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CHAPTER 1

Structural Functionalism, Health and Healthcare

Introduction

In this chapter, we begin with the work of the classical theorist and one of the key founding figures of sociology, Émile Durkheim (1858–1917). His work is essentially concerned with how societies reproduce themselves through collective belief systems and practices, and how individual members are collectively bound by values and norms that govern societal practices. In turn, these practices regulate society and create a sense of social solidarity. Like other classical theorists, he was interested in understanding the transition from traditional to modern society in order to explain the impact of social change. We go on to discuss structural functionalism as a distinct body of modern social theory, which represents one particular line of influence from the classical work of Durkheim. Within the sub-disciplinary field of the sociology of medicine, Talcott Parsons (1902–1979) is the most noted of the structuralist functionalist theorists. (Robert Merton is another central figure in the development of this theoretical perspective and his work is discussed in Chapter 7 in relation to the sociology of knowledge and science). A central thread that links the classical legacy of Durkheim to structural functionalism is the idea that shared norms and values are fundamental to society functioning as a cohesive whole. This core idea became the hallmark of Parsons' work and, more generally, has led to the characterization of structural functionalism as a 'consensus theory' of society. An example of what we mean by this is the emphasis that Parsons places on the function that social institutions such as medicine play in meeting the needs of society to maintain social and political stability.

While structural functionalism dominated American social theory in the 1950s and 1960s, more critical perspectives concerned

with unmasking the tensions and conflicts behind apparently stable and harmonious social and political structures became more mainstream by the mid-1970s. However, some sociologists have noted a revival in Durkheimian sociology since the 1990s in the expanding field of 'social capital' research (Blaxter 2000, Turner 2003). In the discussion on the application of structural functionalism to understanding health, we will explore the contribution of social capital theory to debates about the pervasive problem of health inequalities, a theme that is further developed under the perspective of 'political economy' theories in Chapter 2 and 'critical realism' in Chapter 5. We then turn to the classical account of the doctor-patient relationship offered by Parsons in his 'sick role' theory, which has perhaps more than any other theory earned sociology a place in healthcare research. However, while the sick role remains a remarkably stable concept in medical discourse it has become less popular as an analytical concept in sociological theory and, as we go on to discuss, new lines of enquiry and new explanatory frameworks have overtaken it.

Principles of structural functionalism

Let us start with a definition of the term 'structural functionalism'. Structuralism refers to a view of society which asserts that people's behaviour is structured according to a set of rules or laws. Functionalism is the view that society is a system made up of interconnected parts, each of which functions in a specific way to maintain the system as a whole (Porter 1998). These ideas were developed by the nineteenth-century French sociologist, Émile Durkheim. Durkheim's work is concerned with defining sociology as a distinct discipline that could emulate the so-called 'hard sciences'. He describes sociology as the study of 'social facts' relating to social structures – the work of sociology is to explain patterns that emerge in the social world ('social facts') by linking the *determining cause* of these social phenomena to their *social effect*. Social structures constrain individual actions and, therefore, human deeds cannot be explained solely in relation to individual motivations or behaviours. Moreover, since society is more than simply the sum of the self-interests of individuals, the problem of how society is socially integrated (what ties its members together), particularly as it undergoes processes of change, is a central concern in Durkheim's work.

The social division of labour

Like other classical social theorists, Durkheim is concerned with the way in which the modern processes of urbanization and industrialization break down traditional ways of living. In *The Division of Labour in Society* ([1893] 1964), Durkheim explains that traditional and modern societies are integrated differently. Traditional societies (e.g., agrarian subsistence societies where the family is the dominant economic unit) are structured by a simple 'division of labour', meaning that people perform similar functions to each other, which creates a shared bond within society based on common experiences and shared beliefs (Ritzer and Goodman 2003). He refers to this form of social integration as 'mechanical solidarity'. Modern society, on the other hand, is characterized by a more complex division of labour where people perform specialized tasks in an ever-widening range of structures and institutions. Here we need only to think about the growth in institutions associated with the welfare state in the twentieth century and the important role that these play in social protection, education and health, functions previously associated with the traditional institution of the family. Durkheim characterizes the social integration that arises from mutual dependency created by the more complex division of labour in modern society as 'organic solidarity'.

In modern society social bonds based on a shared way of life are inevitably weaker and social integration is a function of the mutual dependency of people's needs and 'the mutual relationships between [specialized] functions' (Durkheim in Calhoun *et al.* 2002: 145). For Durkheim, this interdependency is consolidated through the 'network of ties' that becomes institutionalized in society over time. As society undergoes rapid social and economic change, the norms, values and beliefs that guide people in the conduct of their everyday lives and that reproduce a sense of collective belonging are weakened. This gives rise to a state of 'anomie' – a concept that Durkheim uses to explain the breakdown in traditional social norms. In this situation, individuals are set adrift and isolated from the kind of common bonds that are formed in, for example, family and kin networks, community and in the work place. Durkheim suggests that the complex division of labour in modern society, which has the potential to create new forms of solidarity based on the interdependency of needs and specialized functions, also has 'pathological' tendencies in the sense of producing unhealthy societies evidenced, for example, by rising rates of suicide.

Conceptualizing suicide as a problem of social integration

Durkheim develops his argument on the problem of social integration in modern society in his study of suicide ([1897] 1951). In this study, which best illustrates his concept of anomie, Durkheim offers an important sociological insight that suicide, more commonly understood as an individual act of self-destruction, can be explained in relation to underlying social factors. In explaining the differential rates of suicides cross-culturally and over time, he argues that too little or too much social integration and social regulation creates the social conditions for different patterns of suicide (Ritzer and Goodman 2003). To this end, he identifies four types of suicide. The two dominant types of suicide in modern societies are 'egotistic' and 'anomic' suicide. Durkheim associates these patterns of suicide with low levels of social integration and regulation in societies marked by individualism and disruptive social change. In the case of the former pattern, suicide is the result of the weakening of social bonds, whereas the latter is associated with the kind of social disconnection that arises from radical social and economic change, which weakens the hold that traditional norms have in regulating individual behaviour. Durkheim identifies 'altruistic' and 'fatalistic' suicide as the dominant patterns in traditional societies, which are more highly integrated and regulated. In traditional societies where individual members are tightly bound by a single belief system, individuals are more likely to sacrifice their lives (as in the case of the martyr) for the greater good of the community, whereas fatalistic suicide occurs when traditional norms and belief systems operate as oppressive structures of regulation.

Durkheim suggests that modern societies are marked by a rise in egoistic and anomic suicides reflecting a breakdown in social bonds and traditional norms following certain social trends such as political apathy, hyper-individualism, the prevalence of nihilistic philosophies, and the widening of social choices at the same time that the norms and moral reference points on how we should live are loosened. Although Durkheim was making these observations over a hundred years ago, they remain pertinent to contemporary commentaries on the social causes of rising suicide rates. A central theme in his approach to the problem of social integration and regulation is the idea that associational forms of social organization are necessary to counter-balance such tendencies. This idea is re-emerging in social capital theory marking what Blaxter (2000) and Turner (2003) describe as a 'neo-Durkheimian'

turn in social theory, which is discussed more fully under the application of structural functionalism to health in the following section.

Parsonian functionalism

For our present purpose, we now turn our attention to the development of structural functionalism (sometimes referred to simply as 'functionalism') as formulated in the work of the American sociologist, Talcott Parsons. Parsons is considered a central figure in the development of modern social theory and his work has left a deep imprint on the development of medical sociology. Influenced by the psychoanalytical theory of Freud, Parsons is interested in the motivations behind illness behaviour and how this is managed in the doctor–patient relationship (Turner 1992). However, Parsons' analytical framework extends beyond the therapeutic encounter to understanding the doctor–patient relationship in terms of the functional needs of society. Therefore, much of the commentary on Parsons' contribution to the sociology of health and illness has focused on his structural analysis of the illness experience. For Parsons, the structures of society (social roles, norms and values) are organized on the basis of its functional needs. In other words, they have a purpose and that purpose is to make society run smoothly. The core of his work is concerned with the problem of social order – how society reproduces and maintains an ordered structure or a state of balance between the different parts of the social system. Unlike the social interactionist theorists discussed in Chapter 3, Parsons does not take the micro-level of individuals interacting with one another as the basic unit of analysis in the study of society. Instead, his work is concerned with the large-scale structural components of the social system and its functional imperatives, including the necessity to maintain social order. It is important to note, however, that Parsons does not dismiss the importance of the micro-level of social interaction; his seminal work *The Social System* (1951), for example, is based on the interactions between doctors and patients in a Boston hospital. However, in understanding the relationship between actors and social structures, Parsons is interested in the way that people are socialized into the norms and values of a given social system and appropriate social roles.

Parsons is not just concerned with explaining individual action but with how that action may be determined by the way the social environment is organized. This idea is developed in his 'action system theory'. In this schema, there are four interrelated action systems – the

social, cultural, behavioural and personality systems. The 'social system' consists of four subsystems (Parsons was very fond of the number four), which perform different but interrelated functions in maintaining the system as a whole. The *economy* serves the function of adapting the external environment to the needs of society through the organization of labour, production and distribution. The *political* system performs the function of defining common goals and mobilizing society to that end. The *socialization* system consists of the main institutions for socializing actors into the dominant norms, values and expectations of society, such as the family and educational system. The *societal community* serves the function of integrating and regulating the other components of the social system through formal legal codes and informal social control (Layder 1994, Ritzer and Goodman 2003). Balance between the various sub-systems of the social system, which is necessary for social stability, is achieved through the exchange of various forms of what Parsons calls 'symbolic media', such as money in the economy, power in the political system and influence and commitment in the societal community and socialization systems, respectively. The 'cultural system' refers to the stock of resources (knowledge, ideas and shared symbols such as language) available within a given society that individuals draw on to help them make sense of their interactions with others. The cultural system is embodied in the norms and values of the social system and the orientations and motivations of individual actors. For Parsons, the 'behavioural organism' (the body) is shaped in interaction with the social environment through processes of learning and socialization, as is the 'personality system' (see Ritzer and Goodman 2003 for a more detailed discussion).

Parsons, therefore, is best described as a macro-theorist in that he understands large-scale social and cultural systems as exerting a determining influence on individual motivations and behaviours. When compared to Marxist theory in the next chapter, which also offers an overarching theory of society, structural functionalism ignores the role that material factors, such as money and power, play in the way that the social system is structured. Moreover, the role that core values and norms play in terms of social integration is seen as operating outside of material interests. But what concerns us here is the emphasis that Parsons places on socialization and social control as mechanisms for maintaining social stability. As Ritzer and Goodman (2003) note, Parsons' overarching concern with social order and the assumptions that he makes about the passivity of social actors in his strong version of socialization theory (the idea

that people internalize norms, values and role expectations) have become major targets of criticism of his work.

Having outlined the key ingredients of Parsons' complex theoretical framework, we go on to look more closely at how he develops these insights in relation to healthcare, particularly his analytical model of the sick role (1951) in explaining key features of the doctor–patient relationship, and how he links these to the wider system problem of social stability.

Applications to understandings of health

The neo-Durkheimian turn and social capital theory

Since the mid-1990s there has been a growing literature linking social capital to a variety of outcomes including better health. In this section, we are particularly concerned with tracing the 'neo-Durkheimian' thread in the way the concept of social capital is applied in understanding the social determinants of health. As is often the case with other classical theories presented in this book, we find only a cursory mention to Durkheim in the contemporary research field on social capital and health, which also largely ignores his work on suicide. However, the link between the classical theoretical precepts outlined in the previous section is suggested by the way that social capital is used as an umbrella term encapsulating the ideas of social integration, social cohesion and social support (Almedom 2005). The key bodies of work that have shaped social capital theory in the field of health research are Robert Putnam's *Bowling Alone: The Collapse and Revival of American Community* (2000) and Richard Wilkinson's *Unhealthy Societies: The Afflictions of Inequality* (1996), and the application of their theories in the much-cited research of Kawachi *et al.* (1997, 1999a). This body of work may be interpreted as neo-Durkheimian in the sense that social capital is understood as a property of social structures and social relationships whose function is to promote social support through norms and values of trust and reciprocity and that, at the same time, regulate deviant behaviour. This conceptualization of social capital proves to be the major point of contention in Marxist materialist analyses in which the link between social inequalities and health inequalities is bound up with the social relations of production in capitalist societies (Muntaner and Lynch 1999, Navarro 2002; see also Chapter 2). We will now consider how

social capital theory is applied to understanding the social determinants of health by exploring the following:

- Definitions of social capital based on its relational dimensions (emphasizing the norms and values that connect people to one another) and its material dimensions (emphasizing social capital as a resource that is determined by an individual's socio-economic or class position);
- How the links between social capital and health outcomes are conceptualized in the key social capital literature, and finally;
- Empirical evidence of the link between social capital and health outcomes.

Defining social capital: The relational dimension

The relational dimension of social capital includes norms, values, social networks, trust and reciprocity, social integration, social cohesion and social support. The core elements of the relational definition are encapsulated in Putnam's (1995, 2000) theory of social capital, which dominates the health research literature (Moore *et al.* 2005), and these may be summarized in the following way:

- a) Membership of social groups or networks (personal or primary social networks such as family, friends, neighbours, co-workers; and secondary, formal networks such as voluntary organizations and statutory organizations).
- b) The norms and values that confer obligations and benefits on individual members of the social network (such as trust, reciprocity, access to strategic resources, sense of belonging and social control).
- c) The outcomes (and function) of social capital (such as social support, civic participation, social cohesion).

Putnam's (1993) original thesis is based on the idea that social capital as a measure of civic participation is a prerequisite to democratic culture, effective political governance and economic development. In 'Bowling Alone' (1995), he equates the demise in the American sense of community with a perceived loss of quality of life. The public health literature draws on Putnam's concept of social capital as a 'civic' property of communities, which he defines as '...features of social organization such as networks, norms, and social trust that facilitate action and cooperation for mutual benefit' (1995: 67). An important feature of Putnam's

definition of social capital is that he understands it as a collective property of society rather than as a property of individuals. The 'stock' of social capital available in a given community is measured by a number of predictive indicators, including membership in voluntary organizations (social capital networks), democratic participation (newspaper consumption, voting patterns and preferences) and expressions of interpersonal trust and reciprocity and institutional trust (social capital values). Putnam also identifies different forms of social capital. *Bonding* social capital refers to primary social groups and informal social networks such as family, kin and friendship networks. Strong ties amongst people who share core beliefs, which promote shared values, mutual trust and norms of reciprocity, typically characterize this kind of network. As well as contributing to an individual's sense of self-worth, this type of network is also a source of informal social control. *Bridging* social capital refers to a looser network of both horizontal and vertical connections between heterogeneous groups, for example between different community/voluntary groups and between these groups and other organizations such as statutory agencies involved in decision-making about the distribution of public goods and services (Almedom 2005). While these secondary, formal institutional networks constitute weaker ties amongst members, they are usually more inclusive than bonding forms of social networks. This type of network promotes collective efficacy and collective decision-making through community and civic participation. There is a strong theoretical correlation here with Durkheim's distinction between mechanistic and organic forms of solidarity. Like Durkheim, Putnam does not argue that we should return to traditional forms of social cohesion, but create new forms of association that can adapt to contemporary social conditions. More recently, Szreter and Woolcock (2004: 655) draw a further distinction between the kind of relationships that define horizontal connections between people who are 'more or less equal in terms of their power and status' and those that 'connect people across explicit "vertical" power differentials', for example, when people are accessing resources from formal institutions such as healthcare. They refer to the latter as 'linking' social capital.

Defining social capital: The material dimension

Those theories that emphasise social capital as a 'public good' and identify social participation and engagement as the key features of social capital accumulation in society belong to the neo-Durkheimian turn. While

Putnam's work stands out in this respect, the concept of social capital is also traced to the work of sociologists James Coleman (1988) and Pierre Bourdieu. Bourdieu's theory of social capital is of particular interest to our discussion because many of the critiques of Putnam's theory point out that the *material* as opposed to the *relational* (the social relationships that form an individual's social ties) dimension of social capital is ignored (Portes 1998, Hawe and Shiell 2000), along with the potentially negative effects of social capital (Muntaner and Lynch 1999), which Bourdieu's theory addresses. More recently, some researchers suggest a productive synergy between Putnam's and Bourdieu's conceptualizations of social capital (Ziersch 2005, Carpiano 2006).

Bourdieu's theory suggests a material analysis – one that is concerned with social power and the question of how *access* to social capital as a resource is determined by wider socio-economic structures. Bourdieu defines social capital as 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition' (1986: 248). He links social capital to the cultural, social and economic dynamics of class formation and, therefore, to other forms of capital including economic capital and cultural capital (such as education). Social networks differ in the amount and transferability of social capital as a resource that individual members can mobilize. In other words, social capital is differently distributed in society and this reflects broader inequalities. Therefore, if Bourdieu's theory was integrated into social capital studies, social network analysis would not only be concerned with social support and social participation and engagement (as a civic measure) but also with the way that social networks can work exclusively by giving group members access to influence and material resources. As Ziersch (2005) argues, Bourdieu's understanding that social capital can serve to reproduce existing social inequalities questions the universal value attributed to social capital as a public good in the way Putnam and his followers assume.

Linking social capital to health outcomes

The basic hypothesis in the health research literature is that certain features of the social environment associated with social capital promote positive health. Wilkinson's (1996) seminal work explaining the relationship between income inequality and health inequality has stimulated considerable debate and research on the role that social

capital plays in health outcomes. While the relationship between income inequality and health inequality is strongly supported by empirical evidence, the mechanisms by which income inequality impact on health are often disputed. We will see that political economists (Chapter 2) and critical realists (Chapter 5) have different interpretations. Wilkinson observes that the wealthiest countries are not necessarily the healthiest societies. He argues that there is a threshold beyond which the absolute wealth of a population no longer has a direct bearing on health in wealthy countries that have undergone an epidemiological shift in the burden of disease from acute, infectious diseases to chronic illnesses. Wealthy societies that show unequal outcomes for health also have the greatest income inequalities and are less socially cohesive. This leads Wilkinson to argue that social capital as a psychosocial pathway is the key mechanism that mediates the relationship between income inequality and health inequality. In other words, the amount of social capital an individual has will affect how that individual thinks, feels and behaves. He suggests that this is the case because in unequal societies there is less social cohesion and people's perceptions of social exclusion and sense of alienation serve to exclude them from the dominant ethos of a society. The psychosocial impact of exclusion (anxiety, feelings of hopelessness, anger and insecurity) leaves its mark on health both directly in terms of the impact of the social environment on the individual's immunity and indirectly in terms of health behaviours. In socially cohesive societies the social environment is a source of social support rather than a source of social instability that undermines supportive social networks and, hence, the well-being of the whole society.

The key question for health researchers then is *what does social capital tell us about the mechanisms by which income inequality impacts on health?* Drawing directly on the work of Putnam, the overarching hypothesis is that social capital in the form of voluntary association and the density (size and frequency of social interaction) of the network amongst these associations in the community is protective of health. Putnam's basic theoretical argument is that civic participation in associations creates trust and reciprocity necessary for the social fabric of a society, which, in turn, sustains social relationships that provide mutual support within the community. High levels of social capital are necessary so that people can act collectively to demand better government and more efficient services for the common good. Kawachi *et al.* (1997) found a strong statistical correlation between social capital and health across 39 US states. Following Putnam, they measure social capital in terms of levels of trust

and membership of voluntary associations and argue that income inequality impacts on health negatively through the social capital variable. The mechanisms by which social capital affects health outcomes suggest a number of direct and indirect pathways. First, community social capital influences the health of individuals by providing social support, mutual respect and self-esteem. In communities with low stocks of social capital, a direct pathway linking social capital to health is the psychosocial stress caused by insufficient social networks, limited social participation and lack of community empowerment (Wilkinson 1996, Kawachi *et al.* 1999a, Kawachi and Kennedy 1999). Second, an indirect pathway is that communities with high stocks of social capital are more likely to collectively mobilize for better public services and amenities that are relevant to health (Kawachi *et al.* 1999a).

A Marxist materialist perspective (developed under the political economy approach in Chapter 2) argues that the social relations of production in capitalist society influence all aspects of life including health and well-being. From the point of view of a Marxist materialist critique, Muntaner and Lynch (1999) argue that social cohesion may well mask class relations within society, and they point out that the middle class generally has more resources to commit to their communities and public participation (also Altschuler *et al.* 2004). Furthermore, Cattell (2001) argues that network typologies (such as bonding and bridging) themselves may be describing class structures, while descriptions of the kind of resources available through networks may well be pointing to the processes involved in the production of health inequalities.

Assessing the evidence of the link between social capital and health outcomes

If we take the two basic hypotheses that emerge from Putnam's and Wilkinson's work – respectively, voluntary association and the density of community networks is protective of health, and social capital is an independent mediating variable linking income inequality and health inequality – we find contradictory evidence. Kawachi *et al.* (1997) found that higher levels of trust and higher levels of participation in social clubs and associations were linked to lower levels of mortality for most major causes of death. Kawachi *et al.* (1999) found that individuals living in states with a low stock of social capital reported higher levels of ill-health even after controlling for socio-economic status (income and education) and other individual risk factors such as access

to healthcare, smoking and obesity. Expanding on this work, Veenstra (2000) did not find a strong statistical relationship between involvement in extended social networks such as clubs and associations and self-related health. He found that trust (in government, community, neighbours and identity groups) and its psychosocial components (sense of identity and commitment) were not significantly linked to self-related health after controlling for socio-economic status. He also found no direct relationship between civic participation and health and any tentative relationships disappeared once he controlled for socio-economic status. The only strong relationships that he found were between socio-economic status (income and education variables) and health.

Cooper *et al.*'s (1999 cited in Campbell 2000: 184) review of health survey data in England also found that material deprivation and socio-economic position had a stronger statistical correlation with adverse health than social capital indicators. However, this statistical relationship is weakened when variation in neighbourhood social capital is controlled suggesting that the context factors of community are important in the link between income inequality, social capital and health inequalities.

So, what do community-based studies on the role of social capital in economically deprived and socially excluded areas tell us? Again, the evidence is very mixed, but these studies paint a more complex picture. Some of the complexities of the association between social capital and health have been well documented at the individual level in studies of social support and social networks in deprived communities. The key hypothesis of these studies is that social supports in the form of primary and informal networks such as family, kin and neighbourhood and formal supports in terms of local services act as a buffer against the health impacts of poverty. These studies show that the structure and function of social networks as a source of social support depends on the social context and that within a given community these networks are not unambiguously supportive either at the individual level or in terms of the social fabric of the community (Campbell 2000, Cattell 2001, Kunitz 2004). We will return to these arguments in Chapter 2. There is strong evidence to support the link between socio-economic status and individual health outcomes and equally strong empirical evidence to support the link between area-based deprivation and high community levels of mortality and morbidity. However, there is very little research on how community context affects different resident groups (Stafford *et al.* 2005).

In terms of conceptual and operational clarity there is a need to distinguish between the different sources of social capital and its functions as a measure of the effects attributed to social capital (Portes 1998). Ziersch (2005) offers a clear operational definition that distinguishes between these two conceptualizations in order to examine the relationship between sources of social capital and their outcomes, and how the social process involved in the interaction between these two elements impacts on health:

SC [social capital] is conceptualized as comprising: *infrastructure* (SCI) – the networks and values that facilitate access to resources; and *resources* (SCR) – the resources available through this infrastructure. (Ziersch 2005: 2119)

Ziersch's (2005: 2128) operational definition of social capital incorporates Bourdieu's conceptualization of social capital, which not only emphasizes '...the ties between people but also the "value" of these ties in terms of accruing resources'. He applies this conceptualization to a quantitative survey of two suburbs in West Adelaide, Australia. Ziersch's main findings are that within a community people will have access to different kinds of social networks depending on their socio-economic status and that some types of social networks are more important for accessing the kind of resources that are protective of health. For example, he found that the informal networks and values associated with being better off also led to better social capital resources that were also linked to better health. However, in line with other studies (a community study by Baum *et al.* (2000) also conducted in Australia, and Veenstra's (2000) Canadian community survey), he found that formal social networks had no relationship to either self-reported mental or physical health. The psychosocial components of social capital resources in this study were respondents' feelings of acceptance, measured by the statement, 'I don't feel fully accepted as a member of [the area]', and the extent to which people felt in control of their lives. Feelings of acceptance were not linked to either mental or physical health, while an individual's sense of control was positively linked to mental health. In Ziersch's study this psychosocial component is linked to social support that directly arises from informal networks rather than from the civic actions that are linked to formal networks. People's perception of relative advantage were also included in the survey and respondents were asked to score their sense of advantage relative to others in the locality in terms of family life, achievements, money and material possessions, quality of

life and so on (see Ziersch 2005: 2123 for a full list of indices for this variable). This variable was positively linked with income level and tenancy (whether people rent or own their homes), and indirectly with work status and education. Not surprisingly, those with better incomes, who owned their homes, were employed and had higher educational credentials were more likely to perceive themselves as relatively advantaged compared to others in their locality. These socio-economic factors are also linked with those elements of social capital that were positively associated with perceptions of relative advantage. While people's perceptions of relative advantage were directly related to mental health, this was only marginally so in relation to physical health.

The primary research that we use as examples to discuss the impact of social capital on health show very mixed and contradictory results (see also Almedom's (2005) review of the research linking social capital and mental health, as well as Hawe and Shiell's (2000) assessment of the literature on social capital and health promotion). The difficulty of assessing the primary evidence is compounded by theoretical and methodological differences within the literature. Primary studies draw on different theoretical definitions of social capital, which produce different indicators of social capital; these studies also follow different research designs and use different sampling techniques, sample sizes and units of analysis. Some studies are concerned with individual level analysis of social capital (Veenstra 2000, Ziersch 2005), others are concerned with measuring the effect of community or aggregate social capital on health (Kawachi *et al.* 1997), while others again are concerned with the contextual effect of community-level social capital or neighbourhood environment on individual health (Cattell 2001, Stafford *et al.* 2005).

Campbell (2000: 182) argues that the utility of social capital theory for understanding the social determinants of health and its usefulness for informing health policy and health interventions depends on research 'identifying measurable indicators of what constitutes a health-enabling community'. However, the empirical field remains dominated by statistical studies, and Almedom (2005) contends that the dearth of qualitative and ethnographical studies of social capital makes it particularly difficult to interpret the causal relationships between different variables produced by statistical data. He suggests that qualitative studies are necessary in order to contextualize and demonstrate the relevance of statistical evidence for policy and practice. While larger aggregate surveys of income inequality and health are more likely to capture significant statistical relationships, smaller scale qualitative studies have

explanatory value in demonstrating the conceptual links between the cultural, relational and material aspects of social capital in mediating the relationship between poverty, social exclusion and health (see in particular Cattell 2001).

Applications to understandings of healthcare

Structural functionalism and healthcare: Developments and critiques

Having examined how the contemporary heirs of structural functionalism understand health and its determinants, we now move back in time to examine the seminal application of structural functionalism to the understanding of healthcare, specifically to the traditional doctor–patient relationship. The doctor–patient relationship is a central component of healthcare since doctors define the needs and treatment of patients, albeit increasingly in the context of healthcare management and governmental guidelines (see Chapter 2 for further discussion on the professional position of doctors). This relationship also demonstrates the links between the micro- and macro-politics of healthcare since it is bound up with public trust in medicine and the authority that is invested in professional values and expert knowledge. Parsons' theory of the 'sick role' is his enduring legacy to the sociology of medicine in terms of stimulating both a wealth of research and instructive criticisms. In this section we trace the shifts in research in professional–patient relationships under the following themes:

- The 'sick role' and its theoretical limitations in understanding professional–patient relationships;
- Illness experience and the challenge that chronic illness posits for Parsons' concept of the sick role;
- Patient-centred approaches to medical care and the shift away from paternalistic healthcare relationships.

The 'sick role'

Parsons, in *The Social System* (1951: 430), wrote that '...from the point of view of the functioning of the social system, too low a general level of health, too high an incidence of illness, is dysfunctional: this is in

the first instance because illness incapacitates the effective performance of social roles'. Here we see how Parsons defines health in terms of our ability to function normally and to fulfil our role obligations. Illness, therefore, is not simply a biological category but it has a social dimension. Parsons understands that there is degree of motivation attached to all forms of illness, in the sense that consciously or subconsciously we may be motivated to withdraw from our social roles and obligations, for example when we are unable to cope with the stresses of everyday life. Hence, he defines illness as a potential form of social deviance, which requires some mechanism of control and regulation. Parsons developed the analytical model of the 'sick role' to explain how society regulates illness behaviour through a system that makes explicit social expectations concerning individual behaviour. The sick role is a particular kind of 'status role' that the sick person can temporarily occupy in order to recuperate from illness free from the obligations of their everyday social roles. Doctors are the gatekeepers of the sick role: by certifying an illness the doctor sanctions the sick role and, therefore, controls the private motivations of individuals to avoid social responsibilities such as work. The sick role orientates both patients and doctors towards mutual expectations about their respective roles. These roles are governed by a set of rights and duties, which the doctor controls ultimately. The sick person has a right to be exempt from the expectations of their everyday social roles and from responsibility or blame for their illness on condition that they seek out competent healthcare and comply with the doctor's orders. The doctor, on the other hand, is obliged to give competent care and to be guided by the patient's best interest.

The rights acquired by doctors in their professional role stem from their expertise and their professional commitment of service to the community over self-interest. The interaction between doctors and patients is guided by what Parsons terms 'pattern variables', which determine the parameters of interaction that shape role expectations. The doctor must not relate to patients in terms of particular criteria (e.g., dealing with patients in specific ways because they belong to a particular social category) or become emotionally attached (the ideal of professionalism); instead, the doctor must treat all patients equally on the basis of their illness (the principle of universalism). Here we see how the sick role is conceived by Parsons as a rule-bound social system that is governed by social roles, role expectations and a system of guiding values. Parsons' characterization of the relationship between doctor and patient as consensual mirrors his macro-theory of society,

which is based on the idea of a harmonious fit between the functional needs of society and its institutional structures (systems integration) and a high level of social integration where people adhere to a core set of norms and values to guide their actions with one another.

The theoretical limitations of the 'sick role'

While Parsons emphasizes that his theory of the sick role is based on an 'ideal type' (an analytical construct that identifies the most important general features of the doctor–patient relationship, but does not necessarily describe all actual instances of that relationship) his characterization of the doctor–patient relationship as one that is based on cooperation and mutual benefit has been subject to much critique, as has his depiction of the ideal patient as passive and compliant in deferring to the expertise of the doctor. An overarching critique of functionalist theory is that it ignores structural relations of power in society. In the context of the doctor–patient relationship this blinkers Parsons to the way that structural relations of power such as class, gender or ethnicity impacts on the illness experience and mediates the relationship between health professionals and patients. Moreover, as a consensus theorist, he sees the power structures of society as a legitimate means of maintaining social order, therefore, the power of the medical profession as an agent of social control is understood in Parsons' terms as a functional prerequisite of society. By emphasizing the norms and values that structure the doctor–patient relationship, Parsons neglects the material interests of such a powerful interest group and the role that biomedical ideology plays in the maintenance of power relations (Freidson 1986). The currency of this Parsonian model of the doctor–patient relationship perhaps lies less with its explanatory power than in the way that it measures up to a commonsensical view of the cultural power of medicine, which is the viewpoint that the power imbalance between doctor and patient is inevitable by virtue of the doctor's technical expertise and the vulnerability of patients who are reliant on the doctor's advice and willingness to act on their behalf so that they can access health resources.

Parsons' theory of the sick role has given rise to a significant body of empirical studies on the doctor–patient relationship and illness behaviour, primarily concerned with understanding patient compliance. However, the sick role theory (defined as doctor-centred) has been overtaken by new analytical perspectives that explore how the

doctor–patient relationship mediates, if not mirrors, broader relations of power and knowledge, for example in feminist critiques of how women are constructed in healthcare encounters (see Chapter 6). Similarly, studies on illness behaviour have begun to problematize the notion of the passive patient, as well as exploring the contextual determinants of behaviour. There is not space here to offer a review of these diverse developments; instead, we will focus on the shift from a focus on illness behaviour to illness experience (Lawton 2003), which arose, in part, from the limitations of Parsons' sick role theory for understanding chronic illness, and the shift in healthcare philosophies from doctor-centred to patient-centred approaches.

Illness experience and the challenge of chronic illness

One of the major critiques of Parsons' sick role theory is that it assumes an episodic view of illness as acute, temporary and potentially curable. The burgeoning chronic illness research literature that began to emerge in the 1980s represents a concern with lay knowledge and subjective experience as part of a growing sociological critique of the dominance of biomedicine. In this sense, the new research interest is seen as part of a wider cultural shift, which Bury (2001: 265) describes as '...the loosening of the authority of the "grand narratives" of science and medicine in the ordering of everyday experience'. Chronic diseases by definition are long-standing debilitating illnesses that cannot be cured and, therefore, challenge medical certainty and the cultural authority of medicine invested in the quest for cure. The growing body of empirical studies and conceptual work on people's experience of chronic illness challenge the underlying theoretical and practical premises of Parsons' theory which, as May *et al.* (2006: 1024) note, is echoed more widely in '...structural and policy shifts in the organization of health care'. This is most notable in changing philosophies of health that emphasize patient-centred therapeutic approaches and holistic models of care promoted in particular professional contexts such as nursing, general practice and occupational therapy; the emerging policy ideology of the patient as discerning customer; and the promotion of the self-care ethic in the new drive towards preventative strategies and health promotion (see also Chapter 4 for a more critical reading of these trends).

There are many aspects of the chronic illness experience that challenge the assumptions underlining Parsons' characterization of the

doctor–patient relationship and his theory of the sick role. For example, the premise that access to the sick role is universal and that those who enter the sick role are exempt from personal responsibility or blame for their condition is challenged by what Conrad (2004a: 130) refers to as ‘contested illnesses’ or ‘elusive illnesses’ that appear to defy organic explanations and, therefore, are ‘biomedically invisible’ (Barker 2004: 134).¹ For example, in a study involving the illness narratives of 30 Finnish women who suffered back pain, Lillrank (2003) found that their sense of self was threatened by the medical disparagement that the women encountered, and that the moral core of these women’s self-narrative accounts was the stigmatizing effect of that experience. For psychiatrist and social anthropologist Arthur Kleinman, chronic illness raises the spectre of moral experience in contemporary life and challenges the strict boundary between lay knowledge and technical expertise in the quest for a humanistic approach to healthcare (1988, also Kleinman and Seeman 2000). This challenges Parsons idealization of the passive patient who defers to the doctor’s expert and superior knowledge and the assumption that the unequal power relationship between doctor and patient is necessarily a functional imperative of a wider system-based need, which is underscored by relations of trust and mutual benefit. It also challenges the privilege status afforded to technical knowledge and foregrounds the potential for conflict to emerge between experiential understandings of illness grounded in everyday explanatory frameworks and expert definitions based on technical know-how and theoretical models. For example, chronically ill people are often very knowledgeable about medical treatments, pharmacological and technological advances in medical science, alternative therapies and environmental risks. Furthermore, in negotiating therapeutic regimes patients may reject the ‘sick role’ duties and the ‘medical logic’ of compliance for a ‘social logic’, which involves trade-offs that balance the demands of daily life with medical regimes (Conrad 2004b). Parsons view of the traditional doctor–patient relationship is incapable of grasping the possibility of conflict between the doctor’s belief system, which informs clinical decision-making and the values and beliefs that the patient brings to the medical encounter.

¹ There is much research to support this observation from the patient’s perspective and experience of what has become defined as ‘functional somatic syndromes’, such as Fibromyalgia Syndrome (FMS), Chronic Fatigue Syndrome (CFS) or Myalgic Encephalomyelitis (ME), Premenstrual Syndrome (PMS), Irritable Bowel Syndrome (IRB) and others.

The conceptual themes running through the research on the experience of chronic illness include the loss of identity experienced in the face of profound uncertainty when people can no longer rely on what Kleinman (1988: 45) aptly describes as the 'the fidelity of [their] bodies'. For the chronically ill person, health or normal bodily processes and daily activities can no longer be taken for granted. The defining feature of chronic illness is less about biophysical changes than it is about what researchers have variously described as a 'loss of self' (Charmaz 1983), 'social death' (Kleinman 1988) and 'biographical disruption' (Bury 1982, discussed in Chapter 3). Another theme is the impact of chronic illness on daily living and social interactions, including the loss of social and economic status, and the impact that this has on other family members who are cast in the carer's role (Charmaz 2000). Yet another theme is the coping strategies that people with chronic illness develop in actively creating meaningful lives in the context of managing felt and enacted stigma (Scambler and Hopkins 1986), and in mobilizing resources to help them to cope (Pierret 2003 citing Anderson and Bury 1988). These studies on chronic illness experience, which are further explored in Chapter 3, expand, albeit in a more critical fashion, Parsons original insight that illness has a strong social dimension.

Patient-centred approaches to medical care

In the context of our current discussion on the limitations of the Parsonian model, it will suffice to note that the shift in research focus from illness behaviour to illness experience represents an emerging trend in health research. This reconceptualizes the boundaries between lay/patient knowledge and expert knowledge and understands the therapeutic encounter as a negotiation between the different explanatory frameworks that health professionals and patients or primary caregivers draw on to explain the meaning of illness and shared decision-making about treatment. For example, in the social scientific literature on doctor-patient relationships, particularly in the area of general medical practice, there has been a notable shift away from patient compliance studies to an emphasis on patient-centred models of interaction and shared decision-making (Ainsworth-Vaughn 1998, Bensing *et al.* 2000, Mead and Bower 2000, Roter 2000 cited in Hyde *et al.* 2004: 145; see also the professional-practice based-text, Stewart *et al.* 2003). These studies represent two critical lines of

departure from the assumptions that underlie Parsons' functionalist theory. At the micro-level of the doctor–patient encounter, Parsons' key blind spot is that he ignores the possibility of conflict between the doctor's belief system, which informs clinical decision-making, and the values and beliefs that the patient brings to the medical encounter. At the macro-level, Parsons presents medical hegemony as a functional imperative of the social system to maintain social order. However, public trust underlying medical authority in the doctor–patient relationship can no longer be assumed. The ideal type of patient once assumed to be passive, deferent and compliant in medical encounters is now expected to be responsible for her health and knowledgeable (see Chapter 4 for a poststructuralist critique of the 'self-responsibilization' of health). For example, expert knowledge is more widely available through electronic media and new forms of virtual communities exist for the dissemination of competing expert information (Nettleton 2004) and the sharing of healthcare and illness experiences.²

While many studies contend that there is a decisive shift away from paternalistic healthcare relationships, there are many contingencies at play in terms of what patients expect and need in therapeutic encounters. Notwithstanding the cultural differences in relation to how both patients and doctors view their respective roles, not all patients at all times want to have responsibility for decision-making, which is not the same as saying that patients do not want information relevant to their diagnosis and treatment. The kind of contingencies that come into play in terms of patients' preferences for a more active or passive role in treatment decisions include social factors such as age, gender or cultural background, as well as individual factors such as the severity of the patient's condition, their emotional needs and the extent to which taking responsibility for treatment is an additional and unwelcome burden (Coulter and Fitzpatrick 2000). Coulter and Fitzpatrick (2000) also note that one of the implications of shifting decision-making towards the consumer is the resource implication that this places on healthcare in terms of patients' rising expectations. Of course there are many factors that drive an ever-expanding healthcare market, not least, as Coulter and Fitzpatrick observe, the ideological emphasis of biomedicine on the benefits as opposed to the risks of treatment.

² An interesting web-based research initiative is the DIPeX project based on patients' personal experiences of illness and healthcare (www.dipex.org).

Conclusion and new directions for healthcare

This chapter addressed the contribution of structural functionalism to a sociological understanding of health and healthcare. We have noted that structural functionalism is a body of theory that is primarily concerned with explicating the macro-structures of society and that the major integrating idea linking the classical work of Durkheim to Parsons is the importance of social integration and regulation to the functioning of society as a cohesive whole. The two main criticisms of structural functionalism linking the classical work of Durkheim to Parsons' theory of social action are: (a) social life is primarily understood in terms of norms and values to the neglect of material aspects of the social world, and (b) social structures in the form of norms and values determine social action, which leaves no room for human agency or understanding social action in the context of how people make sense of the experiences of their everyday lives (see Chapter 3). These critiques re-emerge in the debate on social capital theory and the explanatory value of the neo-Durkheimian turn, particularly in relation to the question about what aspect of the social context of people's lives influences health outcomes, and how the relationship between the micro- and macro-levels of the social context can be re-theorized in order to explain the complex pathways of health and illness. As our discussion shows, social capital is a complex and multifaceted concept that is subject to different and competing theoretical expositions, yielding contradictory empirical evidence and competing understandings about the mechanisms by which the stock of social capital may influence population health. Furthermore, there are no strong claims arising from the primary data on social capital that a direct correlation exists between social cohesion (as an outcome measure of social capital) and health equality.

Social capital is often viewed as synonymous with social cohesion. In part, at least, this can be explained by the way in which social capital has been popularized by a wider political discourse and infused with sometimes competing ideological investments in the ideal of community and voluntarism (the principle of relying on the voluntary action of community members instead of the state) as a panacea against the modern ills of individualism and anomie (Portes 1998, Hawe and Shiell 2000, Navarro 2002). Muntaner and Lynch (1999: 71) caution against the naivety of assuming that social cohesion is a cure-all for health inequalities. Indeed, they argue that such a political analysis harbours the risk that responsibility for health will be transferred to those working-class

communities with the least resources to build social capital leaving ‘... untouched more fundamental economic and political relations’. As Cattell (2001) argues, material deprivation and social exclusion are both barriers to social inclusion and have a direct bearing on health. Hawe and Shiell (2000) suggest that contrary to the neo-Durkheimian emphasis on social capital found in Putnam’s political theory, Bourdieu’s sociological theory may be more relevant to unravelling the contextual complexities of communities. As Campbell (2000) points out, policy makers are often unaware of the level of community resources or how different community members access those resources. In relation to the latter point, the reader may be reminded that the central point that Bourdieu brings to social capital theory is that the capacity of individuals to mobilize resources that are beneficial for health largely depends on the broader structures of (in)equality. Small-scale, qualitative community studies of social capital and social networks also show that the idealization of community is often contrary to everyday experiences and that cohesive communities are just as likely to be intolerant of difference, which may be detrimental to an individual’s health in terms of accessing various resources and supports (Baum 1999). Indeed, there is a strong rationale emerging in the research literature for more qualitative community-based studies to better understand the relational and material dimensions of social capital and how these mediate, directly or indirectly, health outcomes.

Parsons’ analytical model of the sick role is a staple in illness behaviour and doctor–patient relationship studies in what we might broadly term social science research applied to medicine. The importance of Parsons’ work lies in its identification of the fact that being sick is not simply a matter of biology – it also has profound social consequences for both the individual and society. As such, notwithstanding all the criticisms, it has generated a large number of studies on professional–patient relationships including instructive critiques. However, as discussed earlier, structural functionalism has been challenged because it no longer would appear to have explanatory power to address the current realities of healthcare. Current debates about the extent to which the professional dominance of medicine is in decline (see Chapter 2 on the ‘proletarianization’ of medicine) and concerns about the limits of biomedicine, particularly in the context of the growing problem of chronic illness, directly challenge Parsons’ structural analysis of the illness experience and professional dominance. Indeed, changing healthcare philosophies and policies have recast the doctor–patient relationship from a Parsonian consensual model to a negotiative model (Mead and

Bower 2000), which is reflected by new research agendas and theoretical developments on patient-centred models of communication, patient empowerment and the role of experiential knowledge as a legitimate source of authority in therapeutic decision-making and policy decisions about the governance of healthcare. We note that the shift in concern from health behaviours to illness experiences and the emphasis on lay knowledge offer a point of contrast to Parsons' theory of the sick role and the pre-eminence that his theory affords to the medical profession and expert knowledge. Following on from critiques of Parsons' sick role theory and the authority he invests in the medical profession by virtue of the functional role that it performs, new lines of enquiry are opening up that are further explored in various chapters in the book. If we see the burgeoning field of empirical studies on the lay experience of illness as a counter development to and shift away from a Parsonian focus on illness behaviour and macro-theoretical formulations, then it is important to ask in what way do these studies contribute to the key sociological concerns of social structure, social action and power relations? Chapter 3 deals further with the question of the problem of integrating micro- and macro-perspectives in accommodating agency while addressing the underlying structural conditions of healthcare encounters. Another line of enquiry is concerned more explicitly with the social power that derives from doctors' control of healthcare and the various challenges that the authority of medicine now encounters in the face of growing consumerism within healthcare, declining trust in medical authority and new strategies of healthcare governance (see Chapters 2 and 4). Undoubtedly, new research will begin to take shape around what Lupton (1997) sees as emerging dichotomies between paternalism and patient empowerment, expert and experiential knowledge and consumerism and medical authority.

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