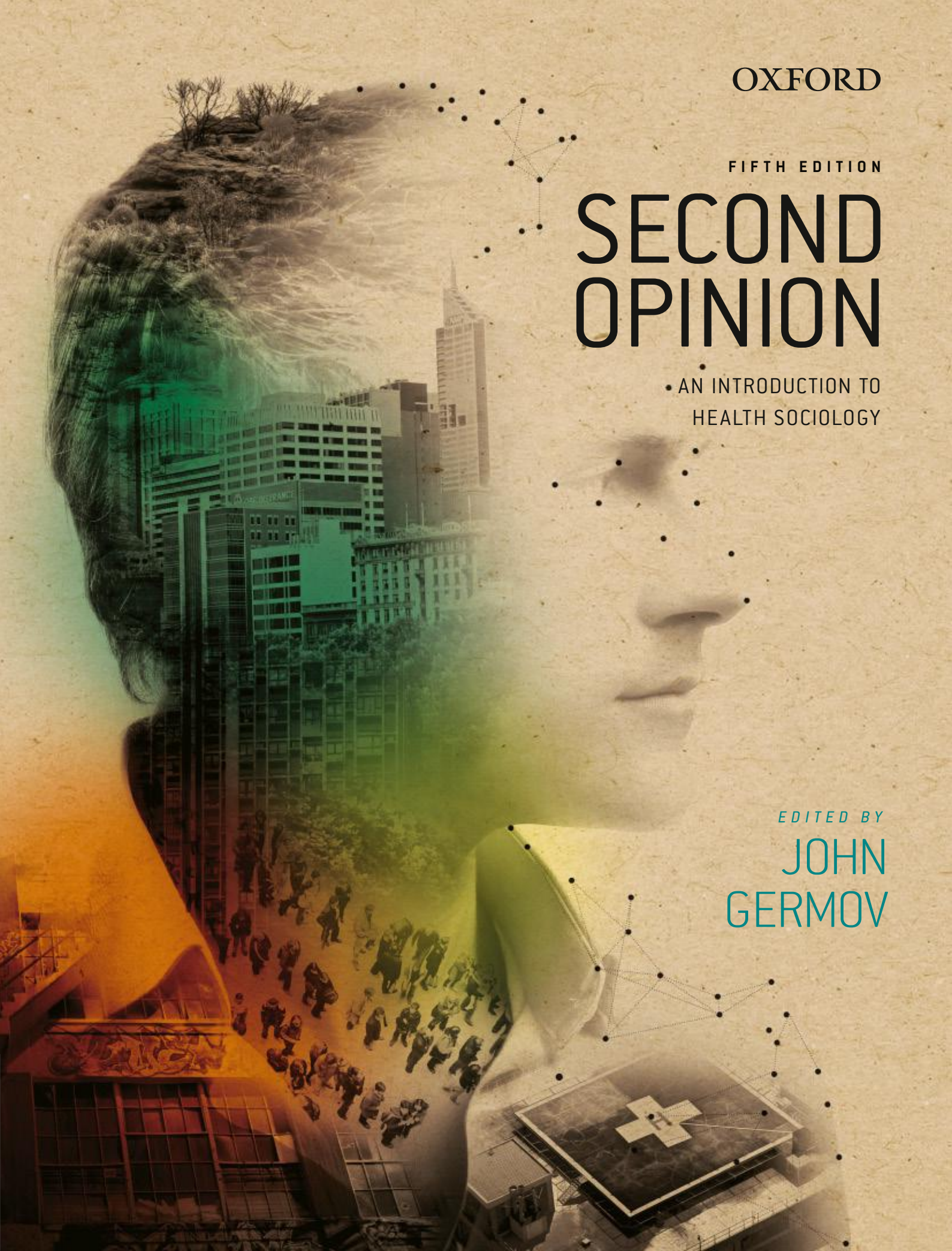


OXFORD

FIFTH EDITION

SECOND OPINION

AN INTRODUCTION TO HEALTH SOCIOLOGY

EDITED BY

JOHN GERMOV

FIFTH EDITION

SECOND OPINION

AN INTRODUCTION TO HEALTH SOCIOLOGY

EDITED BY

JOHN GERMOV

OXFORD
UNIVERSITY PRESS
AUSTRALIA & NEW ZEALAND

OXFORD
UNIVERSITY PRESS

Oxford University Press is a department of the University of Oxford.

It furthers the University's objective of excellence in research, scholarship, and education by publishing worldwide. Oxford is a registered trademark of Oxford University Press in the UK and in certain other countries.

Published in Australia by
Oxford University Press
253 Normanby Road, South Melbourne, Victoria 3205, Australia

First edition published 1998
Revised edition published 1999
Second edition published 2002
Third edition published 2005
Fourth edition published 2009
Fifth edition published 2014

National Library of Australia Cataloguing-in-Publication data
Author: Germov, John, author.
Title: Second opinion : an introduction to health sociology / John Germov.
Edition: 5th edn.
ISBN: 9780195520149 (paperback)
Notes: Includes index.
Subjects: Social medicine—Australia.
Health—Social aspects—Australia.
Australia—Statistics, Medical.
Dewey Number: 306.4610994

Edited by Natasha Broadstock
Cover design by Ana Cosma
Text design by Ana Cosma
Typeset by diacriTech, India
Proofread by Pete Cruttenden
Indexed by Russell Brooks

CONTENTS

EXPANDED CONTENTS

PREFACE TO THE FIFTH EDITION

It has been well over 15 years since the first edition of *Second Opinion*. This latest edition features new and updated chapters to ensure that the book remains relevant, topical, and interesting to its large and varied readership. That said, *Second Opinion* retains its accessible yet authoritative overview of key debates, research findings, and theories in the field of health sociology.

New to the fifth edition

- **New chapters** on Drug Use and Abuse in Australia (Maria Freij and John Germov) and Well-being and Wellness (Daniela Heil)
- **New authors joining:** Maria Freij and John Germov joining Dorothy Broom for the chapter on Gendered Health; Annalee Stearne joining Dennis Gray and Sherry Saggers for the chapter on Indigenous Health; and Tanya Lawlis joining Lauren Williams for the chapter on Allied Health
- **An improved reader-friendly dual-colour layout** with a wide range of pedagogic features; each chapter begins with a topical vignette to draw attention to relevant sociological issues; all chapters include highlighted 'Doing health sociology' boxes that show the application of health sociology to real-life issues of health policy and practice; in addition, an updated list of recommended documentaries and films has been added to each chapter
- **Updated book website:** the website now includes online access to chapter-relevant YouTube and MOOC videos, supplementary reading, chapters from previous editions, and updated web links for all websites recommended in the book.

Guide to the book

In addition to being a contemporary reader on the field of health sociology, the book is also designed to be used as a teaching text, with the following pedagogic features:

- An **overview** opens each chapter, with three main questions the chapter seeks to address
- **Introductory vignettes** grab readers' interest and encourage a sociologically reflexive approach to the topic
- **Key terms and concepts** are highlighted in bold and defined in separate margin paragraphs; these also appear in a glossary at the end of the book
- **'Doing health sociology' boxes** highlight the insights of sociological research and theories for informing health care practice, health policy, and public understanding of the social origins of health and illness
- **TheoryLink notes** clearly cross-reference theoretical discussions in different chapters
- **Summary of main points**
- **Sociological reflection exercises** are self-directed or class-based exercises that help students apply their learning and highlight the relevance of sociological analysis
- **Discussion questions**
- **Further investigation** essay-style questions
- **Further reading**
- Recommended chapter-specific **web resources**
- Recommended chapter-specific **documentaries and films**

- The **appendix on essay writing** provides advice for students on the planning, writing, and referencing of health sociology essays, including tips on the critical use of web resources, how to reference the web, and how to reference chapters in this book
- The **expanded *Second Opinion* website** <www.oup.com.au/germov5e>:
  - **Links to all the web resources** recommended in the book
  - **Supplementary readings**
  - **Access to chapters from previous editions**

Teaching resources for lecturers

The Instructor's Resource Manual, Test Bank, and PowerPoint slides are available **free of charge** from the publisher for those using the book as a course text.

- **Instructor's Resource Manual:** includes case studies and short tutorial exercises for each chapter to facilitate student discussion
- **Test Bank of Multiple-choice Questions:** over 200 questions and answers organised by chapter
- **Downloadable PowerPoint slides** of all diagrams and tables in the book

Suggestions, comments, and feedback

I am very interested in receiving feedback on the book and suggestions for future editions. Please contact me at: <John.Germov@newcastle.edu.au>.

John Germov
The University of Newcastle
June 2013

GUIDED TOUR


Overview

- What is class and how can it help to explain health inequality?
- What is the social gradient of health?
- What can be done to address class-based health inequality?

CLASS MATTERS

Overviews

open each chapter and outline the three main questions the chapter seeks to address.

Introductory vignettes

spark the readers' interest and encourage a sociologically reflexive approach to the topic.

'Doing health sociology' boxes

highlight relevant elements of sociological research and theory that inform health care practice and policy, and public understanding of the social origins of health and illness.

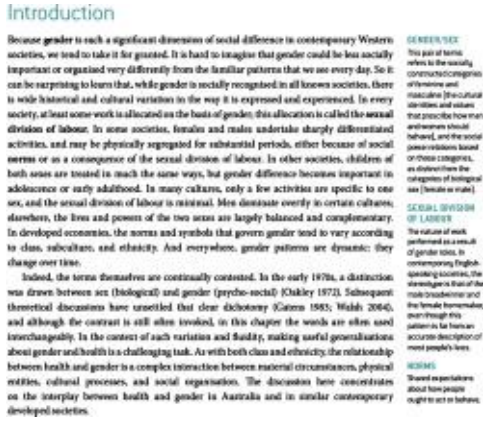

BOX 5.1

DOING HEALTH SOCIOLOGY: LAY UNDERSTANDINGS OF HEALTH INEQUALITY

MATERIALIST/STRUCTURAL EXPLANATIONS

TheoryLink notes

highlight and cross-reference relevant theoretical discussions in different chapters.


Introduction

Because gender is such a significant dimension of social difference in contemporary Western societies, we tend to take it for granted. It is hard to imagine that gender could be less socially important or organised very differently from the familiar patterns that we see every day. So it can be surprising to learn that, while gender is socially recognised in all known societies, there is wide historical and cultural variation in the way it is expressed and experienced. In every society, at least some work is allocated on the basis of gender; this allocation is called the **sexual division of labour**. In some societies, females and males undertake sharply differentiated activities, and may be physically segregated for substantial periods, either because of social **norms** or as a consequence of the sexual division of labour. In other societies, children of both sexes are treated in much the same ways, but gender difference becomes important in adolescence or early adulthood. In many cultures, only a few activities are specific to one sex, and the sexual division of labour is minimal. Men dominate overtly in certain cultures; elsewhere, the lives and powers of the two sexes are largely balanced and complementary. In developed economies, the norms and symbols that govern gender tend to vary according to class, subculture, and ethnicity. And everywhere, gender patterns are dynamic: they change over time.

Indeed, the terms themselves are continually contested. In the early 1970s, a distinction was drawn between sex (biological) and gender (psycho-social) (Oakley 1972). Subsequent theoretical discussions have unsettled that clear dichotomy (Cairns 1985; Walsh 2004), and although the contrast is still often invoked, in this chapter the words are often used interchangeably. In the context of such variation and fluidity, making useful generalisations about gender and health is a challenging task. As with both class and ethnicity, the relationship between health and gender is a complex interaction between material circumstances, physical entities, cultural processes, and social organisation. The discussion here concentrates on the interplay between health and gender in Australia and in similar contemporary developed societies.

GENDER/SEX

SEXUAL DIVISION OF LABOUR

NORMS

Margin notes

illustrate key terms and concepts, which are in bold throughout the text.


SUMMARY OF MAIN POINTS

Summaries of main points

at the end of each chapter help students identify the most important issues covered in the chapter.

Sociological reflection exercises

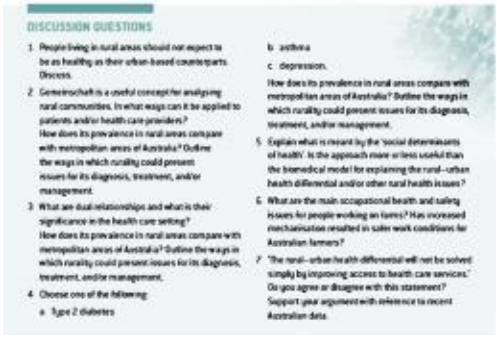
at the end of each chapter are self-directed or class-based exercises that help students apply their learning and see the relevance of sociological analysis.

Discussion questions

can be approached in a variety of ways and allow students to revisit the key themes and ideas raised in each chapter.


SOCIOLOGICAL REFLECTION

ACCESS—MORE THAN MEETS THE EYE


DISCUSSION QUESTIONS


FURTHER INVESTIGATION


FURTHER READING


WEB RESOURCES

Further investigation exercises

are essay-style questions that help students prepare for examinations and other forms of assessment.

Further reading, web resources, and documentaries/films sections

list chapter-specific books, websites, and documentaries and films to allow students to research and explore topics further.


DOCUMENTARIES/FILMS

ACKNOWLEDGMENTS

A book such as this is a team effort and I thank all of the contributors for making my job as editor a pleasurable one. Once again, I was able to rely upon the wonderful editorial and organisational skills of Maria Freij, a great scholar in her own right, without whom this fifth edition of the book could not have been accomplished.

In relation to the various editions of this book, thanks to my dear friend and colleague Lauren Williams for always keeping me attuned to the challenging work of health professionals; and my continuing gratitude to Lois Bryson, Deidre Wicks, and Helen Belcher, who provided advice throughout the evolution of the early editions of the book for which I am forever grateful.

Thanks are also due to my publishers, firstly Jill Henry, Debra James, Katie Ridsdale, Rachel Saffer, and more recently Shari Serjeant and Estelle Tang. Thanks also to our copyeditor Natasha Broadstock for her excellent work, and to the designer, Ana Cosma.

Finally a special note of appreciation to Sue Jelovcan for her support, patience, and good humour during the seemingly endless production of this book over the years, and also to our 8-year-old daughter Isabella, who has sharpened and enlivened my sociological gaze.

The author and the publisher wish to thank the following copyright holders for reproduction of their material.

Extract from *Enough Rope with Andrew Denton* reproduced by permission of the ABC Library Sales and Zapruder © 2006 Zapruder. All rights reserved, p.105; Extract from 'National Health Reform: Outcomes of the 30th Council of Australian Governments (COAG) meeting', 13 February 2011, reproduced with permission from NCOSS, p. 365; Extract from 'Should There Be a Means Test on the Private Health Insurance Rebate?' Peter Dutton, *Sydney Morning Herald*, February 9, 2012. Reproduced by permission of Fairfax Media via CAL, p. 378; Ottawa Charter for Health Promotion logo adapted with permission from WHO, p. 467; 'Department of Health, CNO Directorate 2007' contains public sector information licensed under the Open Government Licence v1.0, p. 417.

Every effort has been made to trace the original source of copyright material contained in this book. The publisher will be pleased to hear from copyright holders to rectify any errors or omissions.

CONTRIBUTORS

Fran Baum is Matthew Flinders Distinguished Professor and an Australia Research Council Federation Fellow at Flinders University. She is Foundation Director of the Southgate Institute for Health, Society and Equity & the South Australian Community Health Research Unit; Co-Chair of the Global Steering Council of the People's Health Movement—a global network of health activists; and has served as a Commissioner on the World Health Organization's Commission on the Social Determinants of Health from 2005–08. She is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Health Promotion Association and a past National President and Life Member of the Public Health Association of Australia. Fran is one of Australia's leading researchers on the social and economic determinants of health and holds grants from the National Health & Medical Research Council and the Australia Research Council. Her book, *The New Public Health* (3rd edition, 2008, Oxford University Press), is widely used as a public health text.

Helen Belcher (PhD) is a conjoint lecturer in the School of Humanities and Social Science at The University of Newcastle. She is a member of the Hunter New England Local Health District Board.

Alex Broom is Associate Professor of Sociology and Australian Research Council Future Fellow at the School of Social Science, The University of Queensland. He specialises in the sociology of traditional, complementary, and alternative medicine and the sociology of cancer and end-of-life care. Recent co-authored and co-edited books include: *Traditional, Complementary and Alternative Medicine and Cancer Care* (Routledge, 2007), *Therapeutic Pluralism* (Routledge, 2008), *Men's Health: Body, Identity and Social Context* (Wiley-Blackwell, 2009), *Health, Culture and Religion in South Asia* (Routledge, 2011), *Evidence-Based Healthcare in Context: Critical Social Science Perspectives* (Ashgate, 2012), and *Traditional, Complementary and Integrative Medicine: An International Reader* (Palgrave-Macmillan, 2012). He is also Visiting Professor of Sociology at Jawaharlal Nehru University (India) and Brunel University, London (UK).

Dorothy Broom (PhD) is a Professor Emerita at the National Centre for Epidemiology and Population Health (NCEPH), Australian National University (ANU), where she is involved in research on inequalities in health, the relationship between work and family health, and gendering health. She also supervises PhD candidates. She was formerly Convenor of Women's Studies at ANU, and is the author of a number of articles and books, including *Damned If We Do: Contradictions of Women's Health Care* (1991), *Double Bind: Women Affected by Alcohol and Other Drugs* (1994), and (with Jane Dixon) *The Seven Deadly Sins of Obesity: How the Modern World is Making Us Fat* (2007). In 1993 she was named Canberra Woman of the Year for distinguished service to the Australian Capital Territory's women's movement and to women's health. In 1994, she was made a Member of the Order of Australia for services to women and women's health.

Maria Freij (PhD) is a Social Researcher at the University of Newcastle, Australia, and a Senior Lecturer in English at Kristianstad University, Sweden. Her sociological interests focus on the representations of health and identity, and in her other career her interests span creative writing,

literature, and linguistics. Her work appears in, among other journals, *Meanjin*, *Blue Dog*, *Softblow Poetry Journal*, *Mascara*, *TEXT*, and *The Australian Journal of French Studies* (*AJFS*). Maria translates between English, Swedish, and French, and her translation of Boris Vian's posthumous collection of poetry is published in *Boris Vian: Poetry and Short Fiction* (Adelaide University Press, 2013). Her first book of poems, *I Was Here*, won the *Harri Jones Memorial Prize* in 2007 and is forthcoming from Puncher & Wattmann.

John Germov (PhD) is Professor of Sociology and Pro Vice-Chancellor of the Faculty of Education and Arts at the University of Newcastle, Australia. He is the President of the Australasian Council of Deans of Arts, Social Sciences and Humanities (DASSH), the peak national body on research and teaching in humanities and social sciences. John is a former President of the Australian Sociological Association and served on the Executive of the International Sociological Association. In 2010, he received the prestigious national honour, the Outstanding Service to the Australian Sociological Association Award. His research interests span the social determinants of health, with a particular focus on food and alcohol consumption in the context of public health. Recent work has focused on the Slow Food movement and ethical consumption, alcohol and harm minimisation, and the historical sociology of wine in Australia. John has published 19 books to date, including *Public Sociology: An Introduction to Australian Society* (with Marilyn Poole), *A Sociology of Food and Nutrition: The Social Appetite* (with Lauren Williams), and *Histories of Australian Sociology* (with Tara McGee).

Dennis Gray (MPH, PhD) is Professor of Medical Anthropology and Deputy Director at the National Drug Research Institute (NDRI), Curtin University. He has worked in the areas of Indigenous and international health since the mid-1970s. In 1992, he established the Indigenous Australian Research Program at NDRI, which he continues to head. He has a theoretical interest in the structural determinants of Indigenous health and is committed to conducting research that has practical outcomes for Indigenous Australians. In 2006, his research team won a National Alcohol and Drug Award for Excellence in Research, and in 2010, he received a National Alcohol and Drug Award for his significant contribution to the reduction of harms from alcohol and other drug use.

Associate Professor **Daphne Habibis** is Director of the Housing and Community Research Centre at the University of Tasmania. She is a sociologist who has published widely in areas of inequality, especially in relation to Aboriginal issues and mental health. She is the co-author, with Associate Professor Maggie Walter, of the monograph *Social Inequality in Australia: Discourses, Realities and Futures* published by Oxford University Press (2008). Recent work includes an investigation of the social dimensions of kindness, the relationship between welfare conditionality and Aboriginal housing, and a study of tenancy management in remote Aboriginal communities.

Daniela Heil is a social and medical anthropologist, and a Lecturer in the discipline of Sociology and Anthropology at the University of Newcastle, Australia. Since 1997, her research, fieldwork, and consultancy work have been in Indigenous Australia, in central-Western New South Wales, the Kimberley in Western Australia and the Torres Straits, in Native Title, and for the Australian Government. Since 2006, another research interest has been in assisted conception and working with German parents who in collaboration with agencies and gestational carriers in the Ukraine are fulfilling their personal desires of their own biological children.

Clarissa Hughes (PhD) is a Senior Research Fellow with the Department of Rural Health at the University of Tasmania. She has a background in sociology and a particular interest in utilising theoretical concepts to strengthen practical efforts to improve health. Her main research interests include adolescent health, physical activity, nutrition, women's health, and normative influences on behaviour change. She has been a consultant to the New South Wales Department of Education and Training, was a lead researcher

on the 'Role of Schools in Alcohol Education' project conducted by the National Centre for Education and Training on Addiction at Flinders University, and also writes regularly for *Oxygen Magazine* and *Clean Eating Magazine*.

Roberta Julian (PhD) is an Associate Professor and the founding Director of the Tasmanian Institute of Law Enforcement Studies at the University of Tasmania. She is a sociologist who has published widely in the areas of immigrant and refugee settlement, ethnicity and health, globalisation and diaspora, and the relationships between class, gender, and ethnic identity. Her unpublished doctoral dissertation explored the changing meaning of ethnicity among postwar Dutch settlers in Tasmania and she researched the resettlement of Hmong refugees from Laos for over ten years. She has published book chapters and journal articles on Hmong identity and Hmong women in *Race, Gender and Class*, *Asian and Pacific Migration Journal*, *Women's Studies International Forum* and the *Hmong Studies Journal.* She has a particular interest in forensic science and is currently the lead Chief Investigator in a five-year ARC Linkage Grant with Victoria Police, the Australian Federal Police, and the National Institute of Forensic Science that examines the effectiveness of forensic science in the criminal justice system. Her most recent books are *Australian Youth: Social and Cultural Issues* (with Pamela Nilan and John Germov) (Pearson, 2007) and the third edition of *Australian Sociology: A Changing Society* (with David Holmes and Kate Hughes, Pearson Longman, 2011).

Dr Helen Keleher is Director of Population Health with the Frankston-Mornington Peninsula Medicare Local and Adjunct Professor in Public Health with Monash University. Her expertise is in the determinants of health and inequity and her work is focused on integrated primary health care, population health planning, and health service evaluation. She is first author for *Understanding Health Promotion* (2007) published by Oxford University Press, and *Understanding Health,* 3rd edn (2011) also published by OUP.

Tanya Lawlis is an Assistant Professor in the Discipline of Nutrition and Dietetics at the University of Canberra. She holds an undergraduate degree in human nutrition, an Honours degree in immunology, and a PhD in interprofessional education. Tanya is the program convenor for the Bachelor of Human Nutrition and teaches in the fields of nutritional science and food science. Her research interests include interprofessional education, food allergy awareness, and public health nutrition. Tanya is a Registered Nutritionist with the Nutrition Society of Australia and an Accredited Nutritionist with the Dietitians Association of Australia.

Marilyn Poole (PhD) is an Associate Professor in Sociology at Deakin University. Although now retired and holding an honorary appointment, she continues to write and do research on ageing. She serves on the Board of Directors and works as a volunteer in a not-for-profit organisation that offers programs and services for socially isolated older people. She is co-editor of *A Certain Age: Women Growing Older* (Allen & Unwin, 1999) and *Public Sociology: An Introduction to Australian Society* (2nd edition, Allen & Unwin, 2011) and editor of *Family.*

Katy Richmond (MA) is a former Senior Lecturer in Sociology and current Honorary Associate at La Trobe University. She has written on women in employment, women and deviance, homosexuality in prisons, and women and health. Her current research is on Aboriginal women's health. She was a founding member of TASA's Women's Section, was President of the Association in 1991–92, and in 2004 was a recipient of the Distinguished Service to Australian Sociology Award.

Sharyn L. Roach Anleu is Matthew Flinders Distinguished Professor at Flinders University, Adelaide. A Fellow of the Academy of the Social Sciences in Australia and a Past President of the Australian Sociological Association, Sharyn has a longstanding interest in the sociology of deviance, regulation, and social control. With Professor Kathy Mack, she is currently engaged in national socio-legal research on judicial officers and their courts.

Sherry Saggers (PhD) is Adjunct Professor in a program on the social contexts of substance use at the National Drug Research Institute, Curtin University. An anthropologist, she was formerly Foundation Professor of Applied Social Science and Director of the Centre for Social Research, Edith Cowan University. She has conducted applied research among diverse populations throughout Australia, and published widely on Indigenous health and social issues, health and disability, and broadly in sociology.

Anne-Maree Sawyer (PhD) is a Lecturer in the Sociology Program at La Trobe University. She teaches undergraduate subjects in the sociology of health and illness, emotions, and work and employment. She has extensive experience as a mental health social worker, having worked in a community-based crisis team for many years and in an old-style psychiatric hospital prior to deinstitutionalisation. Her research interests include mental health policy and practice, emotions and self-identity, and narrative methodologies in the social sciences.

Pauline Savy (PhD) is a sociologist who currently holds an Honorary Associate position at the John Richards Initiative (Research into Aged Care in Rural Communities), Faculty of Health Sciences, La Trobe University. Her research and publishing interests reflect her focus on health sociology and her former nursing roles working with aged and mentally ill people. Pauline is a co-author of the text *Sociology in Today's World* (Cengage Learning, 2012).

Toni Schofield works in the Faculty of Health Sciences at The University of Sydney. She conducts research in the sociology of health and public policy, and has investigated a wide range of issues including workplace health and safety, gender and health, young people's alcohol use, and the health of ethnic minorities. She has worked extensively as a consultant and adviser to Australian community-based, state, and Commonwealth government agencies, and international organisations such as the WHO, the Canadian Health Department, and Swedish Secretariat for Gender Research.

Annalee Stearne (BA, Post Grad Dip) is a Nyungar woman from WA and has been a Research Associate in the National Drug Research Institute's Indigenous Australian Research Program since 2001. Ms Stearne has a background in education and public health. Much of her work involves researching ways to prevent or reduce the harms associated with substance use within Indigenous communities, including evaluating Indigenous Australian substance misuse interventions in the Northern Territory, Western Australia, and South Australia. Ms Stearne has a strong interest in working with community organisations to develop and conduct their own research.

Lauren Williams is Professor and Head of Discipline of Nutrition and Dietetics at the University of Canberra, and Conjoint Professor of Nutrition and Dietetics at the University of Newcastle, Australia. Her undergraduate degree was in science (Honours) and she also holds tertiary qualifications in social science, health promotion and dietetics, and a PhD in public health nutrition. Lauren has been an academic dietitian for over two decades and is primarily involved with dietetic education. She continues to practise as a dietitian as an Advanced Accredited Practising Dietitian. Lauren has published widely in the research areas of weight gain and weight control practices, gendered dieting, the rural and allied health workforce, and the sociological aspects of food and eating. She has co-edited three editions of the OUP academic text and reader *A Sociology of Food and Nutrition: the Social Appetite* with John Germov.

Evan Willis is Professor of Sociology at La Trobe University in Melbourne. He has researched and taught in the medical sociology field for more than 30 years. His interests in the field cover medical technology, alternative medicine, occupational health and safety, and health care work. His first book *Medical Dominance* (Allen & Unwin 1991) was voted by peers as one the ten most influential books in Australian sociology.

ABBREVIATIONS

AA	Alcoholics Anonymous
ABS	Australian Bureau of Statistics
ACATs	Aged Care Assessment Teams
ACHA	Australian Community Health Association
ACQSHC	Australian Common on Quality and Safety in Health Care
AD[H]D	attention deficit [hyperactivity] disorder
AEI-NOOSR	Australian Education International—National Office of Overseas Skills Recognition
AFGC	Australian Food and Grocery Council
AGPS	Australian Government Publishing Service
AHPA	Allied Health Professions Australia
AHPRA	Australian Health Practitioner Regulation Agency
AIDS	acquired immune deficiency syndrome
AIHW	Australian Institute of Health and Welfare
ALP	Australian Labor Party
AMA	Australian Medical Association
ANJ	*Australasian Nurses' Journal*
ANPHA	Australian National Preventive Health Agency
ARIA	Accessibility/Remoteness Index of Australia
ASGC-RA	Australian Standard Geographical Classification—Remoteness Areas
ATSIC	Aboriginal and Torres Strait Islander Commission
BAC	blood alcohol concentration
BMA	British Medical Association
BMI	Body Mass Index
BRW	*Business Review Weekly*
BSE	bovine spongiform encephalopathy ('mad cow' disease)
CACPs	Community Aged Care Packages
CALD	culturally and linguistically diverse
CAM	complementary and alternative medicine
CDM	Chronic Disease Management
CHD	coronary heart disease or chronic diseases and health promotion or community health policy
CHP	Community Health Program
COAG	Council of Australian Governments
CSDH	Commission on the Social Determinants of Health

DAA	Dietitians Association of Australia
DHFS	Department of Health and Family Services
DIMA	Department of Immigration and Multicultural Affairs
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
DOHA	Department of Health and Ageing
DNA	deoxyribonucleic acid
DRS	Doctors Reform Society
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
DSM-IV	Fourth edition of *Diagnostic and Statistical Manual of Mental Disorders*
DSM-IV-TR	Fourth (Text revised) edition of *Diagnostic and Statistical Manual of Mental Disorders*
DSM-5	Fifth edition of *Diagnostic and Statistical Manual of Mental Disorders*
DTC	direct to consumer
DVA	Department of Veterans Affairs
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
EBH	evidence-based health care
EBM	evidence-based medicine
ELSI	ethical, legal, and social implications (of the Human Genome Project)
EPC	Enhanced Primary Care
FAO	Food and Agriculture Organization
FDA	Food and Drug Administration (US)
FSANZ	Food Standards Australia New Zealand
FSD	female sexual dysfunction
GDP	gross domestic product
GFC	global financial crisis
GIO	Government Insurance Office
GM	genetic modification/genetically modified
GNI	gross national income
GP	general practitioner
HACC	Home and Community Care program
HFA 2000	Health for All by the Year 2000
HGH	human growth hormone
HGP	Human Genome Project
HHSC	Hospitals and Health Services Commission
HIV	human immunodeficiency virus
HPCA	Health Profession Council of Australia
HREOC	Human Rights and Equal Opportunities Commission
HRT	hormone replacement therapy

IGAFFR	Intergovernmental Agreement on Federal Financial Relations
IHP	individualist health promotion
ILO	International Labour Organization
IMR	infant mortality rates
IPE	inter-professional education
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MAHS	More Allied Health Services
MDGs	Millennium Development Goals
MLs	Medicare Locals
MLS	Medicare Levy Surcharge
MSIC	medically supervised injection centre
NAAFA	National Association to Advance Fat Acceptance
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHOSN	National Allied Health Organisational Structures Network
NAHS	National Aboriginal Health Strategy
NAOMI	North American Opiate Medication Initiative
NASRHP	National Alliance of Self-Regulating Professions
NATSIHC	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NATSIHEC	National Aboriginal and Torres Strait Islander Health Equality Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDIS	National Disability Insurance Scheme
NESB	non-English-speaking background
NHA	National Health Agreement
NHHRC	National Health and Hospital Reform Commission
NHMRC	National Health and Medical Research Council
NHPAs	National Health Priority Areas
NHS	National Health Strategy (Australia) or National Health Survey (Australia) or National Health Service (UK)
NOHSC	National Occupational Health and Safety Commission
NPHT	National Preventive Health Taskforce
NRRAHAS	National Rural and Remote Allied Health Advisory Service
OECD	Organisation for Economic Co-operation and Development
ODA	official development assistance
OHS	occupational health and safety
OOS	occupational over-use syndrome
OPAL	Obesity Prevention and Lifestyles
PBS	Pharmaceutical Benefits Scheme
PCM	Prevention Community Model
PCPs	Primary Care Partnerships

PHC	primary health care
PHIAC	Private Health Insurance Administration Council
PKU	phenylketonuria
RACGP	Royal Australian College of General Practitioners
RCTs	randomised control trials
RPBS	Repatriation Pharmaceutical Benefits Scheme
RRMA	Rural, Remote and Metropolitan Areas
RSI	repetition strain injury
RUSC	Rural Undergraduate Support and Coordination
RVCN	Royal Victorian College of Nurses
SARRAH	Services for Australian Rural and Remote Allied Health
SCHIP	State Children's Health Insurance Program
SCHP	structuralist–collectivist health promotion
SES	socio-economic status
SG	Superannuation Guarantee
SIDS	Sudden Infant Death Syndrome
TASA	The Australian Sociological Association
TCM	traditional Chinese medicine
TM	traditional medicine
U3A	University of the Third Age
UNA	United Nurses Association
VTNA	Victorian Trained Nurses' Association
WASP	White Anglo-Saxon Protestant
WFS	World Food Summit
WHO	World Health Organization
WHS	workplace health and safety
WSRO	World Sugar Research Organization

PART 1

HEALTH SOCIOLOGY AND THE SOCIAL MODEL OF HEALTH

> *The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.*
>
> BENJAMIN DISRAELI

At the heart of health sociology is a belief that many health problems have social origins. The focus of health sociology is not on medical treatment or individual cures for ill-health. While individuals suffer ill-health and require health care, some of the causes and cures can often lie in the social context in which they live and work. Health sociology asks you to step outside the square and look beyond medical opinions by adopting a second opinion, which focuses on how health, illness, and the health care system are by-products of the way a society is organised.

This introductory part of the book provides an overview of health sociology: what it is, its major theoretical perspectives, and the types of health research it draws upon.

Part 1 consists of three chapters:

01 IMAGINING HEALTH PROBLEMS AS SOCIAL ISSUES

John Germov

Overview

- What is sociology and how can it be used to understand health and illness?
- What social patterns of health and illness exist?
- What is the social model of health and how does it differ from the medical model?

THE FOREST THROUGH THE TREES

We live in a health-obsessed age. We are bombarded with messages from health authorities, health professionals, and fitness gurus to 'do this' and 'not to do that'. Everywhere we turn we are urged to take individual responsibility for our health. Our personal experience of illness means that we tend to view it in an individualistic way—as a product of bad luck, poor lifestyle, or genetic fate. As individuals we all want quick and effective cures when we are unwell and thus we turn to medicine. Yet this is only part of the story. Even the highly individualised and very personal act of suicide occurs within a social context. For example, Australian men have a suicide rate over triple that of women (AIHW 2012). In fact, the social patterning of suicide was first highlighted in the late nineteenth century by the sociologist Émile Durkheim (1858–1917). While Durkheim (1897/1951) acknowledged individual reasons for a person committing suicide, he found that suicide rates varied between countries and between different social groups within a country. By studying such social patterns, health sociology exposes the 'forest through the trees'—how individual health problems can be part of a social patterning of illness that has social origins and requires social solutions.

Key terms

agency
biological determinism
biomedicine/biomedical model
Cartesian dualism
class (or social class)
epidemiology/social epidemiology
eugenics
lifestyle choices/factors
new public health
public health/public health infrastructure
reductionism
social construction/constructionism
social Darwinism
social institutions
social model of health
social structure
sociological imagination
state
structure–agency debate
victim-blaming

Introduction: the social origins of health and illness

This chapter introduces you to the sociological perspective and how it can be used to understand a wide range of health issues. Health sociology focuses on the social patterns of health and illness—such as the different health statuses between women and men, the poor and the wealthy, or the Indigenous and non-Indigenous populations—and seeks social rather than biological or psychological explanations. It provides a second opinion to the conventional medical view of illness derived from biological and psychological explanations, by exploring the social origins of health and illness—the living and working conditions that fundamentally shape why some groups of people get sicker and die sooner than others.

The social origins of health and illness can clearly be seen when we compare the life expectancy figures of various countries. As we all know, life expectancy in the least developed countries is significantly lower than that in industrially developed and comparatively wealthy countries such as Australia, Sweden, Germany, and Japan. For example, the average life expectancy at birth of people living in the least developed countries of the world is around 20 years less than that for developed countries such as Australia, which has an average life expectancy of 82 years (AIHW 2012; UNDP 2013). As Table 1.1 shows, though, life expectancy varies among developed countries as well. Therefore, the living conditions of the country in which you live can have a significant influence on your chances of enjoying a long and healthy life.

Australian life expectancy is one of the highest in the world, second only to Japan. This is not due to any biological advantage in the Australian gene pool, but is rather a reflection of our distinctive living and working conditions. We can make such a case for two basic reasons. First, life expectancy can change in a short period of time, and in fact it did increase for most countries during the twentieth century. For example, Australian life expectancy has increased by more than 25 years since 1910 (AIHW 2012), which is too short a time frame for any genetic improvement to occur in a given population. Second, data compiled over decades of immigration show that the health of migrants comes to reflect that of their host country over time, rather than their country of origin. The longer migrants live in their new country, the more their health mirrors that of the local population (Marmot 1999).

While the average Australian life expectancy figure is comparatively high, it is important to distinguish between different social groups within Australia. Life expectancy figures are crude indicators of population health and actually mask significant health inequalities among social groups within a country. For example, in Australia those in the lowest socio-economic group have the highest rates of illness and premature death, use preventive services less, and have higher rates of illness-related behaviours such as smoking (AIHW 2012). Furthermore, as Table 1.1 shows, life expectancy for Indigenous Australians is around 12 years less than the national average. In fact, the current life expectancy of Indigenous Australians is closer to that of Australians born in the early twentieth century (AIHW 2012). The indigenous population of New Zealand, the Māori, also have a lower life expectancy—around 7.3 years less than the national average (Statistics New Zealand 2013).

TABLE 1.1 LIFE EXPECTANCY AT BIRTH, 2010

COUNTRY	LIFE EXPECTANCY	
	Men	*Women*
Australia	79.5	84.0
Indigenous Australians (2005–07)	67.0	73.0
Canada (2008)	78.5	82.7
France	78.0	84.7
Germany	78.0	83.0
Italy (2009)	79.4	83.8
Japan	79.6	86.4
New Zealand (2010–12)	79.3	83.0
Maori (2010–12)	72.8	76.5
Russian Federation	63.0	74.9
Sweden	79.5	83.5
UK	78.6	82.6
US	76.2	81.1

Source: Adapted from OECD 2013; AIHW 2010; Statistics New Zealand 2013

Introducing the sociological imagination: a template for doing sociological analysis

What is distinctive about the sociological perspective? In what ways does it uncover the social structure that we often take for granted? How is sociological analysis done? The American sociologist Charles Wright Mills (1916–62) answered such questions by using the expression **sociological imagination** to describe the distinctive feature of the sociological perspective. The sociological imagination is 'a quality of mind that seems most dramatically to promise an understanding of the intimate realities of ourselves in connection with larger social realities' (Mills 1959, p. 15). According to Mills, the essential aspect of thinking sociologically, or seeing the world through a sociological imagination, is making a link between 'private troubles' and 'public issues'.

SOCIOLOGICAL IMAGINATION
A term coined by Charles Wright Mills to describe the sociological approach to analysing issues. We see the world through a sociological imagination, or think sociologically, when we make a link between personal troubles and public issues.

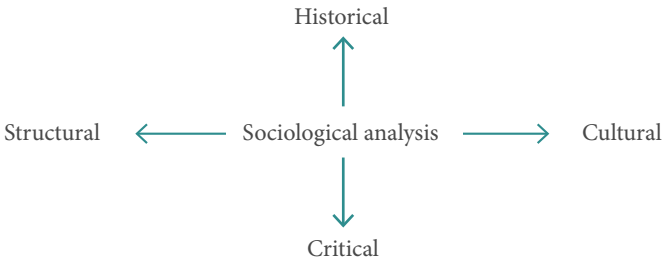
As individuals, we may experience personal troubles without realising they are shared by other people as well. If certain problems are shared by groups of people, they may have a common cause and be best dealt with through collective action. As Mills (1959, p. 226) states, 'many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues … public issues must be revealed by relating them to personal troubles'. The Australian sociologist Evan Willis (1993; 2011) suggests that the sociological imagination consists of four interrelated parts:

1 *historical factors*: how the past influences the present;
2 *cultural factors*: how culture impacts on our lives;
3 *structural factors*: how particular forms of social organisation affect our lives;
4 *critical factors*: how we can improve our social environment.

This four-part sociological imagination template is an effective way to understand how to think and analyse in a sociological way.

Figure 1.1 represents the sociological imagination template as a diagram that is easy to remember. Any time you want to analyse a topic sociologically, picture this diagram in your mind.

FIGURE 1.1 THE SOCIOLOGICAL IMAGINATION TEMPLATE



Sociological analysis involves applying these four aspects to the issues or problems under investigation. For example, a sociological analysis of why manual labourers have a shorter life expectancy would examine how and why the work done by manual labourers affects their health, by examining:

1. *historical factors*: to understand why manual workplaces are so dangerous;
2. *cultural factors*: such as the cultural value of individual responsibility;
3. *structural factors*: such as the way work is organised, the role of managerial authority, the rights of workers, and the role of the state;
4. *critical factors*: such as alternatives to the status quo (increasing the effectiveness of occupational health and safety legislation, for instance).

By using the four parts of the sociological imagination template, you begin to 'do' sociological analysis. It is worth highlighting at this point that the template simplifies the process of sociological analysis. When analysing particular topics, it is more than likely that you will find that the parts overlap, making them less clear-cut than the template implies. It is also probable that for some topics, parts of the template will be more relevant and prominent than others—this is all to be expected. The benefit of the template is that it serves as a reminder of the sorts of issues and questions a budding sociologist should be asking.

IS SOCIETY TO BLAME? INTRODUCING THE STRUCTURE–AGENCY DEBATE

SOCIAL STRUCTURE
The recurring patterns of social interaction through which people are related to each other, such as social institutions and social groups.

SOCIAL INSTITUTIONS
Formal structures within society—such as health care, government, education, religion, and the media—that are organised to address identified social needs.

As individuals we are brought up to believe that we control our own destiny, especially our health. It is simply up to each individual to 'do what they wanna do and be what they wanna be'. This belief ignores the considerable influence of society. Sociology makes us aware that we are social animals and are very much the product of our environment, from the way we dress to the way we interact with one another. We are all influenced by the **social structure**, such as our cultural customs and our **social institutions**. The idea of social structure serves to remind us of the social or human-created aspects of life, in contrast to purely random events or products of nature (López & Scott 2000).

Understanding the structure of society enables us to examine the social influences on our personal behaviour and our interactions with others. Yet to what extent are we products of society? How much **agency** do we have over our lives? Are we solely responsible for our actions or is society to blame? These questions represent a key debate in sociology, often referred to as the **structure–agency debate**. There is no simple resolution to this debate, but it is helpful to view structure and agency as interdependent; that is, that humans shape and are simultaneously shaped by society. In this sense, structure and agency are not 'either/or' propositions in the form of a choice between constraint and freedom, but are part of the interdependent processes of social life. Therefore, the social structure should not automatically be viewed in a negative way, as only serving to constrain human freedom, since in many ways the social structure enables us to live, by providing health care, welfare, education, and work. As Mills maintained, an individual 'contributes, however minutely, to the shaping of this society and to the course of its history, even as he is made by society and by its historical push and shove' (1959, p. 6). Mills was clearly a product of the 'historical push and shove' of his social structure, as he uses the masculine 'he' to refer to both men and women—a usage now seen as dated and sexist.

AGENCY
The ability of people, individually and collectively, to influence their own lives and the society in which they live.

STRUCTURE–AGENCY DEBATE
A key debate in sociology over the extent to which human behaviour is determined by social structure.

Peter Berger long ago warned against depicting people as 'puppets jumping about on the ends of their invisible strings' (1966, p. 140). If we use the 'all the world's a stage and we are mere actors' analogy, we could liken life to a theatre in which we all play our assigned roles (father, mother, child, labourer, teacher, student, and so on). Whether it is how we are dressed as we walk down the street or how we present ourselves at a funeral, customs and traditions dictate expected modes of behaviour. In this sense we are all actors on a stage. Yet, we have the scope consciously to participate in what we do. We can make choices about whether simply to act, or whether to modify or change our roles and even the stage on which we live our lives.

Although we are born into a world not of our making, and in countless ways our actions and thoughts are shaped by our social environment, we are not simply 'puppets on strings'. Humans are sentient beings—we are self-aware and thus have the capacity to think and act individually and collectively to change the society into which we are born. Structure and agency may be in tension, but they are interdependent; that is, one cannot exist without the other. Sociology is the study of the relationship between the individual and society; it examines how human behaviour both shapes and is shaped by society, or how 'we create society at the same time as we are created by it' (Giddens 1986, p. 11).

Social medicine and public health

Recognition of the social origins of health and illness actually occurred prior to the formal development of sociology as an academic discipline, and can be traced to the mid-nineteenth century, with the development of 'social medicine' (coined by Jules Guérin in 1848) or what more commonly became known as **public health** (sometimes referred to as social health, community medicine, or preventive medicine). At this time, infectious diseases such as cholera, typhus, smallpox, diphtheria, and tuberculosis were major killers for which there were no cures and little understanding of how they were transmitted. During the nineteenth century, a number of people such as René Villermé (1782–1863), Rudolph Virchow (1821–1902), John Snow (1813–58), Edwin Chadwick (1800–90), and Friedrich Engels (1820–95) established clear links between infectious diseases and poverty (Rosen 1972; Porter 1997).

PUBLIC HEALTH/ PUBLIC HEALTH INFRASTRUCTURE
Public policies and infrastructure to prevent the onset and transmission of disease among the population, with a particular focus on sanitation and hygiene such as clean air, water and food, and immunisation. Public health infrastructure refers specifically to the buildings, installations, and equipment necessary to ensure healthy living conditions for the population.