The Social Dimensions of Health and Health Care in Canada

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PEARSON
Toronto
To my mother and father who were both far too young to be taken by cancer
TJW

To Lauren, Tyra and Adam Jutai for their inspiration and eternal patience.
ILB

To my family
EN

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Preface

Health is a central aspect of contemporary Canadian society. Health as a concept, however, has been very difficult to define, to conceptualize, and to measure. What does it mean to be “healthy”? Health can mean different things to different people at different times based on their culture, their age, their gender, and a multitude of other factors. Health to some could mean not being sick (i.e., a negative definition) while to others it may mean being able to do certain activities (i.e., a positive definition). People interpret health very differently depending on the context of their lives, which illustrates the social nature of health. Even people who have chronic diseases such as cancer or heart disease may see themselves as healthy, apart from their disease. So how do we begin to understand health? While the concept of health is discussed in detail in Chapter 1, it is informative to examine health more generally here.

The most common way to look at health and health research has been through the prevailing biomedical perspective. What do we mean by a biomedical perspective? First, a perspective is a way of looking at, interpreting, and evaluating the things around us. Each perspective makes certain assumptions about the world, and these assumptions filter observations in light of preconceived notions. As such, a person’s perspective will influence his or her view of the world and the activities undertaken within it. The biomedical perspective of health and illness is rooted within the medical science enterprise, applying the tenets of science, including objectivity, logic, rationality, and cause and effect in a mechanistic fashion. This mechanistic-based perspective objectifies illness and disease, separating it from the person as well as the larger cultural, political, and social context. In this sense, an illness or disease is a physiological or biological deviation from what is defined as normal (Mishler et al., 1981). The deviation can be identified by the physician, assessed as to the cause, and then cured just as a mechanic fixes a car. The physician need not be concerned with the person, just the disease.

The biomedical perspective has been the dominant perspective in health and health research. This dominance is understandable because it has historically demonstrated a great deal of success in dealing with some diseases. It is limited, however, by its underlying assumptions and in its inability to fully understand some dimensions of health. Moving outside the biomedical perspective permits us to examine health and health care using different lenses to assess and challenge commonly held beliefs. To this end, this text largely employs a broader sociological perspective of health.

Sociology, as a scientific discipline, was defined in 1830 by Comte as being “[T]he science of society, social institutions, and social relationships; specifically: the systematic study of the development, structure, interaction, and collective behavior of organized groups of human beings.”

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A sociological perspective (or a sociological imagination, as C. Wright Mills, 1959 coined) permits us to see how personal issues are connected to larger social and structural entities. Mills argues that a sociological imagination allows us to understand how personal troubles affecting people and those close to them, such as family (biography), are rooted in the past development (history) of the current arrangement of society (structure). For example, the death rate among younger cohorts is significantly higher among those who earn less income. Is this a personal trouble? Or are there some common factors among people in lower income brackets that sentence them to a shorter life expectancy? It is this ability to look past the individualist approach (personal troubles) where everyone is responsible for his or her own fate, to examine how the historical and structural organization of society may be a source of the problem.

The sociology of health, or medical sociology, is a subdiscipline of sociology that focuses on the systematic study of human society in relation to health, illness, and health care. It examines the social aspects of health and health care taking a broad perspective from society at large (the macro level) and institutions (the meso level) to individuals and relationships (the micro level). Although disease and death occur at the individual level, a sociological perspective allows us to identify associated social patterns at higher meso and macro levels; that is, how disease and death are differentially distributed across groups and what the reasons are for these differences.

Sociologists differ among themselves in their approach to health issues—they choose different theories, different areas of inquiry, and different methods of study. Looking at social structures and social conditions at the macro level, sociologists are interested in understanding the relationship between social conditions and health. Why, they may ask, are some countries healthier than others? What creates these health inequalities? At the meso level, sociologists study health and illness at the level of institutions. They might be interested in understanding the dynamics of the relationships in hospitals or explore how and why the health professions are gendered. At the micro level, sociologists examine how social interactions among individuals shape the experiences of health and illness. What meaning do people attach to the concepts of health and illness and how is this meaning created in communications with others? Although sociologists employ a number of different theoretical perspectives (or lenses) and methodologies to view and interpret the existence, prevalence, and lived experience of health and illness as well as the social organization of how health care is delivered and distributed across groups, the goal remains the same—to understand health and illness as social phenomena that are experienced and situated in society.

MEDICAL SOCIOLOGY AND THE SOCIOLOGY OF HEALTH

The origins of medical sociology are found in public health and social medicine initiatives in the nineteenth century that grew into a specific subfield from its parent discipline of sociology in the late 1940s (Bloom, 2002). Just as sociology is the study of the social causes
of consequences of behaviour, medical sociology is the study of the social causes of illness and disease. The sociology of health moves beyond medical sociology to focus not only on disease but also on the social causes and consequences of health, health behaviours, and health care. Behaviour, in this sense, is a broad term encompassing individual behaviours and social interaction as well as institutional and societal behaviours and actions. Medical sociology and its evolution into a sociology of health has carved out its own niche from its parent discipline by focusing on the social conditions that help to promote well-being and disease prevention as well as those that cause illness and disease. To facilitate research and the interaction among researchers in the sociology of health in Canada and other countries, various academic associations have been established. (See Box P.1 on the Canadian Society for the Sociology of Health.)

A historical distinction within medical sociology is between the sociology of medicine and the sociology in medicine. First articulated by Robert Straus (1957), the sociology of medicine is oriented toward a better understanding of society or sociological concepts through the lens of health problems, medical settings, or the organization of health care. For example, Elliot Freidson (1970a, 1970b) presents the case that the medical field has laid claim to expertise on a broad array of behaviours, far beyond its demonstrated capacity to treat and cure. Through political lobbying, legislation, and other means, the medical field has taken over many behaviours that used to be in the domain of other institutions, such as the legal system and religion. Determinations such as being “not guilty by reason of insanity” redefine behaviours that were previously considered immoral as a sickness, beyond the control of the individual. It also moves these behaviours from the domain of the legal system to the medical system. Even the difficult or overly rambunctious child whose behaviour used to be defined as unruly and controlled

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Box P.1

The Canadian Society for the Sociology of Health

The Canadian Society for the Sociology of Health/Société Canadienne de Sociologie de la Santé (CSSH/SCSS) is dedicated to the promotion of the sociological study of health, illness, and health care issues in Canada in both our official languages. The Society began in 2008 with the hosting of the Interim Conference of the Research Committee on Medical Sociology of the International Sociology Association in Montreal. This served as an important crystallizing event for Canadian medical sociology. The primary objectives of the CSSH/SCSS are to provide a bilingual venue to bring together Anglophone and Francophone medical sociologists to present cutting-edge research on a variety of critical topics, to advance the discipline and our understanding of health and health care issues in Canada, and to foster greater translation of the knowledge we create to key users to better address health issues in Canada and abroad.

For more information on the CSSH/SCSS, go to www.cssh-scss.ca
through behaviour adjustments and physical restraint is defined now as attention deficit hyperactivity disorder (ADHD) and is controlled through pharmacological restraint.

Alternatively, sociology in medicine is generally oriented toward a better understanding of health-related problems or the development of health policy and programs. Much of the work centred within a sociology-in-health perspective occurs in the health field where researchers examine the social causes of illness and disease. For example, children manifesting high levels of problem behaviour or diagnosed with ADHD are examined to attempt to understand the social factors associated with their behaviour. Such researchers reveal that various social institutions encountered across the lifecourse, including the family, school, and marriage, may explain why some people are hyperactive as children, become risk-takers as adolescents, and in some cases, criminals as adults (Sampson & Laub, 1993). This perspective also describes how the social environment of various groups leads to higher rates of depression and other mental health problems. Researchers have shown that persons in social positions that are associated with higher levels of social stress, be it at home or at work, are more likely to manifest depression and other mental health problems (Avison & Gotlib, 1994).

Although the distinction between a sociology in medicine and a sociology of medicine is important to make, it is not a clear dichotomy. Many sociologists examining health are engaged in both. Initially the work of some sociologists and social psychologists such as Erving Goffman (1963), David Rosenhan (1973), and Talcott Parsons (1951) took more of a sociology of medicine approach. Goffman examined how the label of mental illness was stigmatizing to persons, spoiling their identity and making them less worthy than normal people. Rosenhan examined how people can easily be involuntarily hospitalized and kept confined against their will in psychiatric hospitals by merely pretending to report symptoms that would be consistent with schizophrenia. Parsons examined how society relates to people who are sick by identifying a specific, agreed-upon role that these people play. However, the overwhelming majority of the work on the social aspects of illness and disease was done within the health system using a medically defined approach to examine how these diseases manifested and who was more likely to become sick.

Sociology is not the only social science to focus on health and health care, to understand health and illness as social phenomena. Other social scientific disciplines can help to inform various health and health care issues. Throughout the text, we will complement the sociological perspective with other disciplines such as psychology, demography, epidemiology, geography, political science, economics, and anthropology. For example, when we examine health care seeking behaviour (in Chapter 10) and aging and development (in Chapter 9), we discuss various psychological theories and models. In Chapter 10, we also examine some of the economic arguments for medical tourism, seeking medical care and procedures in other countries. Comparing these explanations with various sociological explanations provides a more thorough understanding of how our social world both influences and is influenced by health and health care. Even various medical subdisciplines can help to inform some of these debates. As such, we intentionally titled the book,
The Social Dimensions of Health and Health Care to embrace this larger “social” framework to complement the sociological perspective to examine various health and health care issues.

OBJECTIVES OF THIS TEXTBOOK

This preface presents an introduction to the importance of taking a social dimensions approach to health and health care. Since the social examination of health is such a large area, this text is structured in a way to provide the broad array of content in a coherent and comprehensible manner. The oversight and writing of the text as a whole was done by the three primary authors. However, since no one can be an expert in all things, various chapters are co-authored with experts in specific areas relevant to those topics. This ensures that a comprehensive coverage of topics is presented while the overall text maintains a consistently clear and fluid presentation.

The text is organized into 13 chapters. The first two chapters provide an overview of theoretical and methodological tools that cut across the thematic content areas presented in three overarching sections. Chapter 1 defines health and presents the theoretical perspectives commonly used in examining the social aspects of health. Chapter 2 presents methodological tools that provide us with a systematic manner in which to collect and evaluate information to help confirm or reject arguments consistent with various theoretical perspectives. These two introductory chapters will be most useful for those who may not be familiar with sociological theory or social research methods but will also provide a good review for others. With these tools, readers are prepared to begin the task of working through the thematic content areas.

We then shift our focus to the health care system in Canada. In Chapter 3, we examine the historical development of the Canadian health care system with a focus on policy and legislation. This provides a foundation for better understanding the current organization of the system. In Chapter 4, we explore professions within the health care system, its division of labour, and how various factors, such as training, professionalization, licensing, and credentialing, influence this division. Moving from professions, Chapter 5 focuses on the various institutions such as hospitals, nursing homes, and facilities for long-term care; their organization within the medical system; and how they influence the delivery of health care. We also examine the process of government decentralization and institution centralization through the regionalization of local health systems.

Next, we focus on population health and the social determinants of health. As discussed, health is generally thought of as an individual issue. In Chapter 6, we move from an individual perspective to a population perspective to discuss health. In doing so, we introduce the discipline of epidemiology and provide a look at the changing demographics of the Canadian population and examine patterns of mortality and life expectancy. Moving from this, in Chapter 7, we employ this population perspective to explore how social factors are associated with health disparities and examine how health and health care is disproportionately distributed across advantaged and disadvantaged groups. This perspective allows us to see past individual-level troubles to look at how health and illness
are distributed across populations. In Chapters 8 and 9, we examine both mental health and aging as two key population health issues because of the important implications they have for Canada now and in the future.

Next, we examine how people experience health and illness and how they encounter the health care system. In Chapter 10, we examine health care seeking behaviour and why some people are more likely to seek care than others. From here, in Chapter 11 we attempt to understand the experience of health and illness. While having an illness can be a physiological experience, how people personally experience illness and how others treat people with various illnesses is very much influenced by social factors. Moreover, the definitions of what constitute illness and disease itself are open to much debate, which we will also describe here. In Chapter 12, we discuss the social factors that may play a role in the identification, definition, and treatment of what we label illness and disease. We also examine the role that institutions such as medicine and industries such as the pharmaceutical industry play in medicalization.

Finally, in Chapter 13, we discuss the social aspects of food and agriculture, an area of critical importance to health but relatively new to our discipline. Examining a variety of issues such as historical changes in food production and food consumption, and current health trends such as obesity and diabetes, we explore the connections between government, industry, and populations, and how these connections influence our consumption habits and, ultimately, our health.

Chapter Features

Each chapter begins with an outline to identify the topic of discussion. We present a list of objectives to orient readers as to the general themes and ideas that you should be able to take away from a specific chapter. It is helpful to keep these in mind as you work through the content. At the end of each chapter, these learning objectives are complemented by a series of critical thinking questions, a list of key terms, and suggestions for additional readings and resources, including reports, websites, and other media for further learning. The key terms are important in any research discipline since engaging in any new area of research is partly the ability to learn some of the jargon and key concepts. Finally, to complement each chapter, we include a series of information boxes and researcher profiles to add to and expand on specific content and to highlight some of the key historical and contemporary Canadian health researchers and their research programs. Although certainly not exhaustive, these information boxes and researcher profiles provide readers with a country-wide view of some of the important work that is being pursued by Canadian researchers and educates them as to the array of potential research opportunities across Canada.

To conclude, it is our intent to challenge readers to move past commonly held beliefs about health and health care to broaden their understanding of how our social world influences health and illness. In doing this, we introduce readers to a broad array of health and health care issues from different perspectives. We hope that students reading this book will walk away with a better understanding of the social influences on health and health care with a particular focus on the Canadian context.
KEY TERMS

Biomedical perspective—a mechanistic-based view that objectifies illness and disease based solely on physiological factors, separating it from the individual as well as from the larger cultural, political, and social context in which it occurs.

Sociological perspective—a perspective that examines how personal issues are patterned across groups and are connected to the larger social and structural organization of society.

Sociology in medicine—sociological inquiry that is generally oriented toward a better understanding of health-related problems or the development of health policy and programs.

Sociology of health—a subdiscipline of sociology that focuses on the systematic study of human society in relation to health and health care.

Sociology of medicine—sociological inquiry oriented toward understanding medical settings, the organization of health care, or the construction and definitions of disease through the lens of health problems.

FURTHER READINGS AND RESOURCES

Relevant Academic Journals

The following are useful journals where key articles in sociology of health, illness, and health care are published:

- *Health and Canadian Society*—includes key social science and health articles with a Canadian context
- *International Journal of Health Services*—particularly for studies from a materialist perspective
- *Journal of Health and Social Behavior*—the American Sociological Association’s flagship health journal, a general health journal focusing on all sociology of health areas
- *Research in the Sociology of Health Care*—published once a year on key themes of sociology pertaining to health care
- *Social Science & Medicine*—an international journal incorporating a variety of social scientific perspectives on health, illness, and health care
- *Sociology of Health and Illness*—the journal of the British Medical Sociology group, leans more toward theoretical articles and those from a critical interactionist or constructionist perspective
- *Women & Health*—focuses on studies of health, illness, and health care organization and provision from a feminist perspective, broadly defined

Relevant Websites

- Canadian Society for the Sociology of Health (CSSH)
  www.cssh-scss.ca/
- American Sociological Association (ASA) – Medical Sociology Section
  www2.asanet.org/medicalsociology/
- Health Sociology group of The Australian Sociological Association
  www.tasa.org.au/thematic-groups/groups/health/
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ACKNOWLEDGEMENTS

Health and health care is one subject about which every Canadian has strongly held opinions and beliefs. Oftentimes, if Canadians aren’t talking about the weather, they are talking about their own health and health care experiences or those of their family and friends. People are eager to share these experiences and stories (especially their bad experiences and stories) and do so with a great deal of passion and emotion with anyone willing to listen. It is through these personal experiences and the stories from others that people form the basis of their opinions and beliefs about Canadian health care. While everyone is certainly entitled to their own views, in this text, it was our intent to make students challenge these personal opinions and beliefs in light of evidence to give them an opportunity to develop a better understanding of the issues surrounding health and health care in Canada.

The building of any textbook is a long journey. And with any journey, there are many people along the way who have had an influence on this project. This project originally stemmed from a textbook previously published by Gail Parry (nee Frankel), Mark Speechley, and Terrance Wade in 1996. We thank both Gail and Mark for allowing us to use some of that material in this textbook. The oversight and writing of the text as a whole was done by the three primary authors. Since no one can be an expert in all things, we enlisted co-authors with expertise in specific areas to assist as required. As such, we thank John Cairney (Chapter 8), Margaret Denton (Chapter 9), and Paul Millar (Chapter 13) for their valuable contributions to improve the overall quality and breadth of the material.

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