Credit value: 5

7 Sociological perspectives for health and social care

Why are UK teenage pregnancy rates the highest in western Europe? Why are recorded rates of anxiety and depression higher for women than for men? Why has there recently been a fall in the divorce rate in the UK? These are the kinds of questions that concern sociologists. This unit provides an introduction to sociology and explains how sociologists can help us to understand society and particularly disadvantaged groups within our society. In this unit you will study the different approaches that sociologists have used to explain health and social care issues.

The unit opens with an introduction to key sociological terms, and to the key sociological approaches. You will then relate these ideas to the study of health and social care issues. You will consider different definitions of health and illness and examine the impact of the family, occupation, social class and other aspects of our environment and culture on our health and well-being. There will be particular consideration of health differences among different social groups, particularly groups identified by social class, gender, ethnicity and age.

This unit also provides a very helpful foundation for those who, later in the course, go on to study Unit 19 Applied sociological perspectives.

Learning outcomes

After completing this unit, you should:

1 understand sociological approaches

2 understand sociological approaches to health and social care.

Assessment and grading criteria

This table shows you what you must do in order to achieve a pass, merit or distinction grade, and where you can find activities in this book to help you.

To achieve a **pass** grade, the evidence must show that you are able to:	To achieve a **merit** grade, the evidence must show that, in addition to the pass criteria, you are able to:	To achieve a **distinction** grade, the evidence must show that, in addition to the pass and merit criteria, you are able to:
P1 Explain the principal sociological perspectives. **See Assessment activity 7.1, page 319**	**M1** Assess the biomedical and socio-medical models of health. **See Assessment activity 7.32, page 323**	
P2 Explain different sociological approaches to health and ill-health. **See Assessment activity 7.2, page 323**		
P3 Explain patterns and trends in health and illness among different social groupings. **See Assessment activity 7.3, page 331**	**M2** Use different sociological perspectives to discuss patterns and trends of health and illness in **two** different social groups. **See Assessment activity 7.3, page 331**	**D1** Evaluate different sociological explanations for patterns and trends of health and illness in **two** different social groups. **See Assessment activity 7.3, page 331**

How you will be assessed

This unit will be assessed by internal assignments that will be marked by the staff at your centre. It may be subject to sampling by your centre's external verifier as part of Edexcel's on-going quality assurance procedures. The assignments will be designed to allow you to show your understanding of the unit learning outcomes. These directly relate to what you should know and be able to do after completing this unit.

Your assignments could be in the form of:

- presentations
- written assignments
- case studies
- essays.

Guidance is included throughout this unit to help you prepare and present your work.

Sam, 18 years old

I've been on placement at a hostel for homeless young people for six weeks so far. Many of the residents at the hostel have very sad life stories. Few of them have any family support. Some have been in care. They have come from poor areas, where unemployment and crime are high and drugs are easily available. They all seem to have had very deprived childhoods. Has this all led to the hostel being their home?

I think of Joe. He was brought up by his grandparents, who were retired and on a very low income. He never knew his dad, and his mum had a drug habit. When he left school he also left home. After that he lived with friends, sometimes in hostels and often on the streets. He has been in hospital at various times with chronic bronchitis, pneumonia and hypothermia. His diet has been very poor – sometimes eating from rubbish bins. He hasn't ever worked. He often seems very depressed. He doesn't seem to talk to anyone very much. His personal hygiene is poor and his self-esteem is low.

This unit helped me to see that guys like Joe are homeless partly because they haven't yet had much of a chance in life. Poverty, little family support, poor housing and poor health seem to have led them to this.

Over to you!

1 Which parts of this unit do you think you will find most interesting?

2 Which other units do you think are linked with the issues covered in this unit?

3 Which parts of this unit will help you better understand the homeless young people at the hostel?

1 Understand sociological approaches to study

Get started

Asking the big questions

Should the state support people who do not care for themselves? How far does family background influence health and well-being? Would reducing poverty lead to a healthier population? Are we all responsible for our own health? These are some of the questions that you will explore in this unit, using a sociological approach to consider the issues they raise. Discuss these questions now and then revisit them when you have completed this unit. It will be interesting to compare your views 'before' and 'after'.

1.1 Sociological terminology

Sociology is a word drawn from the Latin *socius* (meaning 'companion') and the Greek *ology* (meaning 'study of'). Sociologists are concerned with the study of human societies, but most specifically the groups within these societies and how these groups relate to each other and influence individual behaviour.

Social structures

Society can be viewed as the sum of its **social institutions** (its major building blocks). These may include the family, the education system, work and the economic system, the political system, religious groups and the health and social care services. Sociologists look at the way these institutions are structured, and how they relate to each other and influence the way we behave.

For example, sociologists describe the different forms of the family in our society, the changes that are taking place within the family, how the family structure influences our behaviour, and how the family relates to other social institutions. They examine how our family background may influence our values, attitudes, religious beliefs, educational achievements, employment prospects and our health and well-being.

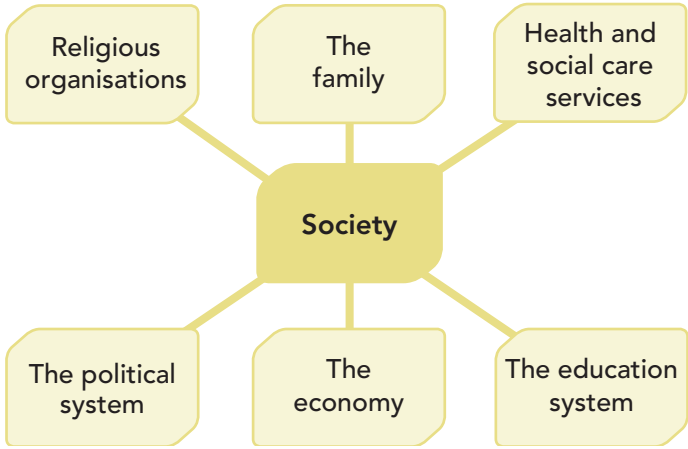


Fig 7.1: Key institutions in our society

Key term

Social institution – A major building block of society, which functions according to widely accepted customs, rules or regulations. The family, the education system and the legal system are all social institutions.

Activity 1: Social institutions

Draw a personal spidergram identifying the social institutions to which you belong. Try to identify how two of these institutions have influenced your behaviour. In small groups discuss why you think these particular institutions have influenced you.

PLTS

Independent enquirer: If you consider the impact of previous experiences on your attitudes and your behaviour, the above activity will help you demonstrate your ability to analyse and evaluate information.

Social diversity

Social stratification

Social stratification is a term used by sociologists and borrowed from geology. In geology, 'strata' refers to different layers of rock laid on top of each other. In sociology, the term is used to describe hierarchies in society, highlighting the fact that some groups of people are seen as having higher status than other groups. People identified as being of higher status are often wealthier and have easier access to the possessions and way of life most valued in that society. Almost all societies have some form of stratification.

In African countries following colonisation, and in America before the Civil War (1861–1865), groupings were based on race. Black communities had far less social status than white communities. Some people would argue that, despite legislation, such hierarchies and inequalities still exist.

In India, the Hindu caste system has five clearly defined social strata, into which people are born:

- Brahmins – the highest caste, priests
- Kshatriya – the military, rulers and administrators
- Vaisya – merchants and farmers
- Sudras – manual workers
- The Dalits, or social outcasts – the people who have almost no status (they have no caste at all).

There is no intermarriage and very little social contact between the castes. There is no **social mobility** (i.e. improving or changing your position in society). It is a closed system of stratification. Indian governments have passed laws attempting to remove the inequalities of the caste system but with limited success.

In feudal England the different strata were called 'estates' and were based on ownership of land. The monarchy and the knights, barons and earls formed the highest estate, the church and clergy were in the second estate, and the merchants, peasants and serfs were in the lowest estate.

Key terms

Social stratification – A term (borrowed from geology) describing the hierarchies in society, whereby some groups have more status and prestige than other groups.

Social mobility – The process of moving from one social stratum (level) to another. Social mobility can be upward or downward.

Social class

Social class is the form of stratification that describes the social hierarchies in most modern industrialised societies. Social class is largely based on economic factors (such as income, property ownership and other forms of wealth). Sociologists are particularly interested in the link between our social class position and other aspects of our lives such as educational achievement, lifestyle choices and health and well-being.

The official classification of social class used by British governments to measure and analyse changes in the population began in 1851. The broad classification of occupations into social 'grades' (later called social classes) was used for the analysis of death rates.

The five social classes identified by the Registrar General of 1921, based largely on perceived occupational skill, remained in place until 2001. Government statisticians and others used these categories to analyse population trends until very recently.

The Registrar General's Scale of Social Class included:

- Class 1: Professional class
- Class 2: Managerial and technical occupations
- Class 3: Skilled occupations:
  - Non-manual (3N)
  - Manual (3M)
- Class 4: Semi-skilled occupations
- Class 5: Unskilled occupations.

Since 2001, the National Statistics Socio-economic Classification (NS-SEC) has been used for official government statistics and surveys. It is still based on occupation but has been altered in line with employment changes and has categories to include the vast majority of the adult population:

- Class 1: Higher managerial and professional occupations
- Class 2: Lower managerial and professional occupations
- Class 3: Intermediate occupations
- Class 4: Small employers and own-account workers
- Class 5: Lower supervisory and technical occupations
- Class 6: Semi-routine occupations
- Class 7: Routine occupations
- Class 8: Never worked and long-term unemployed.

Social class differs from the more closed systems of the caste or feudal systems, or those based on race or gender, in that:

- the class differences are more difficult to define
- the class differences are not backed by law or regulation
- social class barriers are arguably far less rigid
- there is the possibility of social mobility
- people can rise, or indeed fall, in the class system.

We will be studying the links between social class and levels of health and sickness in our society.

Socialisation

Sociology is based on the idea that most of our behaviour is learned through the process of **socialisation** (and very little of our behaviour is instinctive). Socialisation is the process by which individuals learn the **culture** of their society – that is, the language, values and beliefs, customs and ways of behaving that are seen as acceptable. It may be argued that the most critical period of socialisation is in the early years of life.

Activity 2: Social class

Some people think that class differences in our society have disappeared. Write four short paragraphs, giving two arguments in favour of this view and two arguments against this point of view.

Functional skills

ICT: Using the information presented in this chapter, class discussion and your own view of the world, you will need to prepare and present clear points of view as they apply to social class. This may enable you to demonstrate your ability to find, select, present and communicate information.

Key terms

Egalitarian community – A community without hierarchies, where all members are regarded as equal.

Socialisation – The process of learning the usual ways of behaving in a society.

Culture – The values, beliefs, language, rituals, customs and rules associated with a particular society or social group.

Activity 3: Communes and egalitarian communities

Many communes (small and relatively self-contained **egalitarian communities**) were established during the 1960s in the USA, Britain and other parts of western Europe by groups of people who wanted to establish alternative and less materialistic lifestyles.

Communes often try to develop an alternative type of household. Rather than separate family units, there is an emphasis on collective living. All adult members of these communities are seen as equal. Children are seen as the responsibility of the community, rather than of individual parents.

Many communes were short-lived but more longstanding religious communities and therapeutic communities still exist that support people with identified health and care needs.

In groups, carry out the following tasks.

1 Explain the difference between an egalitarian society and a hierarchical society.

2 Describe three differences between the experience of children living in a commune and the experience of children living in separate households with their parents or carers.

3 Discuss two advantages and two disadvantages of this type of community living.

Functional skills

English: In discussion, you will develop your speaking and listening skills and your skill at presenting arguments and listening to other people's arguments.

Reflect

Would you like to live in an egalitarian society, where all members are regarded as equal?

This period of **primary socialisation** takes place, for most of us, within a family – whether it is our birth family, a family of adoption or a foster family. **Secondary socialisation** is the process that carries on as our social life develops through playgroup, nursery, school, friendship or peer groups, religious groups, the mass media and employment.

Our socialisation affects our attitudes towards the care and support of vulnerable people, children and older people. For example, should we care for the very old at home, as part of the family? Or should we access residential care for them? In Islamic and Hindu cultures, care would normally be provided at home by grown-up children and grandchildren; whereas in white British families residential care and other support services would be far more usual. Sociologists would argue that this is largely because of a difference in the values and beliefs learned during primary and secondary socialisation.

The socialisation process affects our attitudes to education and our choice of career. Our home circumstances and the lifestyle of our friends and family can influence our attitudes and our behaviour at school and college. Consider Delton and Nadia in the case study below.

The **norms**, or expected way of behaving, of the society or group to which we belong are learned, it is argued, by absorbing and copying the behaviour of others in our social group. We adopt the main values and beliefs of the society to which we belong. Those who do not conform to expectations, i.e. those who disregard the norms of the society or group, are said to be **deviant**.

Key terms

Primary socialisation – The first socialisation of children that normally takes place within the family.

Secondary socialisation – The socialisation that takes place as we move into social settings beyond the family, such as nursery, school and friendship groups.

Norms – The guidelines or rules that govern how we behave in society, or in groups within society.

Deviant – Someone who does not conform to the norms of a particular society or group.

Reflect

The socialisation process varies from one culture to another. Health and social care workers need to be mindful of the contrasting socialisation of different people living in a multicultural society.

What happens when there is no socialisation? This question can be partly answered by reports on children who have been found living with animals in the wild – sometimes called 'feral children'. These children have no sense of personal hygiene and they are unable to interact with other human beings. They often 'walk on all fours', like the animals they have lived with.

Case study: Delton and Nadia

Imagine two 16-year-olds from very different social backgrounds.

Delton lives with his mother, who has no paid work. His father left them when he was a baby. None of his relatives or friends have been to college or university. Delton does not enjoy school and he and his friends often play truant. There is very little work about, and Delton has no idea what he will do when he leaves school.

Nadia's dad is a solicitor and her mother is a teacher. Nadia is at a very academic school, where most girls get good A levels and go on to university. She is very good at sport, plays the violin and is in the school orchestra. She hopes to go to university and study medicine.

1 Write down three factors that you think might influence Delton's achievements at school and plans for the future. Then write down three factors that might influence Nadia's achievements at school and future career plans.

2 In small groups share the factors that you thought were important and compare them with those identified by others in your group.

3 Discuss how these factors may influence other aspects of their lives, where they live, their range of leisure activities, their opportunities for travel, and so on.

Case study: Celebrating diversity

Karl is a senior member of staff in a residential care home for adults with disabilities. The residents have grown up in an ethnically mixed community and they are from diverse cultural and religious backgrounds.

Karl and the other care staff are committed to ensuring that all residents and their families feel welcome and that they celebrate and enjoy the customs and traditions of others who live at the setting.

1 Explain what is meant by 'celebrating diversity'.
2 In groups, identify two challenges that may face the care staff in promoting equality and diversity at the setting.
3 Discuss ways in which they could ensure that individual cultural needs are met and diversity is celebrated.

They have missed out on socialisation, the process by which the helpless infant gradually learns the norms (beliefs, customs and social expectations) of the society in which they have been born.

Our approach to health and social care issues may be influenced by our socialisation. For example, young people who smoke are more likely to live with carers who also smoke, and children are more likely to eat a wide range of foods at nursery (including a variety of fruit and vegetables) if they are introduced to these foods at home. In these kinds of ways, socialisation can influence our levels of health and well-being.

Social roles and expectations

You may have identified several social institutions or groups to which you belong. Membership of a group brings a range of expectations and obligations. In sociology, these expectations are called **social roles**. For example, there are expectations linked with the social position of being a parent, a son or daughter, or a student. The generally accepted social role (or social expectations) of parents in our society are that they will protect their children, ensure that they are kept safe and warm, provide a home, teach them acceptable ways of behaving, and ensure that they attend school ready to learn.

Activity 4: Social roles and expectations

First try to identify the social expectations linked with your role as a student at school or college. Then compare your list with the expectations listed by others in your group.

Now describe your role at your placement or work. What expectations are associated with your role in the work setting? Present a summary of your ideas to your group.

PLTS

Creative thinker: This activity will help you develop your skills as a creative thinker. You will consider the social expectations linked with social roles in important areas of your life, as a student and as a future care worker.

Functional skills

English: The activity may also enable you to demonstrate your speaking, listening and presenting skills.

Of course the groups to which we belong will change throughout our lives and our position in those groups will change. For example, within our family, as the years pass, we may be the teenager, the married son or daughter, the parent and finally the grandparent.

Most of us occupy multiple roles, sometimes referred to as our 'role set', at any one time. You may be a son or daughter, a student, an employee, a carer and a member of a youth group. Sometimes the associated role expectations will have competing and conflicting demands. **Role conflict** is the term used to describe a situation where the demands of our various social roles clash or cause strain.

Key term

Social role – The social expectations associated with holding a particular position or social status in a society or group.

Role conflict – This exists when the demands of the social roles that we are expected to perform are not consistent with each other, making it difficult and sometimes impossible to meet all demands.

Reflect

Can you identify role conflict within your own role set, i.e. the range of social roles that you are expected to perform?

Case study: Multiple roles

John is a paramedic. His wife, Pat, is a community midwife and works full time. They have three children aged 10, 11 and 15. John's elderly mum has arthritis, lives on her own and needs considerable support with household jobs. She relies on John and Pat and they want to support her. The family are active members of their local church. John runs the youth club and Pat is the church secretary. The children all go to the youth club.

1 Identify the groups to which Pat and John belong and their positions within those groups.
2 Describe the social expectations or social roles associated with those positions.
3 Discuss how and when the various role expectations may cause role conflict.

Nature versus nurture

The **nature** versus **nurture** debate centres on the relative importance of environment and the socialisation process (nurture) in human development, compared to the impact of genetic inheritance (nature). This debate has been particularly important in:

- **education –** whether educational achievements are more influenced by inherited intelligence or by upbringing?
- **crime –** whether criminal tendencies are inherited or a product of environment?
- **gender –** whether observed differences between the behaviour and achievements of men and women are genetically determined or the result of different opportunities?

Sociologists tend to give more weight to environment and socialisation (nurture) when explaining individual differences. The nature/nurture debate is also considered in Unit 4.

Social control

Social control refers to the methods a society uses to ensure that its members conform to the expectations associated with their social roles. It is impossible to imagine a society without norms and rules to guide behaviour or ways of dealing with those who are deviant. Formal methods of social control in our society include the police and judicial system, as well as disciplinary systems in schools, colleges and in employment. There are also informal social control strategies, such as excluding people from group activities, embarrassing them, ridiculing them and gossiping about them. Methods of social control can be positive or negative. Positive methods include giving praise and other rewards for conformity; negative methods include punishment and other reactions to deviance.

Activity 5: Social control methods

In groups, identify and briefly explain two formal and two informal methods of social control used at your work placement. Present your ideas to the rest of your class. Be prepared to take questions at the end of your presentation.

Functional skills

English: In this activity, you can demonstrate your English skills by expressing your ideas clearly, listening carefully to each other and agreeing the key points to share with the rest of the group.

Key terms

Nature – Those human characteristics that are genetically determined.

Nurture – Those human characteristics that are learned through the process of socialisation.

Social control – The strategies used to ensure that people conform to the norms of their society or group.

1.2 Principal sociological perspectives

We are now going to look at the key sociological perspectives, or approaches, that have been used to describe and understand societies and the behaviour of individuals within societies. We will then consider how these approaches can help explain the impact of social life on health and well-being. The key terms introduced earlier will provide the main vocabulary for this discussion.

The first two perspectives that we will consider are structuralist approaches. Structuralists are interested in describing and understanding the main institutions of societies. In modern industrialised societies, these include the family, the education system, the health services, the economy, the political institutions, religious groups and the media. Structuralists are concerned with how these institutions relate to each other and how they influence and mould individual behaviour. The two structuralist approaches that we will discuss are known as **functionalism** (or the consensus model) and Marxism (the **conflict model**). Feminism, considered separately on pages 315–316, is normally regarded as an example of a conflict model that focuses on the continuing oppression of women in our society.

Functionalism

The functionalist approach to sociology can be best understood by likening society to the human body. Just as the body functions through the efficient interrelationship of major organs (such as the lungs, heart, liver and kidneys) and has mechanisms to deal with disease, so the different institutions in society each have particular contributions to make. They work together, and use methods of social control to deal with deviant members or groups, to ensure that society functions smoothly.

Key terms

Functionalism – A sociological approach that sees the institutions of society as working in harmony with each other, making specific and clear contributions to the smooth running of society.

Conflict model – A sociological approach first associated with Karl Marx, which sees the institutions of society as being organised to meet the interests of the ruling classes.

Talcott Parsons (1902–1979) played a vital role in the development of functionalism as a sociological approach. He saw society as a system made up of interrelated institutions, which contributed to its smooth running and continuity. He thought the main role of an institution was to socialise individuals and ensure that they understood the underlying values of their society and behaved in acceptable ways. This ensured that there was order in society.

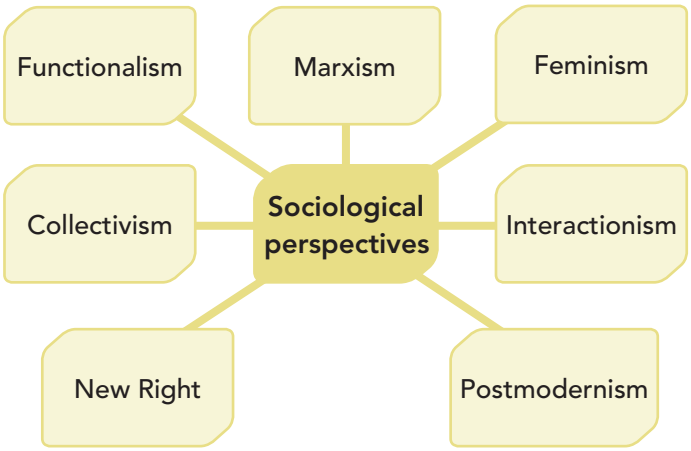


Fig 7.2: Key sociological perspectives

We can go on to consider the functions of the family and how it contributes to the order and stability of society, or the social system (a term that functionalists would often use). George Murdock (1897–1985), in his classic 1949 study of the family, examined over 250 societies, ranging from small hunter-gatherer communities to large industrialised societies, and found some form of the family in all of them.

Murdock claimed that in all societies the family had four functions:

- The sexual function allowed for the expression of sexuality in an approved context.
- The reproductive function provided stability for the rearing of children.
- Socialisation included the responsibility of teaching children the acceptable ways of behaving in society.
- The economic function meant that food, shelter and financial security had to be provided for family members.

Talcott Parsons (1951), writing about American society, argued that the family had two 'basic and irreducible functions':

- the primary socialisation of children

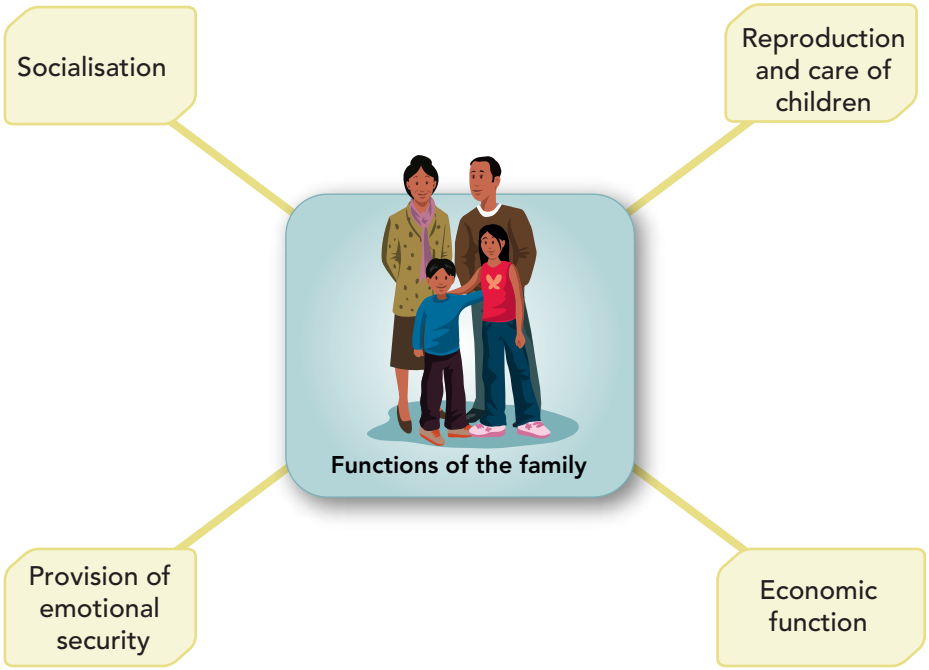


Fig 7.3: The functions of the family

- the stabilisation of adult personalities – in a complex, stressful and demanding world the family provides warmth and emotional security, especially, as Parsons saw it, for the male breadwinner.

Activity 6: The functionalist approach

In small groups, consider the social functions of one of the following social institutions:

- the family
- school or college
- work
- parliament.

1 Compare and discuss the range of answers.

2 Are you able to agree on the principal functions of these institutions?

Functional skills

English: This activity will enable you to demonstrate your listening skills and your ability to communicate clearly in group situations.

Criticisms of functionalism

Probably the most fundamental criticism of the functionalist approach is that it does not address areas of conflict, which certainly characterise modern societies and in principle could be found in all societies. Functionalists emphasise consensus and agreement and paint a rather rosy picture of institutions having clear, positive functions and co-operating effectively for the good of all. However, this does not seem to reflect many people's experience of the modern world, where there are often clear winners and losers and many non-conformists.

Functionalism is based on the idea that in all societies members share some basic values and beliefs – and that this **value consensus** underpins the socialisation process and the working of the main institutions. Researchers have not been able to find that common values are clearly shared in modern societies.

Key term

Value consensus – A general agreement as to the values and beliefs of a society.

Activity 7: Is there a common value system?

In groups, make a list of the values you think are most important for our society. Then compare your list with others in your group, and discuss the similarities and differences.

1 Can you agree a common value system to which most people would subscribe?

2 Do you think we have a common value system in our society?

Functionalists are also very clear that the way we behave is a direct result of the socialisation process and that very little of our behaviour is the result of our personal choices. They believe that we are largely 'programmed' to behave in particular ways. The interactionist model (see pages 316–317) provides an alternative to this view.

Reflect

Do you think we are 'programmed' by our socialisation or do we have some freedom of choice?

PLTS

Independent enquirer: This activity may enable you to demonstrate independent enquiry skills by using previous learning and experience to evaluate information and judge its relevance and value.

Finally, functionalists tend to present a picture of a socialisation process that never fails. They give no clear explanation of deviant behaviour and especially the extreme forms of deviance found in crime, delinquency and abuse, which are destabilising for society as a whole.

Activity 8: Key sociological approaches

Complete this table as you cover the key sociological approaches in your lessons. The first one has been completed for you, as an example.

Sociological approach	Key words	Key ideas	Identify two strengths	Identify two weaknesses
Functionalism	*Structuralism Function Common value system*	*All societies are made up of key institutions (e.g. the family) with functions to perform. These institutions ensure the smooth running of society.*	*Provides explanations for the smooth running of society. Analyses the role of key institutions.*	*Does not address areas of conflict in society. Does not allow for free will. We are socialised into our social roles.*
Marxism				
Feminism				
Interactionism				
Collectivism				
New Right				
Post-modernism				

PLTS

Self-manager: This activity will involve ensuring that you complete the table as you learn about the sociological perspectives. You will need to summarise your knowledge and express your ideas clearly and succinctly. You will also need to be organised about keeping the table up to date!

Key terms

Bourgeoisie – In Marxist theory, the bourgeoisie are the powerful social class, who own the factories, land and other capital and are able to organise the economy and other important social institutions to their own advantage.

Capitalist – Another word for a member of the bourgeoisie.

Proletariat – In Marxist theory the proletariat are the 'working class', who have only their labour to sell. They work for and are exploited by the bourgeoisie.

False consciousness – In Marxist theory, false consciousness is the taking on, by the proletariat, of the views and beliefs of their class enemy, the bourgeoisie. They do not realise that, by working hard, they are serving the interests of the capitalists much more than their own.

Marxism

Marxism, as well as being a conflict model, is also a structuralist model. This approach was first developed by Karl Marx (1818–1883). He also thought that individual behaviour was shaped by society but he believed that the economic system defined society and people's place within it. Marx held the view that in the industrial society of his time there were two social classes:

- the **bourgeoisie**, or **capitalists** – the small powerful group who owned the factories and other places of employment
- the **proletariat** – a much larger, poorer group of 'workers' (the people or 'hands' that the bourgeoisie employed).

His view was that these two social class groups would always be in conflict: the owners of the factories, land and offices would want high profits; and the employees would want higher wages, which would eat into the profits. This is why Marxism is often called the conflict model. He thought that this conflict would lead to revolution. There was an unequal relationship between the bourgeoisie and the proletariat and conflict was inherent in the economic system.

Marxists argue that the ruling class (the bourgeoisie) also hold power in the other social institutions and they shape the society because they control the mass media and the legal system and it is their ideas that influence the curriculum in schools. Through the socialisation process, it is the values and attitudes of the ruling class that are passed on, rather than the common value system of the functionalists. This is so successfully achieved that the majority of the proletariat do not realise that they are being exploited or that they are serving the interests of the bourgeoisie rather than their own class. This lack of awareness by the proletariat is called **false consciousness** – and it is used to explain why the conflicting interests seldom erupt into actual conflict or revolution.

Like functionalists, Marxists have a structuralist perspective. They see the family as contributing to a stable social system and would regard the family as the servant of the capitalist system. They believe that it provides the context for the socialisation of children, preparing them for the disciplines and routines of work. Just as children have limited power in the family, so people are prepared to be obedient to their bosses at work as adults. In addition, Marxists see the family as providing a secure emotional base, a home, from which people will return to work rested and refreshed, ready to make large profits for their employer. As a servant of the capitalists, the ordered family is necessary for passing on inheritance. Children born within the nuclear family are the rightful inheritors of the family's wealth.

Reflect

Are there equal opportunities for all? Or do some people have advantages over others?

If you think there are inequalities in society, what could be done to reduce them?

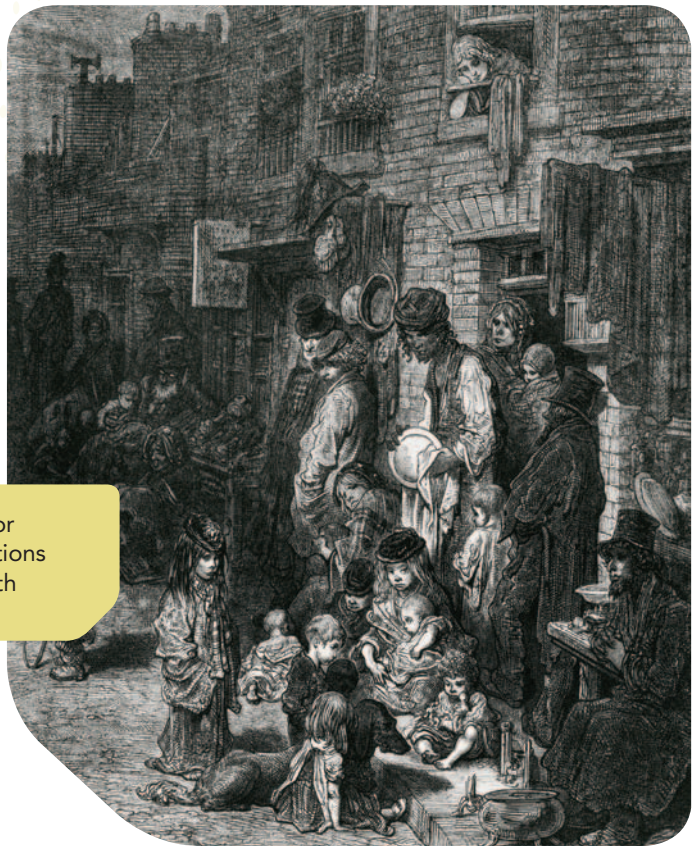
Criticisms of Marxism

Like functionalists, Marxists believe that individual behaviour is the direct result of the socialisation process, with very little individual choice. In the case of Marxist theorists, however, it is a socialisation that meets the values and interests of the ruling classes.

Closely linked with this point is the view that Marxists put too much emphasis on different class

interests and potential conflicts of interest. Although clear inequalities remain, the standard of living in industrialised societies has improved immensely over the last 100 years and arguably employers and employees share some common interests. All will potentially benefit from a successful company.

Some writers believe that the Marxist model, which sees the economy as the institution that drives all others, does not give sufficient emphasis to the power of other institutions – religion, race and family life – in moulding our behaviour.



Why do you think so many poor people lived in dreadful conditions in British cities in the nineteenth century?

Case study: Child labour in the nineteenth century

'Children of the poorer class worked from a very early age… Conditions in the factories were bad and the working day was at least 14 hours. Accidents were common and discipline very strict. Some factories operated the machines day and night, so that one shift of children used the beds vacated by the next shift… the work people were often responsible for recruiting and disciplining juvenile workers.'

Source: Clifford Lines (1990) *Companion to the Industrial Revolution* Facts on File Ltd (Oxford)

1 **Which of the two social classes identified in the Marxist model are described in this passage?**

2 **Explain why Marx expected that working conditions such as these would lead to conflict and revolution.**

3 **Why might these conditions impact on the health and well-being of these children?**

Activity 9: Structuralist approaches

Functionalist sociologists believe that societies are united by common values that are shared across society and which lead to the smooth running of that society. This contrasts with the Marxist perspective, which holds that societies are organised and controlled by powerful minority groups to meet their own needs.

In groups, consider whether the following groups or institutions work for the good of all in society or mainly for the successful and powerful groups:

- schools and colleges
- the economy
- health and social care services.

Feed back your ideas to the whole class.

Functional skills

English: This activity will enable you to demonstrate your listening skills and your ability to communicate clearly in group discussions and when preparing a group presentation.

Feminism in sociology

Feminism is normally seen as an example of a conflict model. There are three main types of feminist approach:

- Marxist feminism
- radical feminism
- liberal feminism.

Feminists have argued that sociology, as an academic discipline, was developed and dominated by men. Hence the term 'malestream' sociology was introduced. Pamela Abbott and Claire Wallace (1997) clearly summarised feminist concerns and criticisms of mainstream (or malestream) sociology. They argued that this male dominance has produced biased descriptions and analysis and that not enough attention has been paid to the issues of women and their unequal place in society.

Marxist feminism

Marxist feminists see women, especially working-class women, as oppressed both by capitalism and by men or the patriarchal society. Women produce the next generation of workers. They meet the physical, social and emotional needs of their children so that they are ready to work in the offices and factories of the future. They support their husbands and partners, cook meals, care for their children and clean their houses – for no pay! Thus they are dominated by their husbands and they are also subsidising industry. The family would not be ready for work if somebody did not take responsibility for domestic life and this, it is argued, remains the primary responsibility of women.

Radical feminism

For radical feminists, it is not capitalism that dominates women, but men. The family is seen as a patriarchal institution. They see the socialisation of women as housewives and mothers as a form of oppression and this oppression as a characteristic of nuclear family life.

Activity 10: Feminism in the home

Are these views dated? Who in your family would normally cook the meals, do the washing-up, vacuum, clean and tidy the house and/or mend electrical equipment? Are the traditional gender roles still in place?

Carry out a research activity in your group to test the hypothesis:

'Women take responsibility for most domestic tasks in the home.'

Each student in your group should identify two households with which they are familiar and identify who normally:

1 does the washing
2 does the ironing
3 mends electrical goods
4 does the household shopping
5 cooks the evening meal
6 tidies the living room
7 cleans the cooker
8 does the gardening
9 does the vacuuming.

Analyse your findings and write a brief report explaining whether your hypothesis is proven or not.

PLTS

Independent enquirer: This activity will enable you to demonstrate your ability to carry out individual research, to share your findings, collate your results and to present one group report.

Functional skills

English: Preparing the questionnaire, interviewing your respondents and discussing the results will develop your speaking and listening skills, and recording your conclusions will develop your writing skills.

Mathematics: Mathematical skills will be developed in analysing your results and justifying your conclusions with statistics.

ICT: You will have the opportunity to develop your ICT skills in presenting statistical information and your conclusions.

Liberal feminism

Liberal feminists would argue that changes have taken place. They believe that, through changing attitudes and legislation, such as the Equal Pay Act (1970) and the Sex Discrimination Act (1975), there is more equality. Liberal feminists believe that improvements will continue by means of legislation and policy.

Activity 11: Equal rights for men and women

1. Write a short report in which you identify and briefly describe the key legislation relating to sexual equality. Remember to include the introduction of civil partnerships through the Civil Partnership Act 2004.
2. Discuss in groups how far changes in the law can influence attitudes to the position of men and women in society, both at home and in the wider community.
3. Summarise your key points and report back to the rest of the class.

How does this photo show that many women remain in traditional domestic roles?

Functional skills

ICT: To complete this task, you will need to find and select relevant and up-to-date equality legislation.

English: In discussing how far changes in the law can influence individual attitudes, you will develop your speaking, listening and presentation skills.

Did you know?

Despite the Equal Pay Act of 1970, the 2009 Social Trends reported that the average wage for men in full-time employment was 12 per cent higher than the average wage for women in full-time work.

Interactionism

Interactionism, or the social action approach, contrasts with the structuralist perspectives in that the focus is not on the large institutions and how they function and link with each other. Instead, the focus is on small groups and how they influence individual behaviour and shape society. Interactionists may study groups as diverse as teenage gangs, staff, patients and visitors on hospital wards or social interaction in school classrooms. They will study the dynamics within these groups. For example, they may ask:

- How do different members of the group see themselves?
- Do some have more power than others?

Key term

Interactionism – A sociological approach that focuses on the influence of small groups on our behaviour, rather than the power of large institutions. Interactionists believe that our behaviour is driven by the way we interpret situations in smaller groups, how we see ourselves in relation to other people in the group, how we see other members and how they see us.

- Who are the formal leaders?
- Are there some informal leaders who actually have power in the group?

Social action or interactionist theorists do not believe that we are 'programmed' by the socialisation process. They see individuals as being *influenced* by the socialisation process but having the power to choose how they will actually behave and create their own roles. These theorists have very little interest in social structure as a whole. They see our behaviour as driven by the way we interpret situations, how we see ourselves and other people and how they see us.

In the family, a mother may understand what is expected of a 'good' mother but social action theorists think that social roles are not clearly defined. They believe that the mother will interpret what that means for her in the context of her family, her relationship with her children, and her links with the wider society. There is no blueprint. For the social action theorist, the main aim is to understand how people interpret situations and behave in small-group face-to-face situations.

Reflect

Try to analyse the social dynamics at work or on work placement. Are some people more powerful than others? Do some people have power and influence even though they are not managers or supervisors? Do some clients or customers have more power than others. If so, can you analyse why?

Criticisms of interactionism

Social action theorists, although they emphasise individual choice, accept that social roles exist – even if they are not clearly defined. They do not, however, study where the social roles come from. They are criticised for paying insufficient attention to issues of power in society. Although they would say that social roles are only vaguely defined, they do not explain where these roles come from and they do not explain why people largely behave in very predictable ways.

In addition, they are sometimes criticised for describing social behaviour 'in a vacuum'. They describe behaviour in delinquent gangs or the relationship between staff and patients in a hospital ward but they do not describe the wider social factors that have influenced this, or the historical factors that might have defined or caused the situation. Social action theorists tend to focus on the interactions within the group, rather than these wider issues.

Postmodernism

Postmodernism is an approach to sociology, or understanding society, that focuses on the rapid change and uncertainty (some would even say chaos) in our society. Postmodernists would suggest that we can no longer talk about established institutions like the family, religion or the economy because nothing stays the same. Domestic arrangements are so varied these days that it is no longer possible to talk about the 'typical' family. Postmodernists hold the view that, because of the constant change, structuralist perspectives like functionalism and Marxism no longer help us to understand society. The social institutions have become fragmented. Individuals and groups of people now make their own lifestyle decisions, choosing from the many leisure activities and consumer goods that are available.

Activity 12: Is there a 'typical' family?

In groups:

1. Identify and list the different types of family in our society.
2. Is there a typical family type in our society?
3. Are the postmodernists right – these days 'anything goes'?
4. Discuss the possible consequences for the individual and for society of one change in family life. You may consider:
   - Fall in the number of marriages
   - Introduction of civil partnerships
   - High levels of divorce
   - Smaller families
   - Higher proportion of lone parent families
   - Increased number of much older relatives
5. Report back to the whole class and compare issues.

Did you know?

In 2006 there were only 237,000 marriages in England and Wales, the lowest number recorded since 1895.

Collectivism

Collectivism is an approach to providing health and social care services that is underpinned by a government commitment to provide care and support for the vulnerable, funded through taxation and National Insurance. This contrasts with the New Right (see page 319), who consider welfare to be the responsibility of the individual and their family and believe that the state should play a minimal role.

Collectivism and the New Right are examples of political responses to the role of government in our society and, for our purposes, their response to meeting identified areas of welfare need. In all societies there are groups of people who are potentially vulnerable. These may include children, older people, people with physical impairments and those with mental health needs. In some societies the care of these people will be seen as the responsibility of the individual or their family; in other societies it will be seen as the responsibility of religious groups, the commune or the local community.

The state has played a role in the care of the vulnerable in Britain since the passing of the Poor Law in 1601. However, it was not until the nineteenth century that governments took a significant role in the support of the vulnerable (many would say this did not happen until after the Second World War with the 'birth of the Welfare State'). The Beveridge Report, in 1942, provided the political foundation for a comprehensive range of welfare services. Lord Beveridge, in his *Report on Social Insurance and Allied Services*, identified five giant evils that urgently needed to be challenged.

There was cross-party agreement that the state should take collective responsibility for:

- addressing poverty through a wide range of welfare benefits including Family Allowance, Unemployment and Sickness Benefit and retirement pensions
- fighting disease through the National Health Service

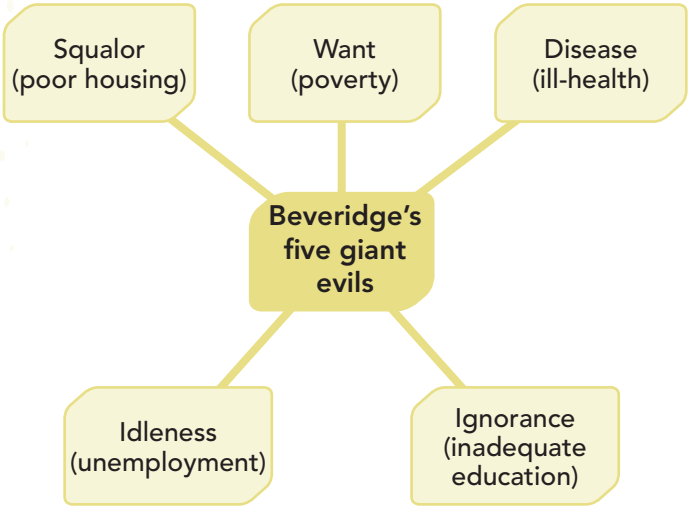


Fig 7.4: Beveridge's five giant evils

- combating ignorance through the expansion of secondary education for all
- eradicating squalor through the building of council houses
- removing idleness by supporting policies of full employment and the development of labour exchanges.

This placed the provision of key services in the hands of the state, working co-operatively with families and voluntary organisations, and was to be financed by taxes and National Insurance.

Activity 13: Yesterday's evils today

In five groups, design posters to identify services that are in place today which address each of Beveridge's 'giant evils':

- Want – Poverty
- Squalor – Poor housing
- Disease – Ill-health
- Idleness – Unemployment
- Ignorance – Inadequate education.

PLTS

Independent enquirer: This activity may help you demonstrate your ability to plan and carry out research and analyse and evaluate information.

The New Right

The post-war collectivist approach to welfare remained largely in place for over a generation and was not seriously challenged or questioned until the election of Margaret Thatcher's Conservative government in 1979. The view of this government was that the state should play as small a role as possible in welfare provision. They believed that welfare should be largely seen as the responsibility of the individual and their family. The New Right regarded state support as intrusive and supporting a dependency culture. Mrs Thatcher and her government thought the welfare state produced a society in which people relied on state benefits rather than planning for the future and taking responsibility for their own needs and those of their families.

Assessment activity 7.1

P1 BTEC

Produce an information booklet explaining the principal sociological perspectives: functionalism, Marxism, feminism, interactionism, collectivism, postmodernism and the New Right.

Grading tips

P1 To achieve a pass grade, you will need to use the sociological terms introduced at the beginning of the chapter, such as culture, values, beliefs, norms, socialisation, social status, social roles, diversity, and social class. You may also find it helpful to refer to your table of perspectives (see page 312).

Around 150–200 words for each perspective would be a good guide to length. Provide examples from your personal or placement experience to show your understanding of, for example, the functions of the family, the place of women in the home or the range of services provided by the state in a collectivist society.

2 Understand sociological approaches to health and social care

2.1 Application of sociological perspectives to health and social care

The functionalist approach

The functionalist approach to considering health and illness derives from the work of Talcott Parsons. Using the traditional functionalist approach, he described how, for society to function efficiently, its members need to be healthy. He described illness as a form of deviance and ill members as performing a form of social role – the sick role. This became a very powerful concept in the sociology of illness. In his view, if people declared themselves ill, specific rights and responsibilities came with their new role.

The rights associated with the sick role were:

- to be exempt from normal social obligations, for example, to go to school, college or work, and from meeting normal family obligations
- to be cared for.

Parsons would see it as one of the key functions of the family to care for the sick and other dependent members of the family group.

The responsibilities of the sick role included the individual:

- taking all reasonable steps to get better and seeking to resume their normal place in society as soon as possible
- co-operating with medical professionals, particularly doctors and their staff.

The functionalist view (and the view of most governments) is that illness has social consequences. The ill are not normally at work and they may need to be cared for, and this must, whenever possible, be swiftly dealt with, in order for society to run smoothly.

The Marxist approach

Marxist approaches believe that the definitions of health and illness, and the health and social care services provided, serve the interests of the more powerful dominant social classes. Doctors are seen as agents who ensure that people go back to work as soon as possible, working in the interests of the employers rather than those of the patient. Their job is to provide the company owner with a healthy workforce. In addition, the government allows companies to make profits from products that cause ill-health, such as tobacco and junk food. Firms and factories continue to produce toxic waste and large cars pollute the atmosphere.

Unlike the functionalists, who regard ill-health as something that occurs almost randomly, conflict theorists see levels of illness as being related to differences in social class. For example, there is a higher level of illness and lower life expectancy in areas of poverty, high unemployment and environmental pollution. The government does not do enough to tackle the issues that lead to illness, as this costs money, which would have to be found by the most advantaged in society.

Reflect

Why do you think there is more illness in areas of poverty and high unemployment?

The interactionist or social action approach

Interactionism is probably the theoretical approach that has devoted the most attention to issues of health and illness. It is concerned with:

- the processes that lead a person to define themselves as ill – people with the same 'complaint' vary as to whether they will call themselves ill and certainly vary as to whether they will seek professional help. Some people with very serious illnesses do not regard themselves as ill.
- the interaction between the professional and the patient in agreeing how ill they are. Although they understand that there are sometimes quite clear diagnoses, interactionists are interested in the negotiation that takes place with the professional in trying to agree on the impact of the illness. Should the patient be signed off work or not? How far should someone's bad back limit their daily activities?
- the impact on people's self-image and on their relationships if they are labelled as 'ill'.

Interactionists, in studying the sociology of health and illness, do not look at structures and institutions but study the complex relationships between people, their family and friends and their links with the professional services. They think that these relationships have as much influence as any medical diagnosis on whether or not people declare themselves to be ill.

Critics of the interactionist approach say that, in concentrating on these relationships and the negotiations that take place, it ignores the 'real' causes of ill-health. These include medical explanations and environmental factors such as pollution, stress and poverty.

The feminist approach

Feminist writers have focused on male domination in the medical professions and its impact on women. They have been particularly concerned with the way in which pregnancy and childbirth have been regarded as medical issues (even sometimes as illnesses), rather than as natural processes. Feminist writers also comment on the way in which the medical profession and the related pharmaceutical industries have given relatively low priority to the development and promotion of the male contraceptive pill (which arguably has fewer harmful side-effects than the contraceptive methods used by women). In considering issues of mental health, anxiety and depression, and the fact that relatively higher numbers of women suffer from these conditions, feminists would see this partly as a result of their exploited position in society and especially in the family. These issues are, however, defined as a medical problem, for which medicines are a solution. This shifts attention away from the fact that a woman's day-to-day circumstances may be the cause of stress.

Marxist and other socialist feminists have been more concerned with the impact of social inequalities on women's health. In *What Makes Women Sick?* Lesley Doyal (1995) particularly highlights the increasingly dual role of women, or the 'double day' as she calls it: women often have full-time jobs outside the home and then also take most of the responsibility for domestic life.

2.2 Understanding different concepts of health and ill-health

Concepts of health

It will come as no surprise that sociologists have great difficulty in agreeing on a definition of what it means to be healthy. Health can be defined in negative terms, as 'the absence of disease'. This is contrasted with a positive definition such as that provided by the World Health Organization (WHO) in 1974: 'not merely an absence of disease, but a state of complete physical, mental, spiritual and social well-being'.

A negative concept of health (as the absence of disease) is therefore opposed to a positive concept of health as being concerned with people's physical, intellectual, social and emotional well-being.

In the health and social care sectors, care professionals usually adopt a holistic approach to care and support. They see their role as addressing the needs of the 'whole' person, rather than single issues or identified problems.

Activity 14: Who is healthy?

1 In groups try to agree a definition of 'good health'. Then compare your definition with those of other groups in your class

2 Think of someone you regard as being very healthy. What makes you think that they are healthy? Do they fit your definition of 'good health'?

PLTS

Self-manager: This activity will require you to agree the key points to share with the rest of the group.

A person with complex needs, such as a young mother with multiple sclerosis, may be supported by a range of professionals. These would include a GP, a community nurse, an occupational therapist, a social worker and a health visitor, often referred to as a multi-disciplinary team. They will each have their particular roles and responsibilities for her care and support but they will also want to carry out a **holistic assessment**, recognising the importance of the young woman's wider needs when providing their specialist care.

Key term

Holistic assessment – An approach to care that addresses the individual's physical, social, emotional and spiritual health, attempting to meet the needs of the 'whole' person.

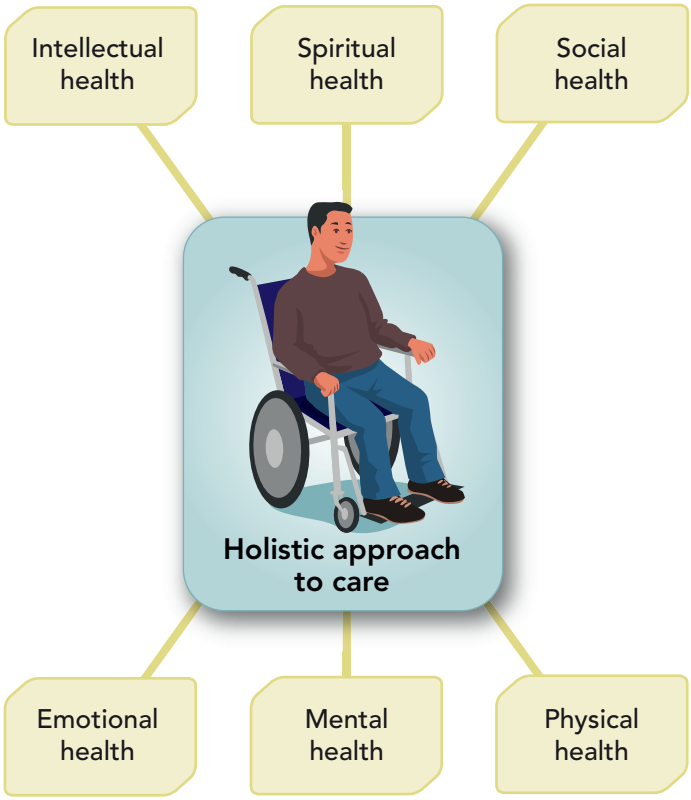


Fig 7.5: A holistic approach to care

Mildred Blaxter (1990) interviewed almost 10,000 people in her large-scale study, *Health and Lifestyles*. She identified three strands to people's understanding of health and well-being:

- a positive definition, regarding health as feeling fit and well
- a negative definition, regarding health as being free from pain or discomfort
- a functional definition, regarding health in terms of being able to perform certain, often day-to-day, tasks.

Defining health, then, is not easy and there is certainly no clear agreement on it among scholars.

In fact, most sociological research concerned with studying and comparing levels of health within and between societies actually focuses on issues of ill-health. For example, sociologists use a great deal of information about death rates, visits to GPs' surgeries, incidence of serious diseases, admissions to mental health units and suicide statistics. This data is often analysed by social class, occupation, ethnicity, gender, age and geographical location.

This type of information can be measured statistically and is generally clearly defined. It is much more difficult to measure the positive indicators of health (people's physical, intellectual, social and emotional well-being), as in the WHO definition on page 321.

Models of health

Biomedical model

The model of health that has dominated Western industrialised societies, certainly since the industrial revolution of the mid-nineteenth century, has been the **biomedical model**. This view of health underpins the policies and practice of the National Health Service (NHS). According to this model, health is largely regarded as being the absence of disease, and the intervention of health professionals is necessary in times of illness. The main purpose of the health services is to cure disease, and health professionals will use scientifically tested methods to address diagnosed illnesses. Sociologists believe that the focus on the individual patient for whom a cure should be found is a limitation of this model. Little regard is paid to environmental and social factors that may have led to ill-health. The causes of illness may be many and varied, but the biomedical approach tends to focus on the individual while largely ignoring the environmental factors that might cause disease.

The biomedical model fits well with the functionalist perspective discussed earlier (on page 317), in which illness is regarded as in itself dysfunctional for society. If people are ill they cannot make their normal contribution to the smooth running of society. For the functionalist, if people adopt the sick role and are exempt from their usual social responsibilities, they also have a responsibility to co-operate with health professionals and take all reasonable steps to get better.

Socio-medical model

The **socio-medical** model of health focuses on the social factors that contribute to health and well-being in our society. Research indicates that life expectancy rose and death rates began to fall, especially infant mortality rates, with improvements in sanitation and the provision of clean water, the building of new council houses and generally improved standards of living during the late-nineteenth/early-twentieth centuries. This was long before 1948 and the introduction of universal free personal health care through the NHS. This sort of evidence supports the view that environmental and social conditions are a significant source of disease, and the causes of ill-health are not solely located in the individual.

The socio-medical model sits more easily with the conflict theorists than the functionalists. The conflict theorist would explain the shorter life expectancy and the relatively higher rates of ill-health among the poor as consequences of the inequalities in society and the life circumstances of the disadvantaged. The poor, they would say, are more likely to have an inadequate diet and live in damp houses, often in inner-city areas where unemployment and environmental pollution tend to have the most impact. The ruling groups in society, the politicians and the owners of industries, are not willing, they would say, to make the changes needed to protect the poor from ill-health and disease.

The biomedical model of health has a clear focus on individual diagnosed illness, and the socio-medical model is concerned with the environmental causes of illness. They can be seen as two complementary approaches to the study of health and illness.

Activity 15: Social factors linked with poor health

Draw a spidergram or similar diagram that summarises the range of social and environmental factors that may lead to ill-health.

Key terms

Biomedical model – An approach to health and illness that identifies health as 'the absence of disease' and focuses on diagnosing and curing individuals with specific illnesses.

Socio-medical model – An approach to health and illness that focuses on the social and environmental factors that influence our health and well-being, including the impact of poverty, poor housing, diet and pollution.

Case study: Life expectancy

The Child Poverty Action Group reports that life expectancy at birth varies significantly according to social class, with professional men expecting to live to around 80 years and unskilled manual men to 72.7 years. For women, the figures are 85.1 and 78.1 years respectively.

Poorer children on average experience poorer health during their childhoods and the effects of this last throughout their lives. Three-year-olds in households with incomes below about £10,000 are 2.5 times more likely to suffer chronic illness than children in households with incomes above £52,000.

The risk of infant mortality is higher for poor children. In the lower social group (routine and manual occupations) infant mortality is 5.9 infant deaths per 1,000 live births. This is 20 per cent higher than the average 4.9 per 1,000.

Source: Child Poverty Action Group Facts and Figures www.cpag.org.uk/povertyfacts

1 In three groups explain why levels of the following vary by social class:
   - life expectancy
   - health and well-being
   - infant mortality rates.

   Be prepared to feed back your views to the rest of your class.
2 Discuss the view that this evidence supports the socio-medical model of health.

Assessment activity 7.2

P2 M1 BTEC

Aziz and Tamsela have four young children. Tamsela's elderly parents live with them. Their three-bedroomed house is in a deprived and rather depressing area of London. Their house is in a poor state of repair; it is damp and very expensive to keep warm in the winter. Neither Aziz nor Tamsela is currently in paid work.

The family is in poor health. In the winter the children seem to have permanent colds. Tamsela suffers from asthma and her father has bronchitis. Tamsela's mother is depressed and has been prescribed drugs for this condition.

Write an essay of 800–1000 words that explains different sociological approaches to health and ill-health P2 and include in the essay an assessment of both the biomedical and socio-medical models of health M1. Use the case study of Azis and Tamsela and/or other examples from those known to you or from placements to illustrate points you make in the essay.

Grading tips

P2
- If using examples from placements or others known to you, respect the confidentiality of individuals and their contexts.
- You should apply the perspectives introduced in Assessment Activity 7.1 when explaining the different sociological approaches.
- Include an explanation of different concepts of health and different definitions of health and illness in the essay.

M1
- To assess the two models of health, you will need to weigh up the relative strengths and weaknesses of each when considering health and illness.
- Apply a range of sociological perspectives when comparing the two models of health as part of the assessment of each.
- Consider the extent to which each model takes into account any environmental and social issues that should be considered when assessing the needs of individuals in health and social care.

Concepts of ill-health

Disability and impairment

The related ideas of **disability** and **impairment** are very closely linked to the medical and social models of health. Like many of the other sociological terms introduced in this unit, the words 'disability' and 'impairment' can be used in different ways, and the term 'disability' is not easy to define. It is important that you are absolutely clear on how you are using these terms when considering the issues. Tom Shakespeare (1998) formalised a helpful distinction between disability and impairment.

Impairment focuses on the individual and refers to the day-to-day restrictions that may arise because of a long-term physical or mental condition, such as the loss of a limb, a sensory impairment or depression. This has similarities to the biomedical model of health and illness. From this point of view, the patient would need to co-operate with the health and social care professionals to limit the restrictions caused by the impairment. They will have similar social obligations to a person in the 'sick role' discussed earlier.

Disability, in contrast, is seen by Tom Shakespeare as a problem that arises when a society does not take into account the needs of people with impairments. For example, there may be no ramps into buildings, and doorways may be too narrow for people who use wheelchairs. A person with a hearing impairment may only be disabled if they do not have access to a hearing aid or have not been taught to lip-read. Disability, from this point of view, is seen as a restriction on the opportunity to take part in the normal life of the community because of physical, social or attitudinal barriers. In this context writers will sometimes refer to the **disabling environment** – an environment where facilities are not in place to ensure that people with impairments can take full part in a social life; this is a social model of disability.

Activity 17: The enabling environment

Write a short report describing:

- either how accessible your college is for people who are wheelchair users
- or how easy it is for wheelchair users to do their shopping in your local high street.

In your opinion are these enabling environments?

Case study: Impairment and disability

Mohammed is 45 years old and has multiple sclerosis. He needs considerable help with daily living activities. He is a wheelchair user and he is unable to leave his house without a carer. Mohammed lives alone, he speaks very little English and he feels socially very isolated.

Mohammed has recently been assessed by the local social services department for a range of community care services. He is going to receive a direct payment so that he can choose his own care provider and he will be able to pay them directly. He is quite confused by this arrangement and does not know where to go for help.

1 Explain what is meant by the terms 'impairment' and 'disability' in this context.

2 Briefly discuss the view that Mohammed lives in a disabling environment.

3 Evaluate the usefulness of the distinction between impairment and disability.

Key terms

Disability – Sociologists will often refer to disability as the restrictions that arise for a person with an impairment because of the attitudes and the lack of appropriate services and facilities to meet their needs.

Impairment – The restrictions on day-to-day activity caused by a physical or mental dysfunction or abnormality, such as the loss of a limb, a sensory impairment or a learning difficulty such as Down's syndrome.

Disabling environment – A social context where adaptions and other facilities are not in place to ensure that people with impairments can take a full part in social life.

WorkSpace

Yasmin Johnson

Nurse practitioner

Yasmin is the nurse practitioner at a busy GP's surgery in a northern town. The practice has a lot of elderly patients and Yasmin runs regular 'well man' and 'well woman' clinics for the over-sixties. Among the couples who come to her clinics are the Tattons and the Bensons, and she has got to know them quite well over the years.

Mr and Mrs Tatton both worked as solicitors and had a very good income all their working lives. They were able to save and now have a very good occupational pension. They have a beautiful home by the sea, and they play tennis and golf all year. They go on holiday abroad most winters and have their grandchildren to stay every summer.

They just don't seem to age, and hardly ever come to the surgery for treatment. Their daughter Sally married John Benson, the Bensons' eldest son, and John and Sally settled down in London.

The Bensons have lived very different lives. Mr Benson was a miner and was made redundant in the 1970s. He managed to get other work but the jobs were all poorly paid. He now has to rely on his state pension. Mrs Benson has worked part-time all her life in unskilled jobs. She doesn't have a works pension and she never paid into the state pension scheme. They still live in the three-bedroomed council house they moved into when they got married. It is damp and difficult to heat. In the winter they have to choose between eating well and keeping warm. They do manage to get away for a week in the summer but they have never been on holiday abroad. Some would say that they are rather proud and will not accept financial help from their grown-up children. Mr Benson has angina and Mrs Benson has suffered from asthma for about ten years. They both attend the surgery frequently so Yasmin tends to see them every few weeks.

Think about it!

1. List the factors that might contribute to and detract from the health and well-being of the Tattons and the Bensons.
2. What services will be available to each couple in their later lives?
3. Are there additional services that might be available to the Tattons?
4. How have changes in the family made it more difficult for children to look after their ageing parents? What are the implications for families, social services and government finances?
5. There is evidence that people in socio-economic class 1 have a greater life expectancy than those in socio-economic class 8. Using the Internet or other sources, check the current statistics for life expectancy by socio-economic class.
6. Which factors mentioned in the case study could indicate that the life expectancy of the two couples might be different?

2.3 Understanding patterns and trends in health and illness among different social groupings

Measuring health

Statistical trends in the levels of health and illness are generated from three main sources:

1 **Government statistics**
The Office of National Statistics (ONS) provides current data on a wide range of health and care issues. Publications include *Social Trends*, *Population Trends* and, for more detailed information on health issues, *Health Statistical Quarterly*. These publications (available in hard copy and electronically) provide a wide range of statistics on birth rates and death rates, **infant mortality rate** and suicide rates, as well as appointments at GPs' surgeries and hospital admissions, and these are often analysed by social class, gender, geographical location and age.

2 **Charitable organisations and pressure groups**
Many charitable groups and special interest groups also collect and publish statistical and other information which informs the discussion on issues of health and illness. For example, Mind (www.mind.org.uk) and YoungMinds (www.youngminds.org.uk) are charities that support people and young people with mental health needs, and www.youreable.com (formerly www.disabilitynet.co.uk) is a website that provides a disability-related news service on the Internet. All provide ongoing and up-to-date information relating to their areas of concern.

3 **Academic researchers and other authors**
Largely based in universities, researchers and authors also contribute to the evidence and debate on a wide range of health and social care issues.

Throughout this book you will find references to evidence drawn from all these sources.

Government statistics not only include **mortality rates** (death rates) in the population but also the **morbidity rates**, the number of people who have particular diseases during a specified period, usually a year. These trends will be compared over periods of time. Have rates increased or decreased? They may be analysed by sex, age, geographical location or social class. Are mortality and morbidity rates higher in some parts of the country than in others? Is there a difference in mortality and morbidity between social classes? Specific morbidity rates may be measured in terms of the prevalence of a disease. **Disease prevalence** is the total number of cases of a specific disease in a population during a specified period of time. **Disease incidence** is the number of new cases of a specific disease occurring in a population during a specified period of time.

Mortality rates, especially infant mortality rates, are often used as an indicator of the health and well-being of the population as a whole. If they are higher or rising in a particular location, or among a particular social group compared to others, this is seen as a sign that levels of general health and well-being may be declining within those groups and that the causes of this may lie in their social and economic environment – perhaps inadequacies in a range of social and economic services and higher levels of poverty and economic hardship.

Mortality rates are collected from the official and required registration of deaths, and the causes of death from the legally required death certificates. Information on morbidity rates is drawn from a wide range of sources including GP and hospital appointments, hospital admissions and the registration of notifiable diseases (certain infectious diseases). There have also been more general studies measuring levels of ill-health. These studies are not related to

Key terms

Infant mortality rate – The number of deaths occurring in infants under one year old per 1000 live births.

Mortality rate – The number of people who have died in the population in a given year. The crude death rate is expressed as the number of deaths in a year per 1000 of the population.

Morbidity rate – This refers to the number of people who have a particular illness during a given period, normally a year.

Disease prevalence – The total number of cases of a specific disease in a population during a specified period of time.

Disease incidence – The number of new cases of a specific disease occurring in a population during a specified period of time.

a specific condition; instead they use self-reported measures of health, which ask people to describe or rank on a scale of 1 to 10 how healthy they feel.

Difficulties in measuring health

When referring to statistics and using them in your work, it is always important to quote the source of the data. Were they collected by a particular group in order to persuade and gather support? Should you also consult data from an organisation with an opposing view? Was the information published in a newspaper to satisfy the views and prejudices of their readers? Does the newspaper support a particular political party? Statistics must be treated with caution!

Furthermore, statistics gathered from official sources may not provide an accurate picture of patterns of health and illness. For example, some people who are ill may not go to the doctor; and conversely some people who visit the doctor may not really be ill.

Two doctors presented with similar symptoms may suggest different diagnoses. For example, a patient describing persistent fatigue with no interest in life and no energy may be described by one doctor as depressed, while another doctor may diagnose ME or post-viral fatigue syndrome. Another doctor might decide that they are a malingerer who simply does not want to go to work. This would certainly distort the official figures of the number of people with a specific illness.

Ken Browne (2006) provided a useful framework to explain this problem:

'For people to be labelled "sick" – and also to be recorded as a health statistic – there are at least four stages involved:

- Stage 1: Individuals must first realise that they have a problem.
- Stage 2: They must then define their problem as serious enough to go to the doctor.
- Stage 3: They must then actually go to the doctor.
- Stage 4: The doctor must then be persuaded that they have a medical or mental condition capable of being labelled as an illness requiring treatment.'

Official statistics on levels of illness are sometimes described as 'the clinical iceberg' because it is thought that the 'true' levels of illness are largely concealed. This is because, for a wide range of reasons, people who are ill do not necessarily visit their doctor.

Similarly the reasons for death (as recorded on death certificates) may not always be accurate or reflect the 'real' causes of death. The cause of death of a street person dying in freezing conditions may be stated as 'hypothermia' but it could be argued that the 'real' cause of death was years of malnutrition, substance abuse and inadequate or no housing. A person with AIDS may die of liver failure but it is probably AIDS that gave rise to the liver condition. The cause of death recorded on the death certificate will depend on the doctor's interpretation of the symptoms. Sometimes the doctor may record a condition that is one of a number of contributory reasons, but they choose the one that will cause least distress to the relatives of the deceased. Statistics drawn from death certificates therefore need to be used with care and an understanding of their limitations.

Social class and patterns of health and illness

Although official statistics must be treated with caution, there is overwhelming evidence that health, ill-health and life expectancy vary according to social group and especially according to social class. Members of the higher social classes are living longer and enjoying better health than members of the lower social groups. The most influential modern studies that consider the reasons for this difference are *The Black Report* (Townsend *et al*, 1980) followed by *The Acheson Report* (1998). They provide detailed and comprehensive explanations of the relationships between social and environmental factors and health, illness and life expectancy.

In fact, the findings of *The Black Report* exposed such vast differences in the levels of health and illness between different social classes that the government of the time suppressed its publication. A small number of duplicated copies were circulated and made available just before an August Bank Holiday weekend, when they would expect to get very little press coverage. Nevertheless, this study has been extremely influential and the explanations offered in it are still used by sociologists today when examining and considering these issues.

The Black Report considered four types of explanation that might account for the differences in levels of illness and life expectancy experienced by different social classes. The researchers were persuaded that the differences in health and well-being were an effect

of the level of people's income, the quality of their housing and the environment in which they lived and worked.

The four possible sociological explanations were:

1 the statistical artefact explanation
2 natural or social selection
3 cultural or behavioural explanations
4 material or structural explanations.

The statistical artefact explanation

Here the researchers working on *The Black Report* suggested that the differences could be explained by the fact that the statistics themselves produced a biased picture. They argued that the people in the lowest social classes had a higher proportion of older people and people working in traditional and more dangerous industries and so it would be expected that they would have higher levels of illness than the more prosperous, younger people working in offices, call centres and other service industries. This explanation suggests that it is not really social class but the age structure and patterns of employment of people in the lowest social classes that really explain the differences. However, more recent studies have shown that, even when the researchers account for this bias in employment and age, they still find a link between low social class and high levels of illness, and lower life expectancy.

Natural or social selection

This explanation suggests that it is not low social class and the associated low wages, poverty and poorer housing that *cause* illness, higher infant mortality rates and lower life expectancy for adults – it is, in fact, the other way round. People are in the lower classes *because* of their poor health, absenteeism and lack of energy needed for success and promotion. This explanation has been rejected by sociologists because there is evidence to show that ill-health is caused *by* the deprived circumstances rather than causing it.

Cultural or behavioural explanations

This explanation focuses on the behaviour and lifestyle choices of people in the lower social classes. There was evidence that people in the lower social classes smoked more, drank more heavily, were more likely to eat junk food and take insufficient exercise. Their poor lifestyle choices were linked to a range of chronic illnesses including heart disease, some forms of cancer, bronchitis and diabetes. However, the fact is that many people in economically deprived circumstances use smoking and alcohol to help them cope with their difficult circumstances. It is their difficult circumstances that lead to their lifestyle choices – not the other way round.

Material or structural explanations

Material explanations claim that those social groups for whom life expectancy is shorter, and for whom infant mortality rates are higher, suffer poorer health than other groups because of inequalities in wealth and income. Poverty and persistently low incomes are associated with poorer diets, poor housing in poor

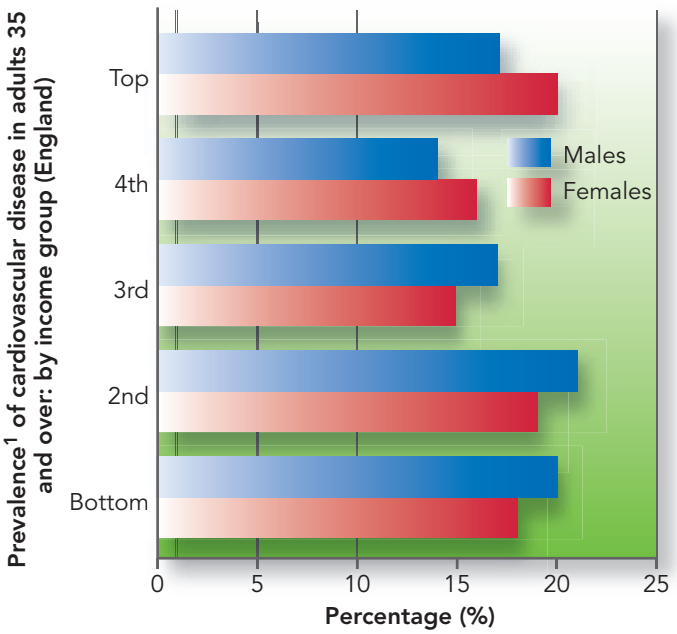
Why do you think people's lifestyle choices, such as the amount of exercise they take, can have such a dramatic impact on their health?

environments, and more dangerous and insecure employment. It is these inequalities and the associated deprivation that lead to the differences in health and well-being – an explanation that can be traced back to the work of Marx and Engels in the nineteenth century. The writers of *The Black Report* (Townsend *et al*, 1980) presented very persuasive evidence to support the materialist explanation. Shaw *et al* (1999) completed a major review of all the research in this area and concluded that the major factors that contributed to these differences in health and illness were social factors. Put simply, a consequence of poverty in a community is poor health and lower life expectancy.

Gender and patterns of health and illness

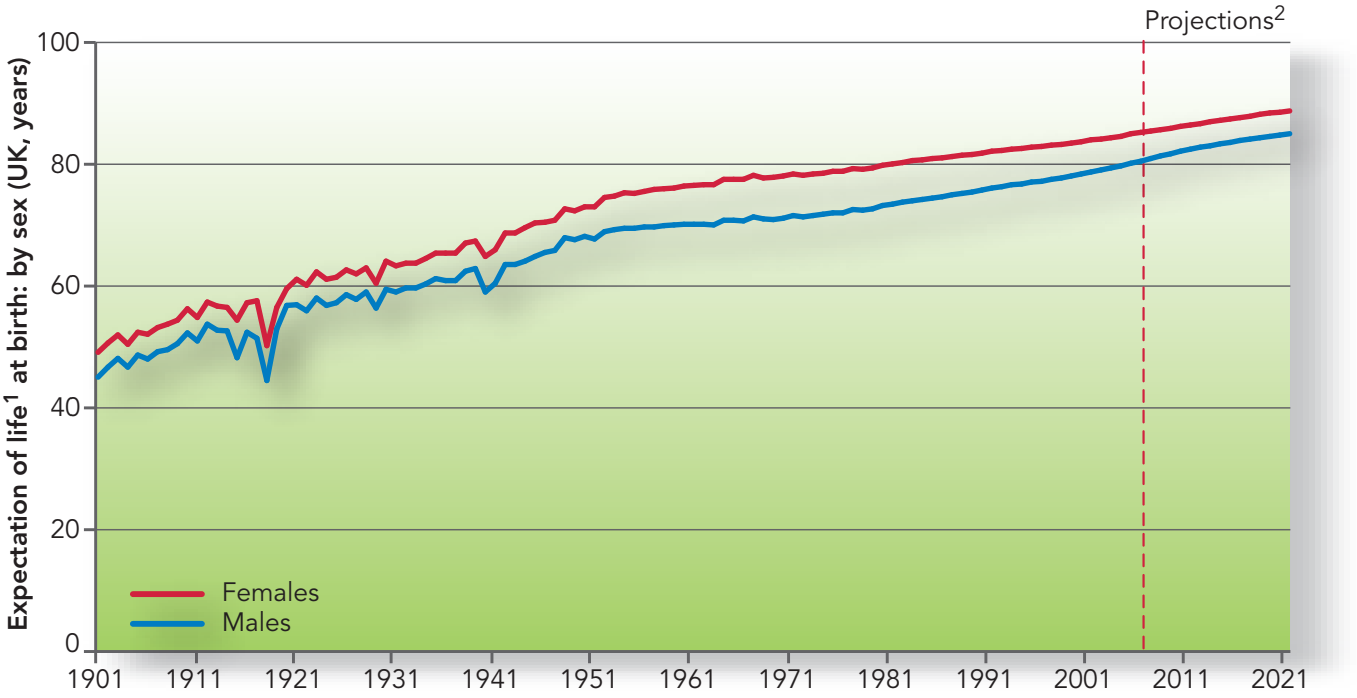
Although women's life expectancy is higher than that of men (with women in our society typically living some five years longer than men and with the infant mortality rates for boys being persistently higher than those for baby girls), studies consistently report higher levels of illness for women than for men. The social factors that contribute to these differences can be identified as:

- risk factors
- economic inequalities
- the impact of the female role, especially in the family.



1 Equivalised household income has been used to rank the households into five groups of equal size. The bottom fifth, or bottom quintile group, is then the 20 per cent of households with the lowest incomes.

Fig 7.7: Prevalence of cardiovascular disease by household income and sex, *Social Trends* (2006)



[1]Expectation of life. The average number of years a new-born baby would survive if he or she experienced age specific mortality rates for that time period throughout his or her life.

[2]2006 based projections for 2007–2021.

Fig 7.6: Expectation of life at birth by sex, *Social Trends* (2006)

Risk factors

The higher death rate for men can be linked with the higher levels of cigarette smoking and drinking by men, and their participation in more risky and dangerous sports and other activities. The relatively high death rate of young men between 17 and 24 is specifically linked with this risk-taking and the associated deaths from road accidents.

Economic inequalities

Despite changes in the law, women still earn less than men. In a recent survey by the Higher Education Statistics Agency, women who have degrees, for example are paid, on average, less than men. Men earn £1,000 more than their female college classmates within three years of leaving university. They are much more likely to go straight into high paid jobs with 40 per cent of men earning over £25,000 a year compared with 26% of women three years after graduating.

A higher proportion of women than men are in low-paid part-time work. They are also far more likely to be the main carer in a lone-parent family and are more likely to be on means-tested state benefits. In older age they are more likely to be in poverty because they are less likely to have an employer's pension and may not, because of family responsibilities, have a full state pension either. As discussed earlier in the unit, there are clear and direct links between poverty and poor health.

Impact of the female role

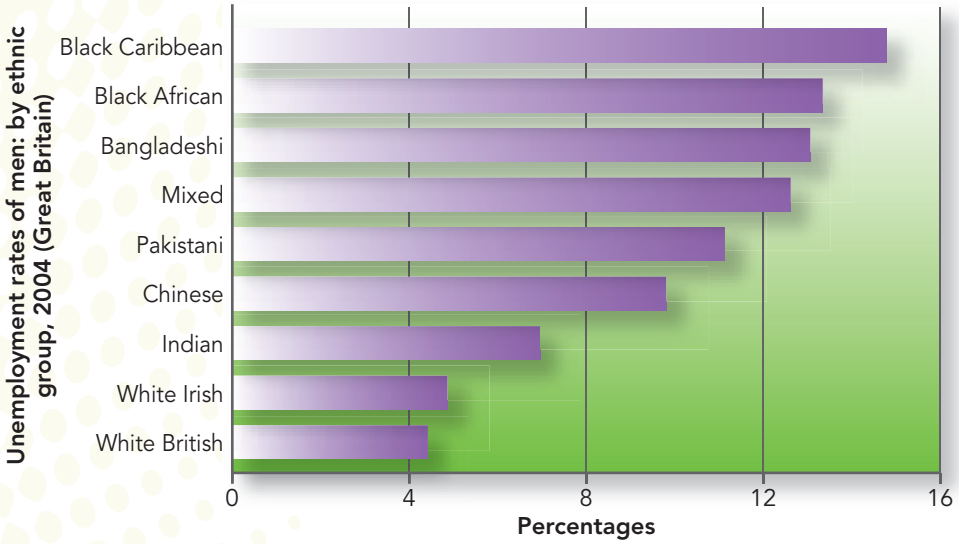
Women still take responsibility for housework in most homes, and the higher incidence of depression in women may be linked with the dull repetitive nature of this work. Popay and Bartley (1989), studying the hours spent on domestic labour in 1700 households in London, found that women spent up to 87 hours per week on housework and that women with children spent 64 hours per week even if they had a full-time job. Often women will be managing on a limited budget, working long hours, and will have little time to themselves. Nevertheless, it may be that the higher rates of diagnosed stress-related illness for women are due to their willingness to discuss mental health issues with their doctor, rather than them actually having a higher rate of stress-related illnesses.

Did you know?

In England and Wales suicide rates for men aged 25 and over are three times higher than the suicide rates for women. Source: *Social Trends* (2009)

Ethnicity and patterns of health and illness

Evidence for a link between race (or ethnicity) and illness is difficult to study systematically because there are difficulties in defining a person's racial type, particularly in the context of the increasing numbers of people who are of mixed race. In addition, a high proportion of people from minority ethnic groups live in areas of deprivation in inner-city areas with associated poor housing, pollution and relatively high unemployment. It is therefore difficult to know whether the poorer health is due to poverty or ethnicity. Nevertheless, compared to the white majority ethnic group, there is evidence that:



Source: *Annual Population Survey, Office for National Statistics*

Fig 7.8: Unemployment rates of men by ethnic group, *Social Trends* (2006)

- there is a higher incidence of rickets in children from the Asian sub-continent because of a deficiency of vitamin D
- most minority ethnic groups have a shorter life expectancy
- most minority ethnic groups have higher infant mortality rates.

In addition to the health implications of higher levels of poverty, there are issues of access to the health services. Language problems and other cultural barriers may limit full use of the health services. Asian women are often reluctant to see a male doctor, many of them speak little English and, despite improvements, translators are in short supply and much important information is not translated into minority languages. In addition, racism, or the fear of racism, is stressful. Unless health and social care workers understand the religious and cultural beliefs and practices of minority ethnic groups, their care needs are unlikely to be fully met, leaving them vulnerable to higher levels of ill-health.

Age and patterns of health and illness

Many people over retirement age are fit, healthy and making valuable contributions to our society through paid work, voluntary activities, and caring for their families. In fact, the 2001 census revealed that 342,032 people aged 65 and over provided 50 hours or more unpaid care per week. However, it is also true that there are higher levels of illness among the older population and particularly those people over the age of 75. During a three-month period in 2003, 24 per cent of people over the age of 75 had attended the casualty or out-patient department of a hospital, compared with 14 per cent of people of all ages (General Household Survey 2003). The Alzheimer's Society in 2007 estimated that one in 20 people over 65 and one in five people over the age of 80 suffered from dementia.

Locality and health and illness

There are also regional variations in patterns of health and illness. Mortality and morbidity rates vary in different parts of the country and also within towns and cities in the UK. It is probably no surprise to learn that it is in the poorer regions and the poorer parts of cities that higher levels of illness are recorded.

For example, research has shown that there are regional trends in the incidence of lung cancer across the UK. Within England, the rates for lung cancer are higher than average in the north-west, northern and Yorkshire regions and below average in the south-western, southern and eastern regions.

Reflect

Can you think of reasons why these regional differences in health and well-being might exist?

Assessment activity 7.3

P3 M2 D1 BTEC

You have been asked by your employer to investigate which social groupings are most in need of health and social care services. In order to assist in the planning of care provision, write a report or an extended essay that will:

1. explain patterns and trends in health and illness among different social groups
2. discuss patterns and trends of health and illness using sociological perspectives
3. evaluate different sociological explanations for patterns and trends in health and illness in two different social groups.

Grading tips

To achieve P3, you will need to explain the different patterns and trends in health and illness in social groupings identified according to factors such as gender, social class, geographical location, ethnicity and age.

To illustrate your answers you may, for example, consider differences in life expectancy, morbidity and mortality rates, incidence of disease and suicide rates, and suggest reasons for these differences.

You will need to refer to statistical data from a range of sources to explain the patterns of health

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Assessment activity 7.3 *continued*

and illness in the range of different social groups. When quoting statistics, make sure that you clearly identify and reference reliable and up-to-date sources for your data.

To achieve **M2**, you may develop material used in your response to **P3**. You need to use the language and tools of sociology to examine trends in health and illness in two different social groups. Make sure that you plan your work carefully. You are not required to apply all sociological perspectives to each group. That would be a textbook in itself!

When examining the patterns of health and illness you may consider, for example, the difficulties involved in defining health and issues relating to the reliability of statistical data. Introduce the sociological approaches as they are relevant to the groups you have chosen.

To achieve **D1**, you will need to evaluate, for both of your chosen social groups, the quality of the evidence for the differences in health and well-being. You will need to consider the strengths and weaknesses of the evidence and come to your own conclusion. For example, you could ask: 'Is there sufficient reliable evidence to suggest that there is a difference in the health and well-being of people in higher social classes as compared with the lower social classes or between men and women?' and 'Is there sufficient evidence to claim that infant mortality rates vary between countries and different social classes?'

Having weighed up the evidence, you may present your evaluation as a final section to the work presented for **M2**. You will not yet have all the evidence required to reach a definitive conclusion. Further research is always needed. However, you have to make a judgement and come to a conclusion based on the evidence you have found.

Resources and further reading

Abbott, P. & Wallace, C. (1997) *An Introduction to Sociology: Feminist Perspectives*, second ed. London: Routledge

Acheson, D. (1998) *Independent Inquiry into Inequalities in Health London*: HMSO

Blaxter, M. (1990) *Health and Lifestyles* London: Routledge

Browne, K. (2006) *Introducing Sociology for AS Level* Cambridge: Polity Press

Doyal, L. (1995) *What Makes Women Sick?* London: Macmillan

Engels, F. (1845) *The Conditions of the Working Class in England* London: Panther Books

Illich, I. (1976) *Limits to Medicine* Marion Boyars: London

Lines, Clifford (1990) *Companion to the Industrial Revolution* Facts on File Ltd: Oxford

Murdock, G.P. (1949) *Social Structure* New York: Macmillan

Oliver, M. (1990) *The Politics of Disablement* London: Macmillan

Parsons, T. (1951) *The Social System* New York: The Free Press

Popay, J. & Bartley, M. (1989) 'Conditions of labour and women's health', in C. Martin and D. McQueen *Readings for a New Public Health* Edinburgh: Edinburgh University Press

Shakespeare, T. (1998) *The Disability Reader: Social Science Perspectives* London: Casssell

Shaw, M., Dorling, G. & Davey, G. (1999) *The Widening Gap* Bristol: Policy Press

Singh, J.A. & Zingg, R.N. (1942) *Wolf-children and the Feral Man* New York: Harper

Social Trends, Vol. 36 (2006) London: HMSO

Townroe, C. & Yates, G. (1995) *Sociology*, 3rd ed. Harlow: Longman

Townsend, P., Davidson, N. & Whitehead, M. (1980) *Inequalities in Health: The Black Report* Harmondsworth: Penguin

World Health Organization (1974) *Alma-Ata Declaration*

Useful websites

Age Concern www.age.org.uk

Alzheimer's Society
www.alzheimers.org.uk

disabilitynet www.youreable.com

Equality and Human Rights Commission
www.equalityhumanrights.com

General Household Survey

www.statistics.gov.uk/ssd/surveys/general_household_survey.asp

King's Fund www.kingsfund.org.uk

Just checking

1. Define the following key terms: socialisation, culture, norms, ethnicity, social role and social class.
2. Provide a definition for the following sociological perspectives: functionalism, Marxism, feminism, postmodernism, interactionism, collectivism and the New Right.
3. Explain the following concepts of health: negative concept, positive concept and the holistic concepts of health.
4. Explain the biomedical model of health and the socio-medical model of health.
5. Identify and give examples of three main sources of statistical information about trends in health and illness.
6. Why may statistical evidence be unreliable as a measure of the nation's health?
7. Identify five social groups who, according to research, have a higher level of illness than the population as a whole.

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Assignment tips

1. The sociological terms introduced at the beginning of the unit (such as socialisation, culture, social class, gender and ethnicity) should be used in class discussion of sociological issues and in your written assignment tasks.
2. To achieve the pass grade in this unit, you are required to **explain** ideas and issues, such as different sociological perspectives, different sociological approaches to health and ill-health, and trends in health and illness among different social groups. Explanations require more detail than a definition or a description. In this case, the grades can be achieved by using appropriate examples to illustrate the concepts introduced. As a rule, you should devote one or two paragraphs to each sociological perspective or approach that you are explaining.
3. To achieve **merit** grade, you are required in M1 to **assess** the biomedical and socio-medical models of health described in P2. When assessing ideas you are should consider the strengths and weaknesses of the approaches or ideas, in this case the two models of health. M2 requires you to discuss trends of health and illness in two different social groups e.g. gender, social class or ethnic group. This requires you to develop further and in more detail two of the groups introduced in P3, presenting clearly the evidence for the patterns and trends explained. You may, further, refer to the difficulties in defining health and to issues relating to the reliability of statistical data. Ensure that you use the sociological terminology accurately and appropriately when considering these topics.
4. To achieve the distinction grade for this unit, you are required, in addition to meeting all other grading criteria, to **evaluate** patterns and trends in health and illness among two social groupings. Draw on the evidence presented earlier, in particular commenting on the strengths and weaknesses of the evidence, and in the final paragraph present your conclusion.