

# Health Sociology In A Globalizing World

## *Sociología de la salud en un mundo globalizado*

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### RESUMEN

Los sociólogos que trabajan en el área de la salud representan uno de los grupos de especialistas de la sociología más grandes en el mundo. Este campo se ha expandido globalmente como respuesta al creciente reconocimiento del papel significativo que tienen los factores sociales a la hora de determinar la salud de individuos, grupo y poblaciones. El carácter especialmente relevante que ha tenido últimamente la sociología de la salud tiene que ver con (1) la utilización de la teoría sociológica para el estudio de la salud y (2) la manera como la perspectiva sociológica ha permitido poner en evidencia las causas y los efectos colectivos sobre los problemas de salud. Hoy en día se puede decir que la sociología de la salud produce información que puede ser útil tanto para la medicina como para los decisores políticos; pero, a la vez, las investigaciones de campo que se realizan desde la sociología de la salud sobre situaciones relacionadas con la salud también son útiles para la propia sociología.

Este papel revisará brevemente el origen de la sociología de la salud y perfilará la transición de su estatus actual, antes de discutir los más recientes desarrollos en las técnicas de investigación y la probable dirección futura de este campo.

**PALABRAS CLAVE:** Sociología de la salud, mundo globalizado.

### ABSTRACT

Sociologists working in the area of health comprise one of the largest sociological specialties in the world. The field has expanded globally in response to growing recognition of the significant role of social factors in determining the health of individuals, groups, and populations. Ultimately, what allows health sociology to retain its unique character is (1) its utilization and mastery of sociological theory in the study of health and (2) the sociological perspective that accounts for collective causes and outcomes of health problems and issues. Today it can be said that health sociology produces literature intended to inform medicine and policymakers, but research in the field is also grounded in examining health-related situations that inform sociology as well. This paper will briefly review the origins of health sociology and outline the transition to its current status before discussing the most recent developments in research techniques and the likely future direction of the field.

**KEYWORDS:** Health sociology, Globalizing world.

### SUMARIO

1. Origins of Health Sociology. Talcott Parsons. The Post-Parsons Era. Period of Maturity: 1970-2000. The Present: 2000-2010. Postmodern Theory. Medicalization. Health Lifestyles. Social Capital. Neighborhood Disadvantage. Socioeconomic Status as a Fundamental Cause of Sickness and Mortality. Future Directions. Conclusion. References.

## ORIGINS OF HEALTH SOCIOLOGY

Compared to other sociological specialties, health sociology—also known as medical sociology—is relatively new. It first appeared in the late 1940s and early 1950s in an intellectual climate far different from sociology's traditional areas of study. Specialties like theory, social stratification, social change, and the sociology of religion had direct roots in 19<sup>th</sup> century European social thought. These specialties were grounded in classical theory with major works by the discipline's founding figures. However, sociology's early theorists ignored medicine likely because it was not an institution shaping the nature and structure of society and the topic of health did not seem to be a sociological subject. An exception is Emile Durkheim's *Suicide* ([1897] 1951) that is sometimes claimed as the first major work in the field, but this connection is indirect at best.

Moreover, physicians, not sociologists, produced much of the earliest literature in health sociology. In the United States, John Shaw Billings, organizer of the National Library of Medicine and compiler of the *Index Medicus*, wrote about hygiene and sociology in 1879; Charles McIntire provided a definition of medical sociology (the study of physicians as a social phenomena) in 1894; Elizabeth Blackwell, the first woman to graduate from an American medical school published a collection of essays on medical sociology in 1902, as did James Warbasse in 1909 (Bloom, 2002). The most important contribution came from Lawrence Henderson, a physician who taught a sociology course at Harvard in the 1930s. Henderson espoused structural-functional theory and published a 1935 work on the patient-physician relationship as a social system. Henderson's most direct influence on health sociology was through Talcott Parsons, one of his students who became the world's leading figure in sociology during his lifetime (Bloom, 2002). The first sociologist to publish extensively on health-related topics was Bernhard Stern who wrote historical accounts of the role of medicine in society from the late 1920s until the early 1940s.

Health sociology evolved as a specialty in sociology in response to funding agencies and policymakers in the U.S. and Great Britain after

World War II who viewed it as an applied field that could produce knowledge for use in clinical practice, public health campaigns, and health policy formulation. Ample funding for research to help solve the health problems of industrial society and the welfare state in the West during the post-World War II era stimulated its growth. In 1949, for example, the Russell Sage Foundation in the United States funded a program to improve the utilization of social science in medical practice that resulted in monographs on social science and medicine and the role of sociology in public health. Particularly important was the establishment of the National Institute of Mental Health (NIMH) in the United States that funded and promoted cooperative research projects between sociologists and physicians. A significant result of such cooperation was the publication in 1958 of *Social Class and Mental Illness: A Community Study* by August Hollingshead (a sociologist) and Frederick Redlich (a psychiatrist). This landmark study produced important evidence that social factors were correlated with different types of mental disorders and the manner in which people received psychiatric care. The book remains the seminal study of the relationship between mental disorder and social class.

At the beginning of health sociology's expansion, many people in the field had tenuous roots in mainstream sociology and an orientation toward applied rather than theoretical work. Some had no training in health sociology whatsoever. Many had been attracted to the field because of the availability of jobs and funding for research. This situation led Robert Straus to suggest that health sociology had become divided into two areas: (1) sociology in medicine and (2) sociology of medicine (Bloom, 2002). The sociologist in medicine performed applied research and analysis primarily motivated by a medical problem rather than a sociological problem. Sociologists in medicine typically worked in medical, nursing, public health or similar professional schools, public health agencies, or health organizations like CDC and WHO. Sociologists of medicine primarily worked in academic sociology departments and engaged in research and analysis of health from a sociological perspective.

The division in orientation created problems in the United States. Health sociologists in

universities were in a stronger position to produce work that satisfied sociologists as good sociology. Sociologists in medical institutions had the advantage of participation in medicine as well as research opportunities unavailable to those outside clinical settings. Disagreement developed between the two groups over whose work was the most important. What resolved this situation over time was a general evolution in health sociology that saw both applied and theoretical work emerge on the part of health sociologists in all settings. Health sociologists in universities responded to funding requests for applied research, while some of their counterparts in medical institutions, such as Anselm Strauss, produced important theoretical work. Strauss, on the faculty at the University of California at San Francisco School of Nursing, was a leading figure in symbolic interaction theory in the 1960s and 1970s.

A related problem in the early development of health sociology was its potential to become dependent on medicine for its direction and research orientation. However, this did not happen, as health sociologists adopted an independent, professional, and critical outlook. They made the practice of medicine one of its major subjects of inquiry, including its core relationships with patients and the organizational structure of health care delivery systems (Bloom, 2002). Health sociologists, in turn, brought their own topics to the study of health such as social stress, health disparities, gender and health, health behavior and lifestyles, and the social determinants of disease.

## TALCOTT PARSONS

A decisive event took place in health sociology in 1951 that provided a theoretical direction to a formerly applied field. This was the appearance of Parson's *The Social System*. This book, written to explain a complex structural-functionalist model of society contained Parson's concept of the sick role. Parson's sick role formulation is a clear and straightforward statement of four basic propositions outlining the normative pattern of physician utilization by the sick and their respective social roles. Parson not only constructed the first theoretical concept directly applicable to health sociology, but by utilizing

the work of Durkheim and Max Weber, he did so within the parameters of classical sociological theory. Parson had become perhaps the best known sociologist in the world and having a theorist of his stature provide the first major theory in health or medical sociology called attention to the young subdiscipline—particularly among academic sociologists. Anything he published attracted interest. Not only was Parson's concept of the sick role a distinctly sociological analysis of sickness, but it was widely believed by many sociologists at the time that Parson was charting a future course for all of sociology through his theoretical perspective. This did not happen. Nevertheless, Parson brought health sociology intellectual recognition that it needed in its early development by endowing it with theory. Moreover, following Parson, other leading sociologists of the time such as Robert Merton, Erving Goffman, and Strauss published work in medical sociology that further promoted the academic legitimacy of the field.

Health sociology in the U. S. could therefore lay claim to a theoretical foundation blended with an emphasis on empirical research and a base in both in both academic and health institutions. Although in its early years it may have appeared to be atheoretical, dominated by medical interests, and a largely applied field existing outside mainstream sociology, American health sociology unfolded over time to be none of these things. Rather, it has a theoretical base, is not dominated by medicine nor is exclusively applied, and is integrated into the wider community of sociologists (Cockerham, 2010a). Although Europe had an older tradition of social medicine and social hygiene, there was not a leading sociologist to take an interest in the field, sociology was struggling to rebuild after World War II, many persons working early in the field had not been trained in health sociology, and most were concentrated in schools of medicine and public health with only a few in university sociology faculties (Claus, 1983). Moreover, the spread of health sociology was uneven with it making an initial appearance in the 1950s in Britain and Germany and in the 1960s in Spain, France, Finland, Austria, Italy, and Sweden. Health sociology was not established in most Eastern European countries until after the collapse of socialism in 1989-91.

## THE POST-PARSONS ERA

The next major area of research after Parsons developed his sick role concept was medical education. Merton and his colleagues (1957) extended the structural-functionalist mode of analysis to the socialization of medical students, with Renée Fox's paper on training for uncertainty ranking as a major contribution. However, structural-functionalism, with its emphasis on value consensus, social order, stability, and functional processes at the macro-level of society, had a short-lived period as the leading theoretical paradigm in health sociology. Four years later, Howard Becker and his associates published *Boys in White* (1961), a study of medical school socialization conducted from a symbolic interactionist perspective. This study became a sociological classic and was important for both its theoretical and methodological content.

With the introduction of symbolic interaction into a field that had previously been dominated by structural-functionalism, health sociology became a major arena of debate between two of sociology's major theoretical schools. This debate helped stimulate a virtual flood of publications in medical sociology in the 1960s. Moreover, the Medical Sociology Section of the American Sociological Association was formed in 1959 and grew to become one of the largest and most active ASA sections. American influence was also important in founding Research Committee 15 (Health Sociology) of the International Sociological Association in 1967 (Bloom, 2002). The Medical Sociology Group of the British Sociological Association was organized in 1964 and became the largest specialty group in the BSA, with its own annual conference.

In 1966 the *Journal of Health and Social Behavior*, founded in 1960, became an official ASA publication, making medical sociology one of the few sociological subdisciplines publishing its own journal under ASA auspices. Decades later, another health-related ASA journal, *Society and Mental Health*, was approved in 2010. In the meantime, in Great Britain, *Social Science and Medicine*, was founded in 1967 that became an especially important journal for medical sociologists throughout the world. The growing literature in medical sociology also led to the publication of textbooks. The first textbook

was Norman Hawkins's *Medical Sociology* published in 1958, but the early leaders were the first editions of books by David Mechanic in 1968 and Rodney Coe in 1970. Howard Freeman, Sol Levine, and Leo Reeder likewise made an important contribution by publishing the *Handbook of Medical Sociology* in 1961 that contained summary essays on major topics by leading medical sociologists and continues today in subsequent editions.

During the 1960s, the symbolic interactionist perspective temporarily dominated a significant portion of the literature. Symbolic interaction maintained that social reality is constructed by individuals interacting with one another on the basis of shared symbolic meanings. The capacity of humans to think, define situations, and construct their behavior on the basis of their definitions and interpretations allowed them to construct their own social reality. Social life was therefore produced by interacting agents choosing their own behavior and acting accordingly, not by large-scale social processes and structures channeling behavior down option-less pathways. Symbolic interaction not only had its particular (micro-level) orientation toward theory construction, but also its own qualitative research methodologies of participant observation that focused on small group interaction in natural social settings.

One feature of this domination was the numerous studies conducted with reference to labeling theory and the mental patient experience. Sociologists expanded their work on mental health to also include studies of stigma, stress, families coping with mental disorder, and other areas of practical and theoretical relevance. For example, Goffman's *Asylums* (1961), a study of life in a mental hospital, presented his concept of "total institutions" that stands as a significant sociological statement about social life in an externally controlled environment. An abundant literature emerged at this time that established the sociology of mental disorder as a major subfield within medical sociology (Cockerham 2010b).

## PERIOD OF MATURITY: 1970-2000

Between 1970 and 2000 medical sociology emerged as a mature sociological specialty. This

period was marked by the publication of two especially important books, Eliot Friedson's *Professional Dominance* (1970a) and Paul Starr's *The Social Transformation of American Medicine* (1982). Friedson formulated his influential "professional dominance" theory to account for an unprecedented level of professional control by American physicians over health care delivery that was true at the time but no longer exists. Starr's book won the Pulitzer Prize and countered Friedson's thesis by examining the decline in status and professional power of the medical profession as large corporate health care delivery systems oriented toward profit effectively entered an unregulated medical market. Donald Light (1993) subsequently used the term "countervailing power" to show how the medical profession was but one of many powerful groups in society—the state, employers, health insurance companies, patients, pharmaceutical and other companies providing medical products—maneuvering to fulfill its interests in health care.

Another major work was Bryan Turner's *Body and Society* (1984) that initiated study on this topic in sociology. Theoretical developments concerning the sociological understanding of the control, use, and phenomenological experience of the body, including emotions, followed. Much of this work has been carried out in Great Britain and features social constructionism as its theoretical foundation. One branch of social constructionism has its origins in the work of the French social theorist Michel Foucault and takes the view that knowledge about the body, health, and illness reflects subjective, historically specific human concerns and is subject to change and reinterpretation. Another branch draws on the work of Peter Berger and Thomas Luckmann's *The Social Construction of Reality* (1967) and Friedson's approach in *Professional Dominance* (1970a) and *The Profession of Medicine* (1970b) that is grounded in symbolic interaction theory.

Other areas in which British medical sociologists have excelled include studies of medical practice, emotions, and the experience of illness.

Conflict theory, with its roots in the work of Karl Marx and Max Weber, joined symbolic interaction in significantly reducing the influence of structural-functionalism. Conflict theory is based on the assumption that society is composed

of various groups struggling for advantages, inequality is a basic feature of social life, and conflict is the major cause of social change. Marx's perspective in conflict theory is seen in the rejection of the view expressed by structural-functionalism that society is held together by shared norms and values. Conflict theory claims that true consensus does not exist; rather, society's norms and values are those of the dominant elite and imposed by them on the less privileged to maintain their advantaged position. Weber adds, however, that social inequality is not based on just money, property, and relationships to the means of production, but also on status and political influence. Since all social systems contain such inequality, conflict inevitably results and conflict, in turn, is responsible for social change.

Whereas the Marxian-oriented features of conflict theory emphasized class struggle, another emphasis was on conflicts that occur between interest groups and the unequal distribution of political power. According to Turner (1988), modern societies are best understood as having a conflict between the principles of democratic politics (emphasizing equality and universal rights) and the organization of their economic systems (involving the production, exchange, and consumption of goods and services, about which there is considerable inequality). Therefore, while people have political equality, they lack socioeconomic equality. This unresolved contradiction is relatively permanent and a major source of conflict. Ideologies of fairness are constantly challenged by the realities of inequalities, and they influence governments to try to resolve the situation through equitable policies and welfare benefits.

This situation represents one of conflict theory's most important assets for health sociology; namely, the capacity to explain the politics associated with health policies. Conflict theory allows us to analyze the maneuvers of various entities, like the medical profession, insurance companies, drug companies, the business community, and the public, as they struggle to acquire, protect, or expand their interests against existing government regulations and programs and those under consideration. Other conflict approaches were connected more directly to classical Marxism by relying on class

struggle to explain health policy outcomes (Navarro, 1976), feminist views of women's health (Doyal, 1995), and the disadvantages of the lower and working classes in capitalist medical systems where the emphasis is on profit (Waitzkin, 1993). While a major focus of conflict theory in health sociology is on the role of competing interests in health care delivery and policy, other research was on the sources of illness and disability in work environments, working-class health, and capitalist ideologies in the physician–patient relationship (McKinlay, 1984; Waitzkin, 1993).

Marxist viewpoints had also been used in studies of health disparities, such as Richard Wilkinson's income inequality thesis that was subsequently debunked by critics. Wilkinson (1996) had claimed that the more equal levels of income are in a country, than the more positive that country's overall of health. Consequently, it is not populations in the wealthiest countries that have the best health, but those in the most egalitarian. In the late 1990s, Wilkinson's perspective generated considerable interest and debate, but support began disappearing as other scholars failed to replicate the same findings and serious methodological shortcomings were noted (Beckfield, 2004; Lynch and Davey Smith, 2002).

Moreover, Marxist theory itself went into decline in health sociology as it did in sociology generally. As Callinicos (2007) points out, Marxism had begun losing influence from the late 1970s onward as political events sank Marxist theory in the universities. First, French scholars turned their back on Marxism as a "theory of domination" in response to Soviet labor camps, the cold war, and the crackdown on Solidarity in Poland in 1981, followed by similar reactions elsewhere in Europe and Latin America. "The process of retreat was slower in the English-speaking world," states Callinicos (2007: 261), "but by the beginning of the 1990s, under the impact of postmodernism and the collapse of 'existing socialism' in Eastern Europe and the Soviet Union, Marx was a dead dog for most intellectuals there as well."

As a political doctrine, Marxist–Leninism also failed to construct healthy social conditions and an adequate health care delivery system in the former Soviet Union and the East European

socialist countries that experimented with it (Cockerham 1999, 2007c). Most of these countries experienced a 30-year decline (1965–95) in male life expectancy and for some—Belarus, Kazakhstan, Russia, and Ukraine—the health crisis is still continuing. The epicenter of the downturn in life expectancy was in Russia where male longevity fell 5.2 years between 1965 and 2005 and female life expectancy rose only 0.3 years. The theoretical and practical failure of Marxism to produce healthy societies substantially undermines the utility of Marxist-based theories in health sociology (Cockerham 2007a). The greatest potential of conflict theory for health sociology thus lies in its non-Marxist aspects, as interest-group competition in welfare states proves more relevant for health concerns than Marxist notions of class struggle.

Health sociology in the meantime became a major sociological specialty in Spain, Sweden, Finland, the Netherlands, Germany, Italy, and Israel, and began to emerge in Russia and Eastern Europe in the 1990s after the collapse of communism. In the meantime, the European Society for Health and Medical Sociology was formed in 1983 that hosts a biannual conference for European medical sociologists. In Japan, the Japanese Society for Medical Sociology was established in 1974 and since 1990 has published an annual review of work in the field. Elsewhere in Asia, medical sociology is especially active in Singapore, Thailand, and India, and is beginning to appear in China. In Africa, medical sociology is strongest in South Africa. Health sociology is also an important field in Latin America and because of its special Latin character many practitioners prefer to publish their work in books and journals in Mexico, Brazil, Argentina, and Chile (Castro, 2005).

From the 1970s through the 1990s, health sociology flourished as it attracted large numbers of practitioners in both academic and applied settings and sponsored an explosion of publications based upon empirical research. Major areas of investigation included stress, medicalization, mental health, inequality and class disparities in health, health care utilization, managed care and other organizational changes, AIDS, and women's health and gender. Another major health sociology journal, the *Sociology of*

*Health & Illness*, was started in Britain in 1978, followed by the journal *Health* in 1999. The Australian Sociological Association initiated their journal *Health Sociology Review* in 1991. Additionally, several books and textbooks appeared. The leading textbook was William Cockerham's *Medical Sociology* that was first published in 1978 and "appears in a 12<sup>th</sup> edition in 2012. A Spanish language edition of this textbook translated by Lourdes Lostao and Enrique Regidor was published in 2002.

In a major development that was likely inevitable, given the growth of the field, its broad research agenda, and utilization of sociological theory, the 1990s saw health sociology move much closer to its parent discipline of sociology. This was seen in a number of areas with health sociological work appearing frequently in mainstream sociology journals and the increasing application of sociological theory to the analysis of health problems. While health sociology drew closer to sociology, sociology in turn moved closer to health sociology as the field emerged as one of the largest and most robust sociological specialties.

The success of health sociology also brought problems. The field faced serious competition for research funding opportunities with health economics, health psychology, medical anthropology, health services research, and public health. These fields not only adopted proven sociological research methods in the form of social surveys, participant observation techniques, and focus groups, but they also employed health sociologists in large numbers. While these developments were positive in many ways, the distinctiveness of health sociology as a unique subdiscipline was nevertheless challenged as other fields moved into similar areas of research. Furthermore, some of the health sociology programs at leading American universities declined in strength or disappeared over time as practitioners retired or were hired away. Yet the overall situation for health sociology was highly positive as the job market remained good, almost all graduate programs in sociology offered a specialization in health or medical sociology, and sociologists were on the faculties of most medical schools in the United States, Canada, and Western Europe (Bloom, 2002).

## THE PRESENT: 2000-2010

The beginning of the 21<sup>st</sup> century witnessed further developments as would be expected with the approach of a new era. Postmodern theory faltered, while medicalization, health lifestyles, social capital, and neighborhood disadvantage emerged as important areas of research.

## POSTMODERN THEORY

Postmodern theory, with its roots in post-structuralism, seemed to be a promising approach for explaining the social changes accompanying the new century. While there was considerable disagreement about the nature and definition of postmodernism, a common theme was the breakup of modernity and its postindustrial social system leading to new social conditions. Postmodernism was generally ignored by sociologists until the mid-1980s when primarily British social scientists decided it was worthy of serious attention (Bertens, 1995). Postmodernism emerged out of poststructuralism as a more inclusive critique of modern sociological theory and grand narratives making sweeping generalizations about society as a whole; it rejected notions of continuity and order and called for new concepts explaining the disruptions of late modern social change (Best and Kellner 1991). Postmodern theory itself posited that there was no single coherent rationality and the framework for social life had become fragmented, diversified, and decentralized (Turner, 1990). Its sociological relevance rested in its depiction of the destabilization of society and the requirement to adjust theory to new social realities. The advantage of postmodern theory is that modern society is undergoing a transition with social conditions different from the recent past (the latter part of the 20<sup>th</sup> century) and the perspective provides a theoretical framework, despite its diffuse literature, for examining some of these changes.

However, there were few works in health sociology explicitly adopting postmodern themes. Exceptions include highly abstract discourses on health and the definition of the body (Fox, 1993), along with works concerning the fragmentation of modern society and medical

authority leaving individuals with greater self-control over their bodies (Glassner 1989), increased personal responsibility for their health (Cockerham et al., 1997), and greater use of alternative forms of health care (McQuaide, 2005). Pescosolido and Rubin (2000) linked postmodern conditions to the deinstitutionalization of the mentally ill in the United States. Despite these few studies, however, the highly abstract orientation of the theory made it difficult to utilize for empirical research which undermined its practical utility for health sociology (Cockerham 2007b).

The theory reached its highest level of popularity in sociology during the early 1990s and momentarily seemed poised to have an important future in health sociology. But this did not occur. Use of the theory abruptly declined in the late 1990s and a strong foothold in medical sociology has yet to be achieved in the 21<sup>st</sup> century (Cockerham 2007b). Why? Postmodern theory turned out to have a number of shortfalls, including its failure to explain social conditions after the rupture with modernity is complete, the lack of an adequate theory of agency, being too abstract and ambiguous, not providing clear conceptualizations, an inability to account for social causation, not having empirical confirmation, and invariably featuring an obtuse jargon that only its dedicated adherents found meaningful and others came to regard as nonsense (Best and Kellner 1991; Cockerham 2007b; Pescosolido and Rubin 2000). It is still popular in some circles although its influence has waned considerably in recent years and become less important.

## MEDICALIZATION

The epidemiological transition from acute to chronic diseases as the leading cause of death also promoted a greater concern in health sociology with medicalization and health-promoting lifestyles. Medicalization was an earlier development which continued to gain attention. Some health sociologists expressed concern that the medical profession had taken responsibility for an ever greater proportion of deviant behaviors and bodily conditions by defining them as medical problems (Clarke *et al.* 2003; Conrad, 2007). As Freidson (1970a)

had put it decades ago, medicine had established a jurisdiction over problems in living far wider than justified by its demonstrable capacity to “cure.” Nevertheless, the medical profession has been successful in gaining authority to define aberrant behaviors and even naturally occurring physical conditions such as aging as illness, and thus problems best handled by physicians. For example, hyperactivity at school by children is defined as Attention-Deficit/Hyperactivity Disorder (ADHD) and requires Ritalin; menopause is treated with estrogen replacement therapy, whose side effects were determined a few years later to promote even greater risk from blood clots, stroke, heart disease, and breast cancer; being short in stature necessitates growth hormones for the person afflicted with below average height; and male baldness is slowed or prevented by using Propecia and lost hair is restored by surgical transplants (Conrad, 2007). There was a time when hyperactivity, menopause, shortness, and baldness were not medical conditions, but they are today.

For some people, new medical treatments for previously untreated conditions were positive, such as the development of Viagra and similar drugs for erectile dysfunction. Success for some problems and hopeful expectations for others apparently stimulated an even greater expansion of the medicalization process. This outcome led Adele Clarke and her colleagues (2003:161) to declare that the growth of medical jurisdiction over social problems is “one of the most potent transformations of the last half of the twentieth century in the West.” Whereas medicalization has traditionally been a means by which professional medicine acquired increasingly more problems to treat, Clarke *et al.* (2003) suggest that major technological and scientific advances in biomedicine are taking this capability even further and producing what she and her colleagues refer to as biomedicalization. Biomedicalization consists of the capability of computer information and new technologies to extend medical surveillance and treatment interventions well beyond past boundaries, by the use of genetics, bioengineering, chemoprevention, individualized drugs, multiple sources of information, patient data banks, digitized patient records, and other innovations. Also important in this process is the Internet, advertising, consumerism, and the role



of pharmaceutical companies in marketing their products.

The increasing commercialization of health products and services in the expansion of the medical marketplace has been noted by other medical sociologists (Conrad 2007). For example, Conrad (2007) argues that the forces (engines) pushing medicalization have changed, with biotechnology, consumers, and managed care now promoting the process. "Doctors," Conrad (2005:10) states, "are still the gatekeepers for medical treatment, but their role is more subordinate in the expansion or contraction of medicalization." He notes that biotechnology has long been associated with medicalization, and the pharmaceutical industry is playing an increasingly central role in promoting its products directly to consumers, while in the future the impact of genetics may be substantial.

In the meantime, consumers have become major players in the health marketplace through their purchase of health insurance plans, health products, and the like and their demand for these products fuels medicalization. "The Internet," says Conrad (2005:9), "has become an important consumer vehicle" as people search health-related websites for medical information and products. Managed care, in turn, has become the dominant form of health care delivery in the United States, which makes insurance companies as third-party payers important in both enabling medicalization through their coverage of health services and a constraint in placing limitations on those services. Thus managed care plays an important role in the medicalization process. While medicalization is prevalent in the United States, observes Conrad, it is increasingly an international phenomenon with multinational drug companies leading the way in expanding its development. While public and professional medical concern about medicalization may be growing, the process it represents is still a powerful influence on behavior and important field of study.

## HEALTH LIFESTYLES

Health lifestyles became another important area of research with the increasing evidence that health-related behavior either promotes

longevity or causes early mortality. Health has therefore come to be regarded as something a person needed to work for in order to achieve (Clarke et al., 2003). This meant that individuals (not physicians) were ultimately responsible for their own health and the best option they had was a health-promoting lifestyle. Health lifestyles are collective patterns of health-related behavior based on choices from options available to people according to their life chances (Cockerham, 2005). A person's life chances are largely determined by his or her class position that either enables or constrains health lifestyle choices. The behaviors that are generated from these choices can have either positive or negative consequences on body and mind, but nonetheless form an overall pattern of health practices that constitute a lifestyle. Health lifestyles include contact with medical professionals for checkups and preventive care, but the majority of activities take place outside the health care delivery system. These activities typically consist of choices and practices, influenced by the individual's probabilities for realizing them, that range from brushing one's teeth and using automobile seat belts to relaxing at health spas. For most people, health lifestyles involve decisions about food, exercise, relaxation, personal hygiene, risk of accidents, coping with stress, smoking, alcohol and drug use, as well as having physical checkups.

Drawing upon the work of Weber (1978) and Bourdieu (1984), Cockerham (2005, 2007a) formulated an initial theory of health lifestyles that maintains certain categories of (1) social structural variables, especially (a) class circumstances, but also (b) age, gender, and race/ethnicity, (c) collectivities (i.e., families, groups, organizations); and (d) living conditions provide the social context for (2) socialization and experience that influence (3) life choices (agency). These structural categories also collectively constitute (4) life chances (structure). Choices and chances interact to commission the formation of (5) dispositions to act (*habitus*) leading to (6) practices (action) involving (7) alcohol use, smoking, diet, and other health-related activities. Health practices constitute patterns of (8) health lifestyles whose reenactment results in their reproduction (or modification) through feedback. Consistent with Weber's thesis, this model views a person's life chances as socially

determined and an individual's social structure as the arrangement of those chances. Choices and chances thus interact to determine a person's health lifestyle, as life chances either enable or constrain the choices made. Overall, this theory is an initial representation of the health lifestyle phenomenon and is intended to display how social structures influence individual participation in such lifestyles.

## SOCIAL CAPITAL

Another relatively new area of research which is experiencing considerable attention is concerned with social capital. Turner (2004:13) defines social capital as "the social investments of individuals in society in terms of their membership in formal and informal groups, networks, and institutions." He explains that the degree to which an individual is socially integrated in networks of family, neighborhood, community groups, churches and other places of worship, clubs, voluntary service organizations, and other social institutions provides an objective measure of that person's social capital. Lin (2001) sees social capital as an investment in social relations that people can use as a buffer against stress and depression, while Bourdieu (1993) viewed it as a resource that people obtain through their memberships in social groups.

Yet social capital is not just a property of individuals, it is also a characteristic of social networks from which individuals draw psychological and material benefits. According to Bourdieu (1993:2), one can get an intuitive idea of social capital by saying that it is what ordinary language calls "connections." While Bourdieu emphasizes the resources of networks, Putnam (2000) emphasizes the cohesion of networks. Putnam defines social capital as a community-level resource reflected in social relationships involving not only networks, but also norms and levels of trust. He maintains that the positive influences of social capital on health are derived from enhanced self-esteem, sense of support, access to group and organizational resources, and its buffering qualities in stressful situations. Social connectedness, in Putnam's view, is one of the most powerful determinants of health. After reviewing several studies, he

found that people who are socially disconnected are between two to five times more likely to die from all causes when compared with similar individuals having close ties to family and friends.

The importance of social capital in health outcomes is seen studies showing that people embedded in supportive social relationships providing high levels of social capital have better health and longevity (Browning and Cagney 2002; Lochner et al., 2003). However, findings on the relationship between social capital and health outcomes have not always been consistent and are affected by the difficulty in measuring a variable with multiple—individual, group, community, and so on—conceptual levels. But the concept has grown in popularity and is a promising area of research in health sociology.

## NEIGHBORHOOD DISADVANTAGE

And yet another new area of research emerging in health sociology is that of "neighborhood disadvantage," which focuses on unhealthy urban living conditions. Cities contain the best that human society has to offer in terms of jobs, arts, entertainment, and other forms of culture and amenities, but also include pockets of the worst social environments. Neighborhoods have resources needed to produce good health or, conversely, harm it. Examples of neighborhood characteristics that can be either health-promoting or health-damaging are found in the work of Macintyre and her colleagues (2002) in the west of Scotland. They determined there are five features of neighborhoods that can affect health: (1) the physical environment; (2) surroundings at home, work, and play; (3) services provided to support people like schools, street cleaning and garbage pickup, police, hospitals, and health and welfare services; (4) the socio-cultural aspects of the neighborhood such as its norms and values, economic, political, and religious features, level of civility and public safety, and networks of support; and (5) the reputation of an area that signifies its esteem, quality of material infrastructure, level of morale, and how it is perceived by residents and nonresidents.

Ross (2000) observes that neighborhoods can be rated on a continuum in terms of order and disorder that are visible to its residents.

Orderly neighborhoods are clean and safe, houses and buildings are well maintained, and residents are respectful of each other and each other's property. Disorderly neighborhoods reflect a breakdown in social order, as there is noise, litter, poorly maintained houses and buildings, vandalism, graffiti, fear, and crime. Many families with children in such neighborhoods are one-parent families headed by females. Ross asked whether people who live in disadvantaged neighborhoods suffer psychologically as a result of their environment and found the answer to be yes. Several studies find that the structural effects of neighborhoods promote ill health through long-term exposure to stress, depression, and unhealthy lifestyles and living conditions (Hill, Ross, and Angel 2005; Wen and Christakis 2006). Conversely, residents of affluent neighborhoods rate their health significantly better than people in disadvantaged neighborhoods (Browning and Cagney 2003). This is not surprising because these neighborhoods have healthier living conditions and significantly better access to health care. Research on this topic illustrates the effects of the structural characteristics of neighborhoods on the physical and mental health of the people who live in them.

#### SOCIOECONOMIC STATUS AS A FUNDAMENTAL CAUSE OF SICKNESS AND MORTALITY

Studies of neighborhood disadvantage join with other research on the powerful effects of social class on health to illustrate the importance of social structural factors in disease causation. The enduring association of low socioeconomic status (SES) with illness, disability, and death has led Link and Phelan (Link and Phelan 1995, 2000; Phelan *et al.* 2004) to propose that SES is a "fundamental cause" of mortality. This is an important proposition because most researchers in the past viewed SES as a factor contributing to poor health and mortality, not as a direct cause. However, the persistent association of SES with a variety of disease patterns during changing historical periods increasingly identified SES as having a causal role. In order for a social variable to qualify as a cause of mortality, Link and Phelan (1995:87) hypothesize that it must:

(1) influence multiple diseases, (2) affect these diseases through multiple pathways of risks, (3) be reproduced over time, and (4) involve access to resources that can be used to avoid risks or minimize the consequences of disease if it occurs.

SES or social class meets all four of these criteria because a person's class position influences multiple diseases in multiple ways, the association has endured for centuries, and higher SES persons have the resources to better avoid health problems or minimize them when they occur. Numerous studies have linked low SES with poor health and high mortality throughout the life course (Cockerham 2007a; Link and Phelan 1995, 2000; Warren and Hernandez 2007). Even though the poor live longer now than the wealthy in past periods of history, people in the upper social strata still live the longest on average than people in the strata just below them and so on down the social scale until the bottom of society is reached. The degree of socioeconomic resources a person has or does not have, such as money, knowledge, status, power, and social connections, either protects health or causes premature mortality. According to (Phelan *et al.* (2004:267), these resources directly shape individual health behaviors by influencing whether people know about, have access to, can afford and are motivated to engage in health-enhancing behaviors. In addition, such resources shape access to neighborhoods, occupations, and social networks that vary dramatically in relation to risk and protective factors. Furthermore, living in a social context where neighbors, friends, family members, and co-workers generally look forward to a long and healthy life contributes to an individual's motivation to engage in health-enhancing behaviors.

In short, Phelan and her associates conclude that there is a long and detailed list of mechanisms linking socioeconomic status with mortality. Included is a sense of personal "control" over one's life because people with such control typically feel good about themselves, handle stress better, and have the capability and living situations to adopt healthy lifestyles. This situation may especially apply to people in powerful social positions. "Social power," states Link and Phelan (2000:37), "allows one to feel in control, and feeling in control provides a sense of security and well being that is [health-promoting]." Persons

at the bottom of society are less able to control their lives, have fewer resources to cope with stress, live in more unhealthy situations, face powerful constraints in choosing a healthy way of life, and die earlier from diseases whose onset could have been prevented or delayed until old age (Phelan *et al.* 2004).

Given that the profile of socioeconomic inequalities in sickness and mortality over the course of the twentieth century has been virtually unchanged, class has emerged as a leading causal factor in relation to poor health (Warren and Hernandez 2007). This is particularly evident when social gradients in mortality universally display a hierarchical gradient from low to high in death rates along class lines. The *enduring* outcome of good health at the top of society and worse health in descending order toward the bottom marks class as a fundamental social cause of health, disease, and death (Cockerham 2007a). Recognition of the causal properties of social variables in health matters has been slow in coming, but there is growing evidence that this is indeed the case.

## FUTURE DIRECTIONS

Current studies of the relationship between health and medicalization, health lifestyles, social capital, and neighborhood disadvantage, along with the increasing evidence of socioeconomic status as a fundamental cause of disease are all part of the growing focus on the role of structure in health matters. This does not mean that microlevel methods and theories like symbolic interaction are obsolete. To the contrary, qualitative research provides some of the most insightful data available on social relationships. However, sociology, from its inception, has been oriented toward investigating the effects of structures—such as groups, communities, classes, institutions, or societies—on human social behavior. The ultimate goal of health sociology, as with all of sociology, is an accurate assessment of social life at all levels which is only possible by fully accounting for the effects of structure on individuals.

Recent developments in statistics currently make it possible to more accurately measure the effects of structure on individuals and assess

structure's causal qualities. Hierarchical linear models now exist that provide efficient estimations for a wider range of applications than previously possible. Hierarchical linear modeling (HLM) makes it feasible to test hypotheses about relationships occurring at different social levels and assess the amount of variation explained at each level (Raudenbush and Bryk, 2002). Briefly stated, HLM tests the strength of the interaction between variables that describe individuals at level one, structural entities like households or families at level two, and sequentially higher levels such as communities, social classes, and nations depending on the variable's conceptual position in a structural hierarchy. By comparing changes in the regression equations, the relative effects of each level of variables on health outcomes can be simultaneously determined. What this forecasts is an emphasis upon fully investigating the effects of structural conditions on health which is increasingly appearing in health sociology journals as the next focus for the field.

## CONCLUSION

Ultimately, what allows health sociology to retain its unique character is (1) its utilization and mastery of sociological theory in the study of health and (2) the sociological perspective that accounts for collective causes and outcomes of health problems and issues. No other field is able to bring these skills to health-related research and analysis. Today it can be said that health sociology produces literature intended to inform medicine and policymakers, but research in the field is also grounded in examining health-related situations that inform sociology as well. Health sociology no longer functions as a field whose ties to the mother discipline are tenuous, nor has it evolved as an enterprise subject to medical control. It now works most often with medicine in the form of a partner and, in some cases, an objective critic. Moreover, health sociology owes more to medicine than sociology for its origin and initial financial support, so the relationship that has evolved is essentially supportive. As health sociology continues on its present course, it is emerging as one of sociology's core specialties as the pursuit of health increasingly becomes important in everyday social life.

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