall view of lay definitions, Williams and Popay (1994) argue that they:

- do not mimic medical views of health
- are logical and coherent assessments of health
- are biographical and based on lived experience
- are framed by cultural beliefs within different societies

? Identify and explain one difference between lay and medical definitions of health.

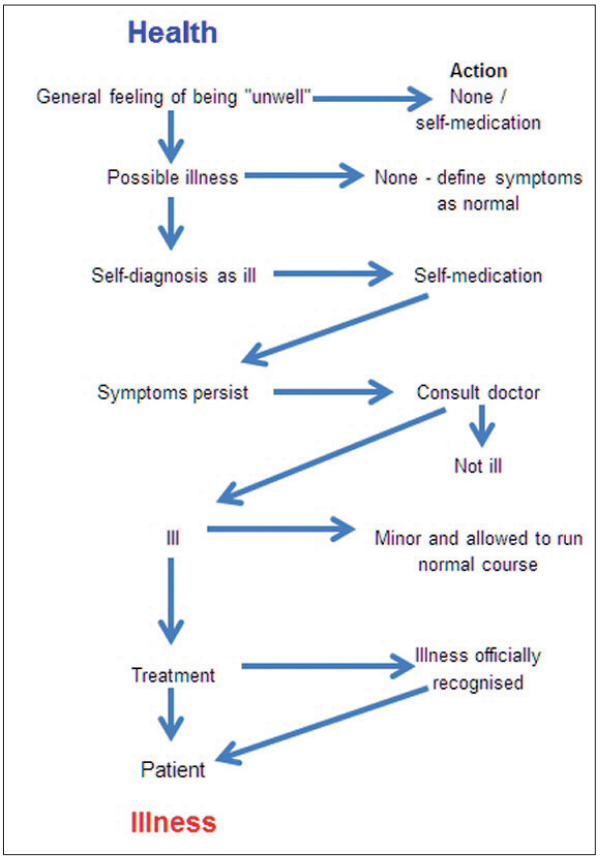
The social process of becoming ill

The relationship between 'health' and 'illness' is a complex one that involves a range of *definitions* (both official and lay, positive and negative) and *processes* (from identifying symptoms, through recognising them as 'illness', to having them officially validated as 'illness').

We can think of the social process of becoming ill in terms of a **labelling** process (Figure 11.3). It begins with the individual who recognises and accepts certain symptoms of illness. By so doing, the individual enters into a systematic process involving certain choices and decisions that ultimately lead to an **official classification** of illness. However, as the diagram suggests, the process may be stopped at a number of points for various reasons:

- Symptoms disappear and no illness develops.
- Symptoms initially interpreted as illness are reinterpreted as 'normal'.
- Self-medication (in the form of rest or over-the-counter drugs, for example) proves effective.
- The doctor finds no evidence of illness.
- Doctor-validated illness proves to be minor and no treatment is required.

Figure 11.3 The social process of becoming ill



Source: adapted from Lawson et al. (2000)

The social process involves three forms of validation:

- Self-certificated illness simply involves the individual 'feeling unwell'.
- Other-validated illness involves the unwell individual convincing (or being convinced by) others, such as family, friends, or work colleagues, that they are ill.
- Doctor-validated illness is the stage at which an illness becomes 'officially defined' as such.