Chapter 1

Health and illness as social issues

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Learning objectives

After studying this chapter, you will be able to:

LO 1.1 Apply the sociological imagination

LO 1.2 Explain the relevance of social structure and agency

LO 1.3 Explore examples of social construction

LO 1.4 Differentiate the biomedical and social models of health

LO 1.5 Compare and contrast the different sociological paradigms for examining health and illness

Introduction

> It can be said that the first wisdom of sociology is this – things are not what they seem. (Berger 1963, p. 23)

Berger's quote provides a challenge to us to look at the society around us with fresh eyes, and pretend we have never seen or encountered it before. This is hard because the everyday world is very familiar and known to us; so much so that we don't often think about why things work the way that they do. By suggesting 'things are not what they seem', Berger is highlighting that our society is created and, by seeing and understanding it as such, we can observe how it works, examine why it works that way and start reflecting on how things could be different. It is an invitation to be curious about the social world. This invitation, and the challenges that come with it, is what we pick up in this chapter, guiding you through what it means to think like a sociologist and to view health and illness through a social and sociological lens.

Sociology of health and illness, which is sometimes also called medical sociology, advances knowledge about health issues by moving beyond psychological or biological explanations. This can be challenging for some, as our society is so entrenched in understanding health issues as personal responsibilities that are embedded within individualistic explanations. Part 4 of this text titled 'Social meanings and experiences of health and illness', which discusses Indigenous health, mental health, ageing, disability and sexuality, moves away from the individualistic, psychological and biological explanations, and presents social patterns of health and illness in these domains.

Seemingly intractable social issues are presented throughout this text and viewed through a variety of theoretical perspectives. Sociology as a discipline is interested not only in how things occur but also why they do. The explanatory theories presented provide insight into the multiple aspects of the social issues at hand.

Case study: Esi, Malika and Ada

Esi stared down at the beautiful baby in her arms. It was late last night – or was it in the early hours of the morning – that Ada had come into this world. As she took in the minutiae of her baby, the hours leading up to coming to the hospital were blurry for Esi. She and her partner Malika had been planning for natural birth. They had practised the Bradley Method for months and both had felt sure of a natural birth. Labour had progressed well at home, giving them a sense of confidence. When the contractions were getting closer, longer and more painful, Esi and Malika had decided to call their obstetrician. After asking some questions, the obstetrician asked for Esi and Malika to come into the hospital. When they arrived at the hospital, Malika was referred to as Esi's 'friend', which they both found upsetting but they ignored it because they were focusing on their baby's birth. There was no room on the hospital admission form to indicate that Malika was also the mother, nor her relationship to Esi. While their obstetrician had been very supportive of their journey to become parents, Malika found these admission processes in the hospital to be marginalising and hurtful.

In the hospital, Esi's private room provided comfort and privacy as she struggled to move to a sitting position to feed Ada. Thinking back, she wondered why labour had slowed down so much once they arrived at the hospital. She recalled the midwife putting the monitor on her to check the baby's heart rate during contractions, and the obstetrician examining her and indicating that it would be best to have a caesarean section because it appeared that the baby was in distress. When given this information, Malika and Esi had not hesitated to say 'yes' to a caesarean section even though Esi had wanted to give birth naturally.

Esi was feeling joyful as she sat with Ada, a healthy baby who was already breastfeeding. She smiled with Malika in happiness at their becoming parents, reflecting on the contrast between their life in Australia and what it would have been like in the African country of their birth, where they would not have been able to live as a couple and have children together. But Esi couldn't shake the feeling of being disappointed in herself. She felt that somehow her body was not able to do what it was supposed to do and give birth to her baby naturally. When Malika shared her hurt at the admission process, Esi also felt upset. After settling in with their new routine as parents, they decided to share the experience with a LGBTQIA+ health association in the hope that their experiences at hospital admission would not happen to other same-sex parents.

The sociological approach

In this section, we will introduce you to some key concepts that sociologists use when thinking about and examining the world around them. For some readers, this section will be a refresher while, for others, these ideas might be new. However, although we are introducing these key sociological concepts as part of our examination of the sociology of health and illness, they are relevant for all fields within sociology. These concepts demonstrate that doing sociology requires a particular way of thinking.

Sociological imagination

A useful concept for thinking sociologically is the **sociological imagination**. The sociological imagination allows an individual to scrutinise how and why society works in the way that it does, and to imagine how society might be different. This means that the sociological imagination is a valuable tool to think about the relationships between structure and agency (concepts we will introduce you to later) and the outcomes and consequences of that relationship, and to propose alternative ways, ideas and solutions. According to Charles Wright Mills (2000, originally published in 1959), 'the sociological imagination enables us to grasp history and biography and the relations between the two within society. That is its task and its promise' (Mills 2000, p. 6). In other words, to understand people we must do so in reference to their

sociological imagination
A concept associated with C. Wright Mills (2000) that involves examining the relationship between personal troubles (or private matters) and public issues by considering the connection between the individual's biography and history. Willis (2020) develops the concept further by encouraging examination of four social aspects: history, culture, structure, and critical thinking. The sociological imagination can help us to see the connection between agency and social structure.

social context as well as their history. To achieve this involves considering 'the personal troubles of milieu' and 'the public issues of the social structure' (Mills 2000 p. 8). To put this another way, the sociological imagination involves examining the relationship between personal troubles (or private matters) and public issues. In essence, this is about seeing the connection between the individual (agency) and the organisation and function of society (social structure).

To assist with applying the sociological imagination and finding the connections between personal troubles and public issues, Australian sociologist Evan Willis (2020) suggests reflecting on four social aspects: historical, cultural, critical and structural. While these aspects are presented separately, they should be considered interconnected and interdependent. This is detailed further in Figure 1.1.

To apply the sociological imagination, let's return to the case study. Esi's experience of an emergency caesarean section (CS) could well be understood by Esi as bad luck and that the biological experience of labour resulted in the unique experience of a CS. However, if we look at the 2019 statistics of pregnancy and childbirth in Australia (see Table 1.1), we see that 30.7 per cent of women giving birth for the first time had a CS (Australian Institute of Health and Welfare (AIHW) 2021). This rate varies according to insurance status, with some private hospitals reporting rates well over 50 per cent (see the chapter, 'Choosing healthcare'). Armed with these statistics, some women will realise that medical interventions such as a CS are not necessarily the result of their physiology. That is, because this is experienced by so many people, CS is a public issue.

Moving beyond the statistics and picking up the four interrelated parts of the sociological imagination (according to Willis 2020) can assist us in further understanding how the historical (how the past influences the present), cultural (how culture will impact on our lives), structural (how the different social organisations in society can impact on our lives) and critical (how can we improve our society?) factors can make sense of the experience of Esi and Malika.

The chapter 'Researching health and illness' in this text shares a few birthing narratives of a study that sought to better understand the increase in medical intervention during pregnancy and childbirth in Australia during the early 2000s (Possamai-Inesedy 2006). Pregnancy and childbirth are treated as medical events that need to be managed rather than as natural events that need to be monitored. As such, they occur largely within a hospital system – and, as the chapters 'The Australian healthcare system', 'Choosing healthcare' and 'The therapeutic encounter'

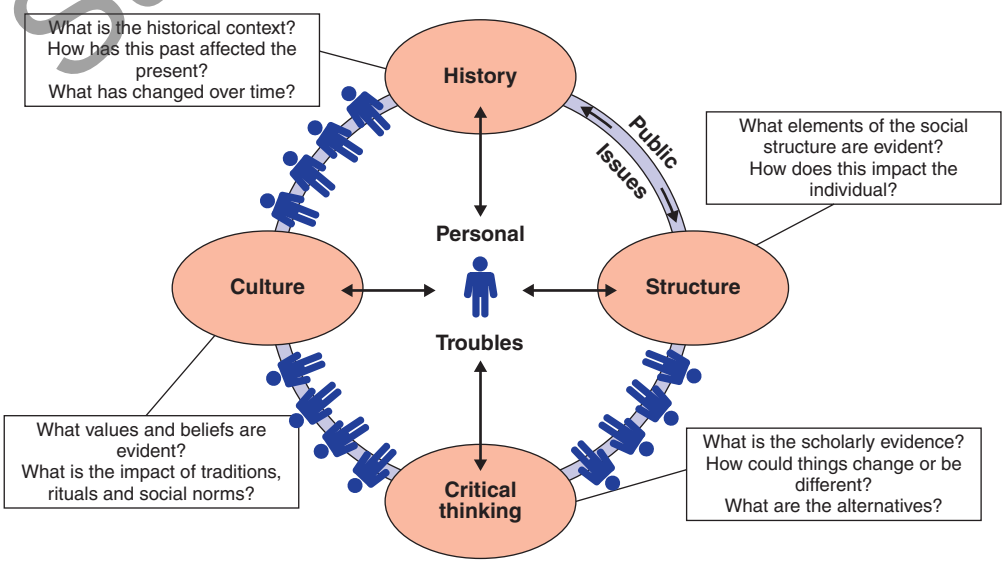

FIGURE 1.1 The sociological imagination, illustrating the relationship between public issues and personal troubles, and accounting for history, culture, structure and critical thinking

Table 1.1 Caesarean section for women giving birth for the first time by state/territory of birth, 2004–19

STATE/TERRITORY	2004	2005	2006	2007	2008	2009	2010	2011
New South Wales	22.7%	23.8%	24.6%	24.8%	25.0%	25.6%	25.6%	26.0%
Victoria	24.7%	25.2%	24.8%	24.8%	24.7%	n.a.	23.1%	26.6%
Queensland	27.2%	28.8%	29.6%	29.3%	29.2%	28.6%	27.6%	28.8%
South Australia	28.7%	30.0%	29.5%	29.5%	27.1%	27.2%	28.0%	28.9%
Western Australia	29.7%	30.6%	28.1%	27.4%	27.5%	29.7%	29.3%	29.7%
Tasmania	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Northern Territory	28.7%	28.8%	26.8%	27.1%	25.7%	27.4%	23.8%	30.0%
Australian Capital Territory	21.7%	22.0%	23.1%	22.8%	21.8%	22.3%	25.6%	27.5%

STATE/TERRITORY	2012	2013	2014	2015	2016	2017	2018	2019
New South Wales	25.7%	26.4%	27.2%	27.2%	28.1%	28.1%	28.8%	29.7%
Victoria	26.3%	27.5%	27.9%	27.6%	28.2%	29.1%	30.2%	32.1%
Queensland	28.8%	28.3%	27.6%	27.6%	27.5%	29.2%	30.5%	30.0%
South Australia	28.3%	28.8%	30.1%	29.9%	31.1%	29.4%	28.6%	28.2%
Western Australia	29.5%	29.1%	29.9%	30.3%	31.3%	33.6%	34.5%	33.7%
Tasmania	n.a.	26.8%	25.3%	27.8%	28.5%	27.8%	30.8%	31.3%
Northern Territory	29.6%	27.6%	31.6%	30.8%	25.7%	26.3%	25.8%	25.9%
Australian Capital Territory	26.2%	26.8%	25.8%	25.7%	26.1%	28.4%	28.5%	29.0%

Source: Australian Institute of Health and Welfare (2021). 'Caesarean section for women giving birth for the first time by state/territory of birth, 2004 to 2019', *National Core Maternity Indicators,* Labour and birth indicators: Caesarean section, AHIW analysis of NPCD data, 18 November, AIHW, Canberra.

detail, hospitals are bureaucratic organisations. Pressure could be placed on the process of labour itself, including how long labour should last. The personal experience of Ada's birth – which Esi is starting to see as a personal trouble – can be better understood by seeing it as a public issue. This is why you will find natural birth advocates make use of official statistics such as those found in Table 1.1. Statistics such as these help birth advocates to move the arguments regarding childbirth and labour away from individualistic explanations to structural ones.

Social structure and agency

Within many societies across the world, there is a belief that individuals are in control of their own lives, including the choices they have. The problem with this assumption is it fails to consider the power of society, and how this can enable and constrain the opportunities and life chances for individuals. What sociologists are interested in is the relationship between individuals and the society (or societies) in which they live. Instead of looking inside the individual to explain things such as patterns of behaviour, human relationships and personal choices (for example, a psychological approach), sociology looks beyond the individual – as illustrated by the sociological imagination – to consider the impact of the various elements and factors that make up a society. Sociology seeks to understand the individual and their relationships within a wider collective and society.

social structure
The interconnected social forces and social relationships that work together to shape society and the people in it. It consists of social groups, culture and social institutions.

agency
The ability of individuals to act independently and collectively, and to make their own choices within the society in which they live. The degree to which an individual can do this is a topic of debate in sociology.

social institutions
The complex forms of social organisation that are geared towards meeting the social needs or preferences of a population, and which have set rules or regulations that must be followed as well as their own procedures and practices. Examples include the legal system, government, education, economy, family, law and healthcare/medicine.

culture
The learned rules and practices of everyday life in human society, spanning from rituals and language to values and belief systems, which allow shared meanings to be created.

social groups
The shared characteristics between people that are defining features or attributes. In some cases, social groups may create a sense of belonging, but they are not always cohesive. An individual can belong to multiple social groups. Examples include class, gender, race/ethnicity, sexuality, (dis)ability and age.

To achieve this, a key component of thinking like a sociologist is to understand the components of society. This involves considering the relationship between **social structure** (or structure) and **agency**. Social structure refers to interconnected social forces and social relationships that work together to shape society. Sociologists seek to understand the dynamics and interrelationships between the different components of the social structure, and its relationship to individuals. While there is some debate about the features of the social structure, here we understand it to include three major components (see Table 1.2):

- **social institutions**: the complex forms of social organisation that are geared towards meeting social needs or preferences of a population, and which have set rules or regulations that must be followed as well as their own procedures and practices
- **culture**: the learned rules and practices of everyday life in human society, spanning from rituals and language to values and belief systems, which allow shared meanings to be created
- **social groups**: shared characteristics between people that are defining features or attributes. In some cases, social groups may create a sense of belonging, but they are not always cohesive. An individual can belong to multiple social groups, which relates to **intersectionality**. Social groups are a form of **social stratification**.

Table 1.2 provides some examples of each of the three components of the social structure. Overall, the social structure is a way to understand social relationships in a society, and how a particular society works. As such, while the three components of the social structure can be found in any society, the features of the social structure and how it works can significantly differ between societies. In turn, within any given society, the social structure will impact on how individuals understand the world and their place within it. Because of how influential the social structure is in forming and creating individuals, it seems to pre-exist us as and, as such, the social structure appears to be enduring and 'fixed'.

Table 1.2 Examples of social groups, culture and social institutions within the social structure

SOCIAL GROUPS	CULTURE	SOCIAL INSTITUTIONS
Age	Beliefs	Government/state
Gender	Values	Education
Class	Social norms	Economy
Race and ethnicity	Language	Healthcare/medicine
Sexuality	Customs	Family
Ability	Everyday practices	Law

The social structure has significant influence over who we are and what we do. However, that is not to say individuals have no choice or control. This is where agency becomes important. Agency refers to the ability of individuals to act independently and collectively, and to make their own choices within the society in which they live (see the chapter, 'Medical tourism'). The degree to which an individual (or a collective of people) can do this is a topic of debate in sociology, but it is worth noting that because society is a social construction, individuals can shape society as well as be shaped by it. As such, our actions both as individuals and as part of a collective can reaffirm the status quo of society or, on the other hand, challenge and change it.

Social movements such as MeToo and Black Lives Matter are good examples of groups of people who are working together to try to influence and create social change (see the chapter, 'Sexuality').

Figure 1.2 illustrates the different components of the social structure and its relationship to agency. By placing the individual (agency) in the middle of the social structure, we wish to indicate the strong dynamic and interdependence between individuals and society, and that the social structure will influence many of the choices individuals make. As we learned as undergraduate sociologists, it's not that the individual is weak – it's just that society is so pervasive and strong.

Social construction

As already noted, how society works is a **social construction**. Social construction is an important concept in sociology. It refers to how knowledge and meaning are created by humans in interaction with each other and applied to a phenomenon or object, or to create a new category or thing. As such, social construction is a process of meaning-making.

Social construction is useful because it provides the ability for people to understand and communicate about the world around them. The outcome of this process, however, can lead to negative social sanctions and, in turn, new medical classifications that marginalise and stigmatise population groups (refer to the section on interactionism later in this chapter). In the chapters 'Mental health' and 'Sexuality', social construction is illustrated by how same-sex attraction was historically classified as a mental health disorder, and in the chapter 'Disability', it is noted how there are different and shifting ways of classifying and understanding disability (for further reading, see Conrad and Barker 2010). We can also see how social construction is applied to parenthood in the case study, as Malika found no space on the admission forms to indicate her relationship to Esi and that she too was the mother of their baby.

The introduction of social construction as a concept can be attributed to Peter Berger and Thomas Luckmann (1966). Berger and Luckmann define social construction by examining how it works. They argue that what we understand as social reality and society is only possible because humans create it through interacting with each other within particular social contexts. This allows us to form a sense of 'social reality' that relates to that context, including learning how things should be done. Repeating these interactions over and over again is what Berger and Luckmann called **habitualisation** (that is, what we need to do or say becomes habit). This habitualisation means we have internalised these social expectations, which also allows us to predict what the actions of others will be.

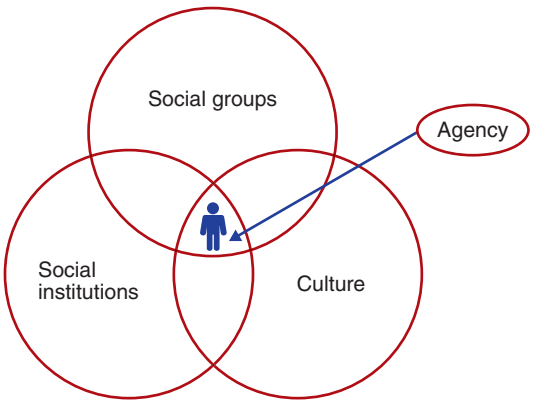

FIGURE 1.2 The dynamic and interdependent relationship between structure (social groups, social institutions, culture) and agency

intersectionality
Intragroup differences within a social group of people sharing a common identity, whereby individuals may belong to multiple social groups. An example of intersectionality is a person with African heritage (race/ethnicity) who identifies as a woman (gender) and a lesbian (sexuality).

social stratification
The categorisation or ranking of people into groups that are unequal in statuses and power. These categories include social groups but also other social factors such as family, wealth and education.

social movements
A group of individuals and/or organisations that come together with a shared interest who seek to resist, create or revisit social reorganisation.

social construction
A process of meaning-making. It involves humans in interaction with each other, creating knowledge and meaning and applying these to a phenomenon or object, or the creation of a new category or thing. This allows people to develop and communicate understanding and to shape reality.

habitualisation
social patterns, expectations and norms have been internalised, which also us to determine our actions and predict what the actions of others will be.

A simple example is lining-up behaviours. We know that when we want to purchase groceries from a supermarket, we must wait our turn in line. When the line moves, we move up with it. If someone tries to skip the line or push in, they may seek to explain their behaviour, or people waiting in the queue may tell them that there is a line or shoot them a dirty look for their 'deviant' behaviour. These reactions are a way of restoring social order. However, lining-up behaviours will change depending on what the line is for. Compare, for example, lining up at the supermarket to lining up to use an automatic teller machine (ATM) – the social distance between people differs. To complicate this matter, different societies may line up for different things, or the personal space between those in the line may be different from what we are used to.

The power of social construction lies in that much of the meaning-making and understandings human society has generated have shaped our expectations and are taken to be 'facts'. Because these become common sense and taken-for-granted knowledge, social constructions often go unnoticed, unscrutinised and unquestioned. Someone jumping a line, and how we might react to such behaviour, is an example of when social construction becomes exposed. The sociological imagination is one tool that enables us to examine the social world and thus expose – and unravel – social constructions. It is worth here returning to the quote that started this chapter: 'It can be said that the first wisdom of sociology is this – things are not what they seem' (Berger 1963, p. 23).

It is important to note that to say something is socially constructed doesn't mean that the category or 'thing' is not important or real. Rather, understanding social phenomena and objects as socially constructed can help to reveal how important and relevant they are to human society. Social construction as a concept is about understanding how we come to know and give meaning to social phenomena and objects. Applying this as sociologists of health and illness involves appreciating that there are many ways of defining and making sense of health and illness, and these are dependent on and variable by time (history) and place (social context).

Sociological approaches

In addition to structure, agency and the sociological imagination, sociologists have a range of sociological paradigms that can be applied to understand and explain social phenomena. Each paradigm offers a different perspective. How a sociologist may choose which paradigm is relevant will depend on the nature and purpose of the research, as revealed by the research question/s, research aims or objectives and who the target audience might be (see the chapter, 'Researching health and illness'). For example, when sociologists are contracted by government agencies or industry bodies, the types of analysis and the writing approach that needs to be undertaken to provide reports and recommendations or indicators for change can be very different from when writing for an academic audience. As such, when doing sociology, it is always important to be mindful of why the research is being undertaken, what the direction and focus of the research are, and who will be the end user (or reader) of the research findings (see the chapter, 'Researching health and illness'). Later in this chapter you will be introduced some different paradigms that sociologists use.

Pause and reflect

1. What is the role of sociology in studying of health and illness?
2. How can the sociological imagination make sense of personal health problems?
3. How does culture influence definitions of what or who is 'healthy' or 'sick'?

The biomedical and social model of health

What we have just introduced you to (or reminded you of) is what it means to think like a sociologist. In this section, we will examine the biomedical and social models of health. We will outline and compare the two models and what they have to offer. As sociologists, we of course have a bias towards the social model of health, but we by no means dismiss the biomedical model. Both models offer different understandings of health (and illness), and for different ends. We believe that problems emerge when the social privileges of the biomedical model results in other understandings of health and illness being ignored, and this can cause negative and long-term outcomes for individuals and populations. This is something we will return to later in the chapter when examining concepts such as medicalisation.

The biomedical model of health

The medical model pursued in the Western world is the **biomedical model** of health (or the Western biomedical lens) (see the chapters, 'Sexuality' and 'Indigenous health'). This model arose with the processes of Industrialisation and became the dominant model in Western societies by the early 1900s. Before this time, illness was treated with herbal remedies or interventions such as prayers. During Industrialisation, science, progress and 'rationality' replaced religion, tradition and 'irrationality'. The new privilege of scientific and medical knowledge, along with social changes bringing better sanitation, cleanliness, education and food (which are public health interventions), led to significant improvements in population health. Today, most people see the biomedical model in circumstances where acute situations must be handled.

biomedical model
The conventional approach to medicine in Western countries, which is focused on health in terms of purely biological factors. It is based on the diagnosis and explanation of illness as a malfunction of the body's biological mechanisms.

Keeping this in mind, Nettleton (2021, p. 2) outlines six features of the biomedical model (see also the chapter, 'Indigenous health'):

- **Mind-body dualism**: This suggests that the physical, biological body can be separated from the thinking, non-corporeal mind. This is known as Cartesian dualism, whereby the mental (consciousness/mind) and physical (body) are considered different substances, and the mind can exist without the body. Historically, the mind-body dualism allowed medicine to separate its practices (focused on the body) from religion (focused on the mind). In medical practice, this means reports from patients can potentially be ignored as too 'subjective'. The separation of the mind-body also means they are seen to not influence each other (for example, see Gendle 2016): the ill body can be treated separately from the patient's mind (see the chapter, 'Emotions').
- Reductionist: The separation of the thinking mind from the physical body leads to **biological reductionism**. That is, explanations for ill-health are based on 'what's wrong' with the individual's body, which often overlooks and underplays the complex role of social, psychological and environmental influences on health and wellbeing.
- Mechanical metaphor: This metaphor equates the human body to a machine (for example, see Cook and McCarthy 2007; Sontag 1978). Biomedicine identifies the physical component that is broken or dysfunctional and seeks to repair it. Another way to think about this is that surgeons are like car mechanics: they identify the failing part and repair or replace it. This objectifies the body (and the patient) and reinforces the mind-body dualism by separating the thinking and physical self.
- **Technological imperative**: This means that because the technology is available, it should be used regardless of whether it is needed or not. It implies that technology is inherently 'good' and 'objective', and will provide the answers to what is causing ill health. Because of these beliefs, technology *must* be used to prevent, identify and treat illness. These

mind-body dualism
An understanding of mind and body, reason and emotion, as separate objects, attributed to the 17th-century philosopher and mathematician René Descartes.

biological reductionism
The separation of the thinking mind from the physical body. The focus on the physical body only overlooks and underplays the complex role of social and psychological influences on health and wellbeing.

technological imperative
The belief that because technology is available, it must be used or, in the case of developing technologies, that they will be used. It includes the belief that technologies are inevitable, essential, objective, should be developed, and are unquestionably good for society.

technologies include the exotic (e.g. life support machines, computerised tomography (CT) scans, deep brain simulators and magnetic resonance imaging (MRI)) and the mundane (e.g. tongue depressors, stethoscopes, pharmaceutical drugs and blood-pressure monitors). The expansive use of technologies adds to the costs of healthcare, including frequency of use, maintenance and upgrades, as well as the associated knowledge (e.g. those who can use, maintain and develop the technologies).

- Doctrine of specific aetiology: Diseases are caused by biological faults (e.g. genetics), failings (e.g. accidents or individual behaviours) or foreign substances (e.g. viruses) that have entered the body. Therefore, the causes of all illnesses and diseases have a specific and identifiable cause or agent that is in or on the body (**aetiology**).
- **Universal**: This means that once a treatment for a specific illness is identified, it is assumed that the illness will present in the same way across all people (that is, they will present the same symptoms) and, as such, treatments can also be applied in the same manner across everyone. Note that in later chapters, 'universal' is used to refer to a specific form of the healthcare system (see the chapters, 'The Australian healthcare system', 'Choosing healthcare and 'The therapeutic encounter').

aetiology
The doctrine that the causes of all illnesses and diseases have a specific and identifiable cause or agent that is in or on the body.

universal
The assumption that once a treatment for a specific illness is identified, the illness will present symptomatically the same each time and treatments can also be applied in the same manner. This definition differs from that of universalism in Australia's healthcare sector.

The biomedical model focuses on individuals, treats acute illnesses, concentrates on cure (also known as the curative model), seeks biological explanations for illness, applies a 'one size fits all' model, requires medical professionals to be objective, separates the mind and body, and uses expensive mundane and exotic technologies. Furthermore, it is assumed that the only way to think about and treat illness is through medical specialists and the scientific method, which helps to reinforce these six features of the biomedical model. (Return to the case study to see how the biomedical model might be applied to what happened to Esi.)

While medical practitioners today may vary widely in how closely they adhere to the biomedical model, the above descriptions remain true of contemporary biomedicine. For example, developments in precision medicine (also known as personalised medicine) may challenge the biomedical model through an individualised, 'tailored' treatment approach that is opposed to universalism, but precision medicine is nevertheless pitched as objective and impartial, typically focused on acute illness, driven by a technological imperative and biologically reductive (Olson and Cook 2018). Furthermore, the biomedical model stands in contrast to First Nations worldviews (see the chapter, 'Indigenous health').

Because the biomedical model has strong focus on treating and curing illness when it arises, it has a negative conception of health because being healthy equates to the absence of ill health, disease and disability. In places such as Australia, this approach to health and illness has been widely accepted. We can see this not only in our individual and familial interactions with healthcare professionals but also in how healthcare funding is distributed by the government. How much government funding different forms of Australian healthcare receive is complicated by the complexity and fragmentation of the Australian healthcare system (see the chapter, 'The Australian healthcare system') and the 'significant differences [that] exist in how different institutions classify general practice and PHC [primary healthcare] spending' (Wright, Versteeg and van Gool 2021, p. 673).

Figure 1.3 illustrates Australian Government healthcare spending in 2017–18. This reveals that hospitals receive the bulk of funding (39.9 per cent), followed by primary healthcare (PHC) (34.2 per cent) (Wright, Versteeg and van Gool 2021, p. 675). PHC consists of numerous services, including general practice, allied health, dentistry, pharmacy and community health services. Significantly, public health (which includes preventative health) received only 1.6 per cent from the total Australian healthcare budget in 2017–18, despite the population-wide health benefits it can bring (as noted earlier).

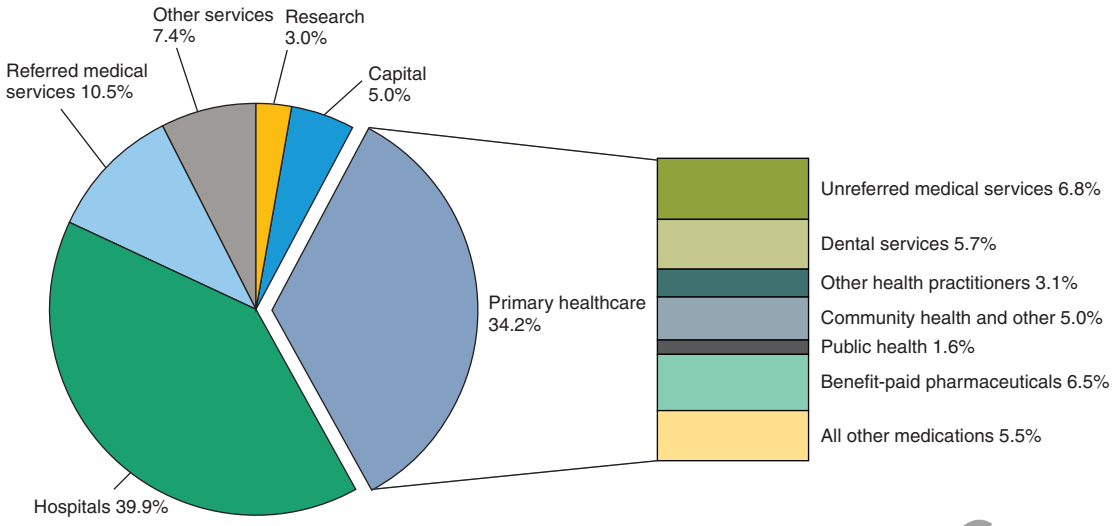

FIGURE 1.3 Classification of total health expenditure and breakdown of primary healthcare spending

Source: Reproduced with permission from The Royal Australian College of General Practitioners, from Wright, M., Versteeg, R. and van Gool, K. (2021), 'How much of Australia's health expenditure is allocated to general practice and primary care?', *Australian Journal of General Practice* 50(9), pp. 673–78, DOI: 10.31128/AJGP-11-20-5746. Available at https://www1.racgp.org.au/ajgp/2021/september/general-practice-and-primary-healthcare-health-exp

The social model of health

Ultimately the biomedical model seeks to explain the conditions of illness and disease solely through biology and genetics. These explanations tend to feature regularly in the media, such as reports on the genetic causes of alcoholism and obesity. Sociologists disagree with this perspective because it ignores or marginalises how health and illness manifest through the social world, social experiences and social understandings. That is, our sociocultural, environmental and historical contexts have significant impacts and outcomes for how health and illness are defined and experienced. For example, while an individual might have a genetic predisposition to develop a disease, the many interacting elements of the social environment can influence whether disease manifests or not. Furthermore, many illnesses and disabilities do not have a genetic component and arise from our life experiences.

The **social model of health** looks beyond the biology and genetics of individuals to consider the influences and impacts of society on health, illness and wellbeing. What the social approach to health advocates is that you cannot separate an individual nor their health from the social contexts and conditions in which they live, and these social contexts and conditions will impact and influence who an individual is and what they experience in life. This connects back to our earlier examination of social structure and agency.

social model of health
A model that focuses on the influences and impacts of society and the individual's social contexts on health, illness and wellbeing.

To examine the social factors that can influence health, let's consider the following short extract from Engels' book, *The Condition of the Working Class in England in 1844*:

> I never saw the peculiar bending of the lower ends of the thigh bones before I came to Leeds ... Thus far I have seen about a hundred such cases, and can, most decidedly, express the opinion that they are the consequences of overwork. So far as I know they were all mill children, and themselves attributed the evil to this cause. The number of cases of curvature of the spine which have fallen under my observation, and which were evidently consequent upon too protracted standing, was not less than three hundred (Francis Sharp, cited in Engels 1892, p. 153).

In this extract, Francis Sharp (a member of the Royal College of Surgeons) is describing physical abnormalities he was observing in teenagers between the ages of 14 and 18. Based on the biological presentation, Sharp originally thought these teenagers had rachitis (now known as rickets). However, with the age indicator of rachitis being 8 to 14 years of age, Sharp questioned this medical diagnosis. In doing so, Sharp went beyond the biomedical model and applied a social model of health. Specifically, Sharp noticed that all his patients had the same physical abnormalities, had the commonality of physically demanding jobs with repetitive actions and worked long hours. This allowed Sharp to make a connection between disability and working conditions: the injuries experienced by the mill children may have been physical, but the injurious cause was not biological – it was from work routines or practices that did not protect their personal safety and wellbeing. While Sharp may have been able to treat some of the side effects from their disability, he could not manage nor deal with the cause. The social model of health indicates the need to consider wider social environments, and how they play a role in health, illness and wellbeing.

In the extract from Engels, we can also see the connection between health and socio-economic status: mill children came from poor families who needed their children to contribute financially to the household income and therefore to be in paid employment. In turn, this reflects on the economic system of that society at a specific time in history. While there are now laws and prohibitions against child labour in many parts of the world, as well as minimum-wage laws, it is notable that socio-economic status remains associated with health status. In Australia, people with high socio-economic status have lower rates of mortality than people with low socio-economic status (see Figure 1.4). The living and working conditions of individuals and populations groups, as well as socio-economic status, therefore remain a strong focus in the social model of health. This relates to the **social determinants of health**.

social determinants of health
The social and environmental conditions in which people are born, grow, work, live and age and the structural factors (social, economic, cultural) that shape health outcomes for individuals and groups.

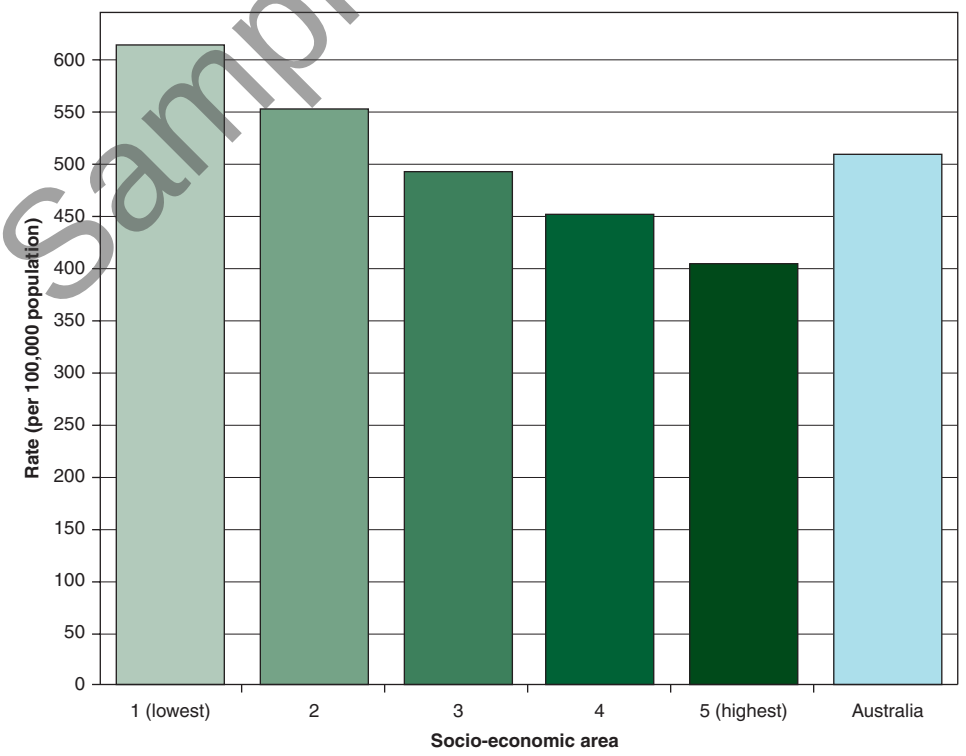

FIGURE 1.4 All-cause mortality rate by socio-economic area from lowest to highest, Australia 2018

Source: Australian Institute of Health and Welfare (2020). 'Australia's Health 2020: Health across socioeconomic groups', Snapshots, Figure 3, AIHW, Canberra.

The World Health Organization defines the social determinants of health as:

> ... the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. (World Health Organization 2022)

As such, the social determinants of health consider the social patterning of health. This involves examining how the interactions between social structure (particularly social groups) and agency impact on the health of individuals and populations. This requires a different approach to examining health from that of the biomedical model. The individual focus of the biomedical model, including the acute treatment of people who are ill, cannot account for – nor address – the influence and power of wider society. The social model of health therefore moves the responsibility of health away from the individual and towards society.

As the social model of health involves considering the social determinants of health, it is not surprising that some of our students have thought that the sociological approach to health and illness is no different from a social determinants of health approach. Certainly, the social determinants of health are important for understanding the social distribution of health, and health inequality and inequity. For sociologists, however, the social determinants of health are just a starting point.

Part of the sociological approach to health and illness includes interrogating social factors that might be missed in social determinants of health approaches. For example, numerous scholars have called for an expansion of the social determinants of health to encompass other factors that historically have been missed or, worse, ignored.

For example, Czyzewski (2011) has argued that **colonisation** should be included as a social determinant of health (see the chapters, 'The Australian healthcare system' and 'Indigenous health'). This is because while acknowledging that some social groups may have poorer health than others, it is also vital to recognise that within the social structure there are uneven distributions of power and resources that facilitate systematic inequality, and additional social burdens and exclusions for some social groups. For Indigenous and **First Nations peoples**, this occurs on a global scale. The importance of considering the legacy of colonialisation has led to the emergence of postcolonial theoretical perspectives to privilege the perspectives and needs of First Nations people, and address the structural inequalities emergent from the social, historical and political contexts that continue to impact their lives and health (Browne, Smye and Varcoe 2005; Sherwood 2013). As such, ethnicity alone cannot explain the differential health status between White Australians and First Nations people – colonialism must be taken into account (see the chapters, 'Indigenous health' and 'The Australian healthcare system').

Another argument is that different forms of discrimination should be considered social determinants of health. As explored in the chapter, 'Ageing', the World Health Organization (WHO 2021) reports that one in two people worldwide hold ageist beliefs against older people. These beliefs impact on healthcare delivery to older people, and older people's health and mortality. In addition, addressing **ageism** could not only reduce healthcare costs to individuals and society, but it will also improve the health, welfare and longevity of older people (Curryer and Cook 2021).

In addition, the social determinants of health approach does not adequately consider intersectionality. For a moment, return to the case study. Both Malika and Esi migrated to Australia from an African country where same-sex relationships are illegal. They are from two social groups that can experience social marginalisation and discrimination in Australia: sexuality (same-sex attraction) and race/ethnicity (African). Some of their experiences will be like those of other people who are same-sex attracted, but they will also be different because of their African heritage (and vice versa).

colonisation
An ongoing process, rather than a historical event, of establishing and maintaining power and control over the lands, lives and wellbeing of Indigenous peoples.

First Nations peoples
Indigenous peoples of Australia (also known as Aboriginal and Torres Strait Islander peoples) with distinct, and dynamic, complex social, cultural, economic and political systems that have existed for millennia.

ageism
The use of chronological age to classify and react to people in a negative way, resulting in prejudice, stigma and discrimination about and towards people because of their age. Ageism can be experienced across the life course; for example, both older and younger people might be denied a job because of their age (e.g. 'you are too old/too young for the job').

hysteria
A disease that historically was believed to affect women, and to be associated with the uterus or womb. The example of hysteria reveals how social morals and belief systems can be translated into a medical condition associated with particular 'types' of people (in this case, women).

A sociological approach to health and illness goes beyond a social determinants of health approach by considering what constitutes medical knowledge, and how the social construction of health and illness (as noted previously) can reflect dominant social values. An often-used example of this is **hysteria**, a disease that historically was believed to affect women. Hysteria was associated with the uterus or womb, which it was believed would make women erratic and emotional. For example, in Ancient Greece, it was believed the womb was unstable and would move around the body. The symptoms of hysteria have varied historically and included screaming, fainting, moodiness, tantrums, headaches, insomnia, melancholy, anxiety and a tendency to cause trouble; all traits considered to be 'undesirable' in women who were meant to be meek and mild (Jaffray 2015). Women who did not subscribe to the expected social behaviours of their gender were often seen to be the most at risk of hysteria, which included virgins and women without male partners. Treatments for hysteria included massage, bed rest, electroshock, no physical or mental activity, marriage, regular heterosexual sex and sexual reproduction (Jaffray 2015).

What the example of hysteria illustrates is how social morals and expectations can be translated onto the human body and, in turn, become a medical condition in need of treatment. This illustrates that what makes something an illness is the *belief* that it is an illness, thus highlighting how knowledge about health and illness can be socially constructed.

Another way the sociological approach to health and illness delves deeper than a social determinants of health approach is considering how healthcare is organised in society. For example, the chapter 'The Australian healthcare system' examines how the healthcare system is fragmented, and the chapter 'Choosing healthcare' reveals how equitable and affordable healthcare can be undermined through ideas of individual 'choice' and 'responsibility'. Sociological examination of the healthcare system also includes scrutinising the power afforded to the medical profession to determine the jurisdiction of its work and that of other health professionals (see the chapter, 'Professions and professional identity'), and how notions of self-responsibility may create health as an international commodity (see the chapter, 'Medical tourism').

It is important to note that the social model of health does not dismiss the relevance of the biomedical model. Indeed, understanding biological processes is important when it comes to health and illness. However, when the focus is placed purely on biological function and disfunction, it means that the social influences are ignored and, as a result, structural patterns remain unnoticed, structural changes do not happen, and power arrangements (the status quo) are accepted and unchallenged. As we now move onto examining some of the major sociological paradigms, we invite you to reflect on what each of these sociological paradigms offer for examining the social model of health.

Pause and reflect

1. What are the features of the biomedical model?
2. What are the shortcomings of the biomedical model?
3. In contrast to the biomedical model, what does the social model of health offer?
4. How does a sociological approach to health and illness include and move beyond a social determinants of health approach?

Popular culture

Scrubs

Watch the following clip from the American television show *Scrubs*, a medical comedy-drama:
www.youtube.com/watch?v=lSO5wJjzIME (also at: https://youtu.be/4lmzo9vdqqg?t=177)

In this extract from episode 13 of season 4, Carla Espinosa (head nurse) believes that staff are 'not getting to know our patients'. She appeals to the staff to be more interested in patients and their needs, rather than simply administering drugs. Laverne Roberts (nurse) does not believe there is time do that. Carla turns to her partner, Christopher Turk (surgeon), to receive his support. Turk responds with what procedures he has planned for three of his patients. This was not the response that Carla was seeking.

After watching the clip, explore the following questions.

Questions

1. What features of the biomedical model are evident?
2. How does Carla's appeal to staff align with or diverge from the biomedical model?
3. Is the social model of health evident and, if so, how?
4. If you have been in hospital, reflect on your own experiences as a patient. Does this extract from *Scrubs* relate to your experiences?

Sociological approaches to health and illness

There are two major approaches to health and illness in sociology. The first approach is to look at health institutions and how they work. This includes examining the knowledges being applied and produced, specialisations and hierarchies within, and directions and changes. Essentially, this focus is about how health institutions and medical professionals work, why they work that way, and what the outcomes or consequences are. The second other common approach in the sociology of health and illness is to examine the social distribution of health and the health experiences of populations, social groups and individuals. You will pick up these different foci as you progress through this text. To examine health institutions, the social distribution of health, and health experiences, sociologists draw on different **paradigms**.

paradigm
A general way of seeing the world. Paradigms are a form of knowledge or viewpoint, which contains concepts or theories. Sociology has numerous different paradigms.

Paradigms can be understood as a form of knowledge or viewpoint. A paradigm may have concepts or theories that can be applied to help to explore and explain the social world. As such, a paradigm is a useful tool because it provides a way to organise our thoughts and helps to shape how data is collected and understood. Sociology has numerous paradigms. Perhaps confusingly, within each paradigm there are different approaches to and applications of that paradigm.

In sociology, there are three main paradigms: consensus theory (or structural functionalism), conflict theory and interactionism. As Figure 1.5 illustrates, each of these paradigms breaks down into sub-paradigms.

A good way to think about these paradigms and sub-paradigms is as a tree. The trunk is the paradigm that provides a framework on how to think about and generate knowledge, and the branches are the sub-paradigms, which are different approaches to the paradigm. All the branches (sub-paradigms) of the tree will connect back to the trunk (the paradigm). Each tree is a different paradigm, and each will have its own array of branches. Some of these trees may also be similar (for example, the focus on structure in consensus and conflict theories), but they have significant features that differentiate them.

In this section, we cover the three main paradigms. We also include poststructuralism and feminism, due to the significant contributions they make to the sociology of health and illness.

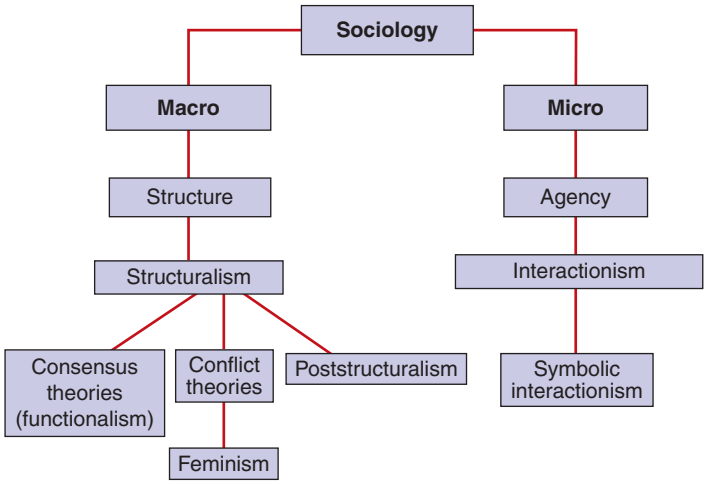

FIGURE 1.5 Key paradigms in sociology, organised by their relationship to structure (macro perspective) and agency (micro perspective)

Consensus theory (structural functionalism)

structural functionalism
A sociological paradigm that views society as a system consisting of different parts that work together to ensure society works or functions smoothly.

consensus
Agreed norms and values that are shared within a given society. According to structural functionalists, consensus can be achieved only because all people are socialised into the society's social structure (which is taken to be a social fact).

macro level
The level of sociological analysis focused on social institutions and their effects on human experiences.

role theory
The belief that there are pre-defined social roles that are guided by social norms and social expectations. Fulfilling the requirements and duties of these roles is required for the smooth functioning of society. Associated with structural functionalism.

Consensus theory (or **structural functionalism**, or simply functionalism) views society to be a system that consists of different parts. These parts work together to ensure that society works or functions smoothly. The different structures of society exist so different societal needs can be met, and the structures work together in social **consensus** to achieve social stability. This allows the maintenance and preservation of social and moral order (see the chapter, 'Professions and professional identity').

An analogy that is often used to explain structural functionalism is the human body. The human body is composed of number of different body parts, each of which has its own purpose or function. These body parts, however, do not sit in isolation. Rather, each body part is interrelated and interconnected to other body systems. When body parts all work together, the body can function and work but when a body part fails, it can cause problems for the entire body. The body is like society because the social structure is composed of numerous social institutions, social groups and cultural aspects that all work together.

Structural functionalism is considered a **macro level** perspective. This is because the focus is placed on social structures (or what some call a 'top down' theory). Structural functionalists assert that social structures (or society) shape individuals and are stable social facts. As such, structural functionalism is not concerned with what individuals believe or their experiences, but what their role or function is in contributing to the social whole. A vital part of this process is consensus, which refers to agreed norms and values that are shared. This can only be achieved because people are socialised into a society's social structure.

A leading figure in the structural functionalist approach to health and illness is Talcott Parsons (1951), who applied role theory to understanding how society works. **Role theory** suggests that there are pre-defined social positions and categories, or roles, that are guided by social norms and social expectations. Fulfilling the requirements and duties of these roles is required for the smooth functioning of society, with individuals slipping in and out of roles as society needs. Let's take a hypothetical example. Being a mother is a social role that comes with social expectations, but this individual mother is also Dr Sidwell, a neurosurgeon. The medical role of neurosurgeon comes with its own responsibilities and obligations. The duties of being a mother and neurosurgeon cannot be fulfilled at the same time and, as such, this mother/Doctor Sidwell must change their role as needed.

In Parsons' (1951) work, role theory is evident in his concept of the **sick role**. Parsons asserted that illness not only alters our biological state; it also changes our social role. Let's consider for a moment what happens if Dr Sidwell becomes too unwell to perform their work role. This would mean that Dr Sidwell needs to get well and recuperate at home. Therefore, Sidwell moves out of their work role as a neurosurgeon and into the sick role.

sick role
According to Parsons (1951), the sick role is a temporary role that an individual can occupy when ill, and which comes with rights and obligations to claim the sick role.

When in the sick role, there is a range of individual rights that come with it. However, to claim these rights, the unwell individual has obligations to fulfil. It is the combination of these rights and obligations that allows an individual to occupy the sick role. These rights and obligations are outlined in Figure 1.6, which illustrates that people who are unwell have the right to be supported when occupying the sick role and are obligated to resume their normal social roles as soon as possible. This also places an obligation on medical professionals to perform their work role and help the unwell person in the sick role to get better. As such, within the sick role, there are social roles that doctors and patients must perform and do so in relation to each other – it is an interrelationship. For Parsons, this is interrelationship is cooperative, though the medical doctor is in control.

The sick role was viewed by Parsons as a temporary role – it is a role that people move into when needed and move out of once they are well. Occupying the sick role is only permitted if a person is legitimately unwell, hence the rights and obligations. For Parsons, the sick role is an undesirable social role that is deviant because it is in opposition to the smooth functioning of society. In seeking support, the ill person desires to leave the sick role and to return to their normal roles; for Parsons, this equates to a return to the paid workforce.

On initial inspection, the sick role seems to make sense. The coronavirus pandemic, for example, has required many people to take time off from their employment role to recover from infection. To claim this role, evidence is required such as a medical certificate from a medical professional or evidence of a positive test result. The individual can then access sick leave benefits, so they are not financially penalised and are not dismissed for being unwell. Once the individual has recovered from coronavirus (in this case, evidenced by a negative test result and have finished their time of physical isolation), they can return to work and social order has been restored.

RIGHTS

1. The sick individual is exempted from normal activities without loss.

2. The sick individual is not responsible and cannot be blamed for being ill.

OBLIGATIONS

1. The sick individual must not want to be ill.

2. The sick individual must accept the help of others (medical professionals).

Source: Dragana Gordic/Shutterstock.

FIGURE 1.6 Rights and obligations associated with the sick role

This process sounds smooth and straightforward. However, not everyone is entitled to the sick role – and this isn't necessarily because they don't follow the rules and obligations. Some criticisms of the sick role include that it:

- gives significant power to medical professionals to determine who is well and unwell
- does not account for long-term illness, chronic illnesses (including fluctuating or recurrent illnesses) or disabilities (see the chapters, 'Disability' and 'Mental health')
- fails to consider care roles that an individual needs to continue to fill while sick (for example, parental responsibilities)
- presumes that medical doctors:
  - are objective
  - provide equal treatment and support to all patients
  - do not have any biases or prejudices (either consciously or unconsciously)
  - are easily accessible and affordable.

We could also add the criticism that within the sick role, not everyone has a smooth transition back to work. For people precariously employed and who may experience financial insecurity (such as casuals and contract staff), being unwell does not necessarily entitle them to sick leave benefits. This makes it difficult for some people to claim the sick role while maintaining financial safety and wellbeing. In addition, precarious workers may be at risk of losing their jobs because they need to stay home and recover from illness, particularly if the illness is long term. The concept of the sick role therefore presumes that a person can suspend other roles and responsibilities by having access to resources that enable them to experience safety and security while they recover. It also presumes that recovery *will happen*, and that the person's health status will return to the social norm or standard. With these criticisms said, it must also be remembered that Parsons was putting forward an ideal-type model.

In sum, the structural functionalist perspective is that illness threatens the smooth and efficient functioning of society. The healthcare system and medical doctors help to enforce social control and the smooth functioning of society by supporting people who are unwell to get better and resume their usual roles.

Conflict theory

conflict theory
A sociological paradigm which asserts that the different parts of society are in competition and conflict with each other over scarce social resources. The unequal distribution of resources in society creates a power imbalance that favours one group over another and leads to social inequality.

Like structural functionalism, **conflict theory** is a 'top down' theory that focuses on the macro perspective (that is, the social structure). However, this is where the similarities between these two theoretical approaches mostly ends. For conflict theorists – also referred to as Marxism due to the influence of the work of Karl Marx and Friedrich Engels – the different parts of society are in competition and conflict with each other over scarce social resources. Instead of the parts of society working together to create social cohesion (as in structural functionalism), the unequal distribution of resources in society creates a power imbalance that favours one group over another and leads to social inequality.

Where structural functionalists believe the medical system works for the benefit for everyone in society, conflict theorists suggest that the medical system is a form of social control and dominance that is rooted in capitalism: the healthcare system treats health as a commodity that determines who can access healthcare, which, in turn, influences an individual's health status. As such, capitalist relations within the healthcare systems create the 'haves' (the ruling class – those with power who can afford healthcare and thus enjoy good health), and the 'have nots' (the lower classes – those without power who cannot afford healthcare and thus experience poorer health). Therefore, class privileges based on economics are reproduced throughout the social structure, benefitting some at the expense of others.

universalism
A commitment to ensuring equal healthcare access for all, and health treatment on an equal basis. The concept is based on the collective wellbeing of populations being good for the welfare and prosperity of the nation-state.

Australia's healthcare system is based on the principle of **universalism**, whereby everyone in society can access healthcare and health treatments regardless of their income and wealth. As the chapters 'The Australian healthcare system' and 'Choosing healthcare' indicate, however,

this is not necessarily the case. The Australian healthcare system is a hybrid model that consists of a mix of public (paid by the government) and private (paid by the individual) health services. While this mix is based on the idea of 'choice', there is a social divide between those who can and those who cannot afford private health insurance. Those living in Australia with private health insurance (or those with higher socio-economic status, who can pay private costs without accessing private insurance) generally do not wait as long as those in the public health system to receive **primary healthcare** (general practitioners, dental practitioners, and community healthcare) and **secondary healthcare** (hospitals, outpatient services and medical specialists) (Martin, Siciliani and Smith; McIntyre and Chow 2020) (see the chapter, 'Choosing healthcare'). As noted by Van Doorslaer et al. (2008, p. 97), 'The unequal distribution of private health insurance coverage by income contributes to the phenomenon that the better-off and the less well-off do not receive the same mix of services [in Australia]'. In addition, those with wealth may choose to receive expensive medical procedures overseas at their own expense, and these medical procedures may or may not be available in Australia (see the chapter, 'Medical tourism').

Conflict theorists are also interested in the dominance and control asserted by the medical profession that enables it to maintain its power and autonomy. This is connected to the work of Eliot Freidson (1970) and Evan Willis (1989), who note that medical professionals can control their work and the conditions under which it occurs as well as determine the division of labour – such as the work of other healthcare professions – that ensures that medical professionals retain a position of privilege and power (see the chapter, 'Professions and professional identity'). While there are ways that **medical dominance** may be challenged (such as **de-medicalisation** and **deprofessionalisation**), it nevertheless remains a prevailing feature of the Australian healthcare system (see the chapters, 'The Australian healthcare system', 'Choosing healthcare', 'The therapeutic encounter' and 'Professions and professional identity'). For example, new and emerging forms of genetic and precision medicine serve to reproduce features of medical dominance (Latimer 2013; Olson and Cook 2018).

The conflict perspective also suggests that the structure of contemporary work makes people ill, such as unsafe working conditions and placing unrealistic demands on employees. Another example is how the coronavirus pandemic has exposed and intensified social inequalities globally that, for those influenced by conflict theory, are attributed to capitalism (Alexiou 2021; Stevano et al. 2021). For essential workers, the need to 'keep working' during the spread of coronavirus put them at heightened health risks, which 'has not translated into wage increases or a substantial increase in spending on health and social care' (Stevano et al. 2021, p. 7). For Waitzkin, these are 'structures of oppression' that he claims 'penetrate medicine and that medicine helps replicate' (2000, p. 53). This connects to the concept of **medicalisation** (for example, see the chapters, 'Medicalisation', 'Disability', 'Mental health' and 'Emotions').

For scholars such as Ivan Illich (1975) and Peter Conrad (1992, 2005; Conrad and Barker 2010), medicalisation refers to how non-medical events or experiences become medical problems. Illich (1975) asserts that more aspects of everyday life are being defined as medical problems which, in turn, frames these new medical problems as illnesses that are in need of medical intervention. Examples of this include undesirable behaviours (such as excessive alcohol consumption or hyperactivity), unpleasant feelings (such as sadness, grief or stress), normal life events (such as birth and death), common problems (such as sexual difficulties or learning problems), appearance differences (such as being short or overweight), and ordinary biological processes (such as ageing, infertility and menstruation) (Bell 1987; Conrad 2005; Conrad and Barker 2010; Zola 1972). For Moynihan and Henry (2006, p. e191), the most dangerous forms of medicalisation are best described as **disease mongering**, which refers to 'the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments'. The pharmaceutical industry is a good example of this capitalist enterprise: in creating new illnesses and engaging in health literacy education, it expands

primary healthcare
General practitioners, dental practitioners, and community healthcare (including Indigenous health workers). This is the primary way that people access healthcare in Australia.

secondary healthcare
Hospitals, outpatient services and medical specialists.

medical dominance
Control by the medical profession over the scope of its own practice as well as over patients, the healthcare system, healthcare policymaking, and the resources, knowledges and activities of other health practitioners. This explains why medical knowledge is privileged over other forms of health and healthcare knowledge.

de-medicalisation
The process by which something is that was previously defined as 'unhealthy' and in need of treatment is no longer viewed as a medical issue.

deprofessionalisation
A process in which the power of the medical profession is deceased due to a decline in public trust.

medicalisation
Recasting non-medical problems as medical or psychological problems in need of a biomedical or psychological intervention.

disease mongering
The most dangerous form of medicalisation, involving 'the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments' (Moynihan and Henry 2006, p. e191).

opportunities to generate profit (Moynihan, Heath and Henry 2002; Moynihan and Henry 2006).

In other words, for conflict theorists, social life is being redefined and medicalised, taking away individuals' personal freedom, autonomy and power to deal with such events. This is because medicalisation results in the population having less capacity to deal with the natural processes of life. Additionally, medicalisation can produce illness rather than treat it. For example, illness and disability can be caused by medical treatment or malpractice, and pharmaceuticals can cause side effects and allergic reactions, a process that Illich (1975) labelled as **iatrogenesis** (see the chapter, 'Medicalisation and biomedicalisation').

iatrogenesis
Complications, side effects or outcomes of medical treatments that can cause ill-health and disability. This includes the consequences of medical errors and negligence. In sociology, this concepts also relates to overmedicalisation.

Feminism

Like conflict theories, **feminist perspectives** assert that society is underpinned by a power imbalance. However, while conflict theorists assert that class and economic inequality are the basis of this power imbalance, feminists believe **patriarchy** has created a system of power that privileges men and subjugates women. While we have placed feminism under a structural approach (see Figure 1.5), it is important to note that an interactionist (**micro level**) perspective is also used within feminism to highlight the stories of individual women. There are 'top down' and 'bottom up' feminist approaches, though they all seek to critique gender inequality that disadvantages women in society.

feminist perspectives
Perspectives that focus on society being underpinned by a power imbalance that privileges men and subjugates women. This relates to patriarchy. There are multiple feminist perspectives to understanding women's experiences of health and illness, but they all share this focus.

patriarchy
A social system where men dominate and hold power over women, which is replicated throughout and reinforced by the social structure.

micro level
The level of sociological analysis focused on individual interpretations and small-scale human interaction.

There are several forms of feminism, each of which seeks to examine and critique patriarchy and gender inequality that benefits men at the expense of women. Some of the major forms of feminism include the following (and are described in Table 1.3):

- liberal feminism
- Marxist feminism
- radical feminism
- poststructural (or postmodern) feminism.

It is important to remember there are many feminist approaches (including many that we have not addressed here) and, as a result, there are disagreements between feminists on the best way to address patriarchy and gender inequality.

Reproductive technologies such as in vitro fertilisation (IVF) are an example of a contentious feminist topic. Radical feminist Shulamith Firestone (1970) argued that women needed to seize control of new technologies (which have traditionally been used for masculine domination) for feminist means. She advocated for the elimination of sex and biological distinctions by moving beyond what is considered 'natural'. Firestone believed this was possible through reproductive technologies, which break down sex–gender dualisms (this is also associated with her imaginings of an androgynist future), allows women to take control of their bodies, and frees them from reproductive labour (Wajcman 1991). As noted by Halbert (2007), Firestone's belief that technology can be used to challenge biology and the gender binary was a precursor to work by Donna Haraway (1985), who noted the centrality of technology in contemporary life and used the image of cyborg to challenge (among other things) gender power relations. Through these feminist perspectives, technology is a tool for feminist means.

Other feminist approaches suggest that reproductive technologies are a tool of patriarchal oppression and control. These perspectives suggest that women should not engage with reproductive technologies because they are tools that dominate women's bodies, including their (female) biological function. As such, while reproductive technologies are marketed as enabling 'choice and control' (aligning with personal agency), this perspective frames them as a form of social control that disempowers women by appropriating their reproductive capacity and benefits men (Wajcman 1991). Reproductive technologies are therefore just another form of masculine domination that medicalises reproduction and fertility (see the chapter, 'Medicalisation and biomedicalisation'), and subordinates and controls the bodies (and minds) of women.