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The sociology of health in the United States: recent theoretical contributions

A sociologia da saúde nos Estados Unidos: contribuições teóricas recentes

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Abstract *This paper examines recent trends in theory in health sociology in the United States and finds that the use of theory is flourishing. The central thesis is that the field has reached a mature state and is in the early stage of a paradigm shift away from a past focus on methodological individualism (in which the individual is the primary unit of analysis) toward a growing utilization of theories with a structural orientation This outcome is materially aided by research methods (e.g. hierarchal linear modeling, biomarkers) providing measures of structural effects on the health of the individual that were often absent or underdeveloped in the past. Structure needs to be accounted for in any social endeavor and contemporary medical sociology appears to be doing precisely that as part of the next stage of its evolution. The recent contributions to theory in the sociology of health discussed in this paper are fundamental cause, medicalization, social capital, neighborhood disadvantage, and health lifestyle theories.*

Key words *Sociology of health, Recent sociological theory, Durkheim, Weber, Middle range theories*

Resumo *O artigo analisa as tendências teóricas recentes da sociologia da saúde nos Estados Unidos e revela que o uso destas está florescendo. A tese central é que o campo atingiu a sua maturidade e está na fase inicial de uma mudança de paradigma de um foco anterior no individualismo metodológico (em que o indivíduo é a unidade primária de análise) em direção a uma crescente utilização de teorias com orientação estrutural. Este resultado é objetivamente auxiliado por métodos de pesquisa (por exemplo, a modelagem linear hierárquica, biomarcadores) que fornecem as medidas de efeitos estruturais sobre a saúde do indivíduo, que muitas vezes eram ausentes ou não desenvolvidos no passado. A orientação estrutural precisa ser considerada em qualquer empreendimento social e a sociologia médica contemporânea parece estar fazendo exatamente isso, como parte da próxima fase de sua evolução. As recentes contribuições à teoria da sociologia da saúde discutidas neste trabalho são as seguintes: causa fundamental, medicalização, capital social, desvantagens locais, e as teorias de estilo de vida em saúde.*

Palavras-chave *Sociologia da saúde, Teoria sociológica recente, Durkheim, Weber, Teorias de médio alcance*

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The sociology of health in the United Sates: recent theoretical contributions

The purpose of this paper is to examine recent theory in the sociology of health in the United States. The field in the U. S. has moved a great distance from its early reputation as largely atheoretical to become a highly theoretically engaged sociological subdiscipline[1-4]. Considerable theoretical work has taken place in major American sociology departments, while health or medical sociology matured as a subdiscipline and became more closely aligned with general sociology through their common basis in theory and methods. Contemporary medical sociology has a rich and abundant literature with its own theories specific to the subdiscipline, some of which are based on perspectives shared with sociology at large and others that are unique to its subject matter. The result is that health sociologists in the U. S. are making greater use of sociological theory than ever before.

Paradigms shift

The central thesis of this paper is that the recent contributions to theory in the sociology of health constitute an early stage of a paradigm shift away from a past focus on methodological individualism (in which the individual is the primary unit of analysis) toward a growing utilization of middle-range theories with a structural or macro orientation. Past studies of attitudes and behavior typically focused on individuals; however, as Smelser[5] points out, it is impossible to fully understand the events and situations of individuals without considering some higher order of organization. Structural-functionalism had been the dominant theoretical perspective in all of sociology, including health sociology in the 1950s and early 1960s. This theoretical dominance did not last long. Structural-functionalism was severely criticized for its advocacy of a static image of dominant social structures highly resistant to change; moreover, its emphasis upon consensus, stability, order, and balance seemed to justify the maintenance of the status quo perpetuating existing social inequalities and the power of elite groups. Conflict theorists found structural-functionalism also lacking because it did not adequately consider conflict as a catalyst for social change, especially rapid and revolutionary change. Symbolic interaction attacked structural-functionalism for its disregard of individual creativity and micro-level social processes.

Conflict theory, in turn, was condemned by some because it also did not credit the individual with the capacity to be creative, was never fully developed, and ignored social order and stability, just as it had earlier attacked structural-functionalism's failure to account for conflict and change[6]. The result over time was the ascendency of symbolic interaction that flourished during 1963–70, with important contributions in health sociology from Howard Becker, Erving Goffman, and Anselm Strauss. The rise of symbolic interaction in sociology brought with it an increase in the influence of agency and methodological individualism in sociological theory. By the 1980s, however, symbolic interaction likewise entered a period of decline that extended to its use in the sociology of health. The theory showed signs of stagnation, was devalued by quantitative sociologists for its dependence on subjective methodology and interpretation, and was unable to explain relationships between institutions and societal-level processes that affect each other, not just individuals, along with difficulty in satisfactorily linking small group processes to higher structural-level social phenomena.

Consequently, at the beginning of the 21st century, American sociology's three major theoretical perspectives—structural-functionalism, conflict theory, and symbolic interaction—still featured in most introductory textbooks—had all become what Ritzer and Yagatich[7] describe as 'zombie theories' or at least dying and transitioning into 'a zombie-like state.' Ritzer and Yagatich[8] observe, that the 'theories seem alive to many, especially supporters and textbook authors, but in fact, if they are not yet dead, there is only the faintest of pulses reflecting a bare minimum of life.' They maintain that having three major theoretical 'schools' under which newer theories were subsumed provided a tidy categorization system, even if the categories were established over half a century ago and could no longer be justified. In their view, theory is a liquid, not a solid, in line with Bauman's[9] notion of liquid modernity, in which theories are not viewed as fixed in time and space, but are constantly flowing and changing.

We see fluidity and change in the fact that structural-functionalism, once *the* theory in sociology, has gone beyond a zombie state and is actually dead, as there has been no significant work using this approach for decades. Ritzer and Yagatich argue that conflict theory can also be considered a zombie theory because it developed largely in opposition to structural-functionalism that has died and many of its sub-theories, such

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as economic determinism and structural Marxism, have hit dead ends. In their view, just because theorists find conflict in a society does not automatically mean they are conflict theorists. Nevertheless, although the broader spectrum of conflict theory is in decline, there is important work in the related areas of Marxist theory and political economy that allow it to currently avoid the ultimate fate of structural-functionalism. As for symbolic interaction, Ritzer and Yagatich find it on life support and headed toward zombification. When symbolic interaction appeared to reach its limits, some in the field embraced postmodern theory, but that perspective, despite its early promise to explain social change, was unable to account for the structure of postmodern society after its transition from modernity, never gained a foothold in medical sociology, and can be considered a zombie theory as well[10]. Symbolic interaction theory, on the other hand, continues to persist, as it also underlies many qualitative methods and grounded theory, while influencing social constructionism.

Given the beleaguered status of its three traditional categories of theoretical work, it might be presumed that theory development in sociology in general and health sociology in particular is in trouble. This is not true. The problem is with the outdated categories, not a lack of vibrant theories or theorizing. Rather, what we are seeing in the first decade of the 21st century is growth and change. Most significantly, as noted, there is a return to theories that focus on social structures which is an essential component of what sociology is actually about.

The current expansion of what might be termed a" neo-structural" focus in theoretical work in health sociology is influenced by two factors. First, is the recognition that agency-oriented theories are unable to adequately account for the effects of social structures on each other or on individuals. Explanations and theories of social behavior neglecting these effects are incomplete since they omit an important component of everyday life, namely the social structures within which people live their lives. As Emirbayer and Mische[11] point out in a statement that applies equally to both quantitative and qualitative studies, 'there is no hypothetical moment in which agency actually gets "free" of structure; it is not, in other words, some pure Kantian transcendental free will.' Social structures channel social behavior down particular pathways as opposed to others that individuals could choose and such behaviors, when selected and acted out, reflect the structures (e.g., social class, gender, race/ethnicity, religion, kinship) from which they emanate[12,13]. Individuals have choices, but in *all* circumstances those choices are structurally constrained by (1) what is available to be chosen and (2) the social rules or codes telling the individual the rank order and appropriateness of choices[14].

Second, is the ready availability today of advanced statistical techniques allowing researchers to determine the separate effects of successive or multiple levels of social structures on the health of individuals. This includes not only hierarchal level modeling and similar techniques, but also measures of biomarker data to uncover the effects of social structural variables on physiological outcomes such as allostatic load, inflammation, or glucocorticoid secretion. Hierarchical linear modeling (HLM) simultaneously determines the relative effects of different levels of structural variables on health outcomes by comparing changes in the regression equations and assessing the amount of variation at each level[15]. Consequently, the strength of the interaction between variables characteristic of individuals at level 1, perhaps households at level 2, neighborhoods at level 3, followed by sequentially higher levels in a structural hierarchy can be determined.

Biomarker studies measure physiological responses to social conditions (e.g., poverty, stress) external to the individual that are associated with negative health outcomes, including mortality. This approach provides objective measures of health risks obtained through clinical assessments (e.g., blood pressure, urine, blood tests for cholesterol and c-reactive protein, waist-hip ratios) of individuals independent of their self-reports and perhaps even awareness. Seeman et al.[16], for example, used multivariate logistic regression to determine that low socioeconomic status (SES) is consistently and negatively associated with cardiovascular, metabolic, and inflammatory risks, as well as total biological risks. The biomarker approach helps us understand the physiological paths that link SES and other structural variables to health disparities.

Symbolic interactionists and other sociologists favoring social constructionism might strongly disagree with this thesis about a return to structural concerns. Yet, as this author[17] has stated elsewhere: "Sociological concepts reflecting literally all theories of social life attest to the fact that *something* (namely structure) exists beyond the individual to give rise to customary patterns of behavior." Structure *is* out there; the task at hand is to account for its effects on health,

regardless of the theory, methodology, or level (micro-macro) of analysis. With respect to qualitative research based on interviews, focus groups, social histories, or participant observation, researchers need to be attentive to patterns of social interaction and the structural influences beyond the individual shaping those patterns that emerge in the analysis of their data. Searching for structural bridges from the macro to the micro is required. This is seen in Lutfey and Freese's[18] study of two diabetes clinics showing how SES and the organizational structure of the clinics affected treatment and individual outcomes. Regardless of theoretical preference, medical sociology today has the methodologies to more fully account for structural effects on the health of the individual. We therefore find that while symbolic interaction, Marxist political economy, Foucault, Bourdieu, social constructionism, stress theories, life course theory, and the work of Durkheim, Marx, and Weber from earlier periods are still utilized, the most recent theorizing in American health sociology consists of middle-range theories focused on the effects of social structures on health. These theories include (1) fundamental cause, (2) medicalization, (3) social capital, (4) neighborhood disadvantage, and (5) health lifestyle theory.

Fundamental cause

Fundamental cause theory has become popular in the U. S. and, in the process, promotes a structural orientation toward health and mortality. This is seen in Link and Phelan's[19-21] assertion that social conditions are *fundamental* causes of disease; that is, there are conditions by which society makes people sick. Studies of the powerful effects of social class on health, for example, illustrate the importance of social structural factors in disease causation. Evidence for this is seen in the enduring relationship between of low socioeconomic status (SES) and illness, disability, and early death. This is an important proposition because most researchers in the past viewed SES as a factor contributing to poor health and mortality, not as a direct cause. However, the persistent association of SES with a variety of disease patterns during changing historical periods increasingly pointed toward SES as having a causal role. In order for a social variable to qualify as a fundamental cause, Link and Phelan[19] hypothesize that it must (1) influence multiple diseases, (2) affect these diseases through multiple pathways of risk, (3) be reproduced over time, and (4) involve access to resources that can be used to avoid risks or minimize the consequences of disease if it occurs. They define social conditions as factors that involve a person's relationships with other people.

SES or social class meets all four of these criteria because a person's class position influences multiple diseases in multiple ways, the association has endured for centuries, and higher SES persons have the resources to better avoid health problems or minimize them when they occur. Historical accounts going back to the black plague in the fourteenth century, for example, describe how the poor at that time were more heavily afflicted than the rich and suffered the most in an association that continues today[22]. Even though the poor live longer today than the wealthy in past periods of history, people in the upper social strata still live the longest on average than people in the strata just below them and so on down the social scale until the bottom of society is reached. The degree of socioeconomic resources a person has or does not have, such as money, knowledge, status, power, and social connections, either protects health or causes premature mortality. Persons at the bottom of society are less able to control their lives, have fewer resources to cope with stress, live in more unhealthy situations, cope with powerful constraints in choosing a healthy way of life, and die earlier.

A supportive study is that of Lutfey and Freese[18] of patients at two diabetes clinics in a large Midwestern city. One clinic (Park Clinic) had a primarily white, upper- and middle-class clientele, while the other (County Clinic) served a largely minority, working-class, and uninsured population. This study focused on the control of blood sugar (glucose) levels that is essential for the survival of diabetics, as high glucose levels significantly increase the risk of complications. High SES patients had much better continuity of care in that they usually saw the same physician. This was not the case at County Clinic, where the physicians were on rotation and dependent on whatever information about the patient was retold by the patient and entered in their record. The County Clinic patients also faced financial, occupational, and social network constraints. While the cost of care was subsidized by the state, low-income County Clinic patients had to provide documentation of residency, earnings, and whether they had insurance in order to qualify and this took about three months to process. They also did not have the financial resources to assist them in maintaining glucose control, such

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as paying for insulin pumps that the Park Clinic patients could purchase when needed. Additionally, the low SES patients at County Clinic were much less likely to have jobs with refrigeration available for storing insulin and maintaining glucose control. Some worked as manual laborers and others had night shifts that interfered with medication schedules. Patients taking state-subsidized medications could only get their prescriptions refilled in person at the clinic pharmacy, which was time-consuming and took time away from jobs that adversely affected their incomes. Not surprisingly, these social constraints result in poorer glucose management.

Another study is that of Phelan et al.[20] who investigated causes of death data on some 371,000 subjects in a nationwide study. This research found a strong relationship between SES and deaths from causes that were preventable. Persons with higher SES had significantly higher probabilities of survival from preventable causes because they were able to use their resources (money, knowledge, etc.) to obtain what they needed to live longer. Conversely, the lower the SES, the more likely the person was to die from something that could have otherwise been prevented. The deliberate use of socioeconomic resources was found to be a critical factor in maintaining the differential in mortality. The same pattern is seen in a different nationwide study by Chang and Lauderdale[23] who found that individuals with high socioeconomic status were significantly more likely to have reversed their formerly high levels of cholesterol through the use of statin drugs to the point that low SES persons are now more likely to have high cholesterol.

When fundamental cause theory is reduced to its most basic proposition, it is the idea that resources consisting of money, knowledge, power, prestige, and social connections are vital to maintaining a health advantage. Conversely, an absence or shortage of these resources causes poor health outcomes and earlier deaths. People with resources have less risk of exposure to preventable diseases in the first place and are better able to achieve positive outcomes when they occur by employing their resources. Persons with lower income, education, and social status lacking such resources not only have greater exposure to risk and more likelihood of the risk being realized, but also a diminished capacity for preventing negative consequences.

Medicalization

Medicalization theory is largely based on the work of Peter Conrad[24,25] and its use has become widespread in North America and Europe. Medicalization means to 'make medical,' which in the case of health sociology refers to the *process* by which nonmedical problems (deviant behavior, natural life events, problems in living, and body enhancements) become redefined to varying degrees as 'medical,' with the medical profession taking jurisdiction over their management. That is, physical conditions or behaviors that might have been defined as sin or crime and controlled by the church or the law are increasingly regarded as illnesses to be controlled through medical treatment, as are certain physical differences like short stature, small female breasts, and male baldness. Thus we see the trend, known as 'medicalization,' where previously non-medical problems are defined and treated as medical problems, usually in terms of illnesses or disorders.

Conrad observes that the 'engines' (the social forces) underlying medicalization have shifted from the medical profession to include the influence of biotechnology, the pharmaceutical industry, consumerism, and genetics. Conrad notes that biotechnology has long been associated with medicalization, and the pharmaceutical industry is playing an increasingly central role in promoting its products directly to consumers, while in the future the impact of genetics may be substantial. Whereas medicalization has traditionally been a means by which professional medicine acquired increasingly more problems to treat, technological advancements and scientific advances in biomedicine are taking this capability even further. For example, hyperactivity at school by children is defined as Attention-Deficit/Hyperactivity Disorder (ADHD) and requires Ritalin; being short in stature necessitates growth hormones for the person afflicted with below average height; and male baldness is slowed or prevented by using Propecia and lost hair is restored by surgical transplants[24]. There was a time when hyperactivity, shortness, and baldness were not medical conditions. While medicalization is prevalent in the United States, observes Conrad, it is increasingly an international phenomenon with multinational drug companies leading the way. While public and professional medical concern about medicalization may be growing, the process it represents is still a powerful influence on behavior and medical adjustments to the body.

Social capital

Social capital is generally described in the research literature as a characteristic of social structures consisting of a network of cooperative relationships between residents of particular neighborhoods and communities. The degree to which an individual is socially integrated with parents, neighborhood, community groups, churches, clubs, voluntary service organizations, and so on provides an objective measure of that person's social capital[26]. Networks providing social capital are characterized by interpersonal trust, norms of reciprocity and mutual aid, and a supportive social atmosphere within which people look out for one another and interact positively with a sense of belonging. People embedded in such supportive networks have been consistently found to have better health and longevity than those who lack this resource[27]. In locales where there are serious social problems (e.g., crime, stress, slums) and breakdowns in social networks, social capital is reduced or absent with the residents having poor health and shorter life spans.

Nan Lin[28] sees social capital as an investment in social relations that people can use as a buffer against stress and depression, while Pierre Bourdieu[29] views it as a resource that accrues to individuals through their memberships in social groups. Yet, social capital is not just a property of individuals, it is also a characteristic of social networks from which individuals draw psychological and material benefits. While Bourdieu emphasizes the resources of networks, Robert Putnam[30] emphasizes the cohesion of networks. Putnam defines social capital as a community-level resource reflected in social relationships involving not only networks, but also norms and levels of trust. He maintains that the positive influences of social capital on health are derived from enhanced self-esteem, sense of support, access to group and organizational resources, and its buffering qualities in stressful situations. Social connectedness, in Putnam's view, is one of the most powerful determinants of health. After reviewing several studies, he found that people who are socially disconnected are between two to five times more likely to die from all causes when compared with similar individuals having close ties to family and friends.

The various theories of social capital, such as those by Putnam, Lin, and Bourdieu, are contemporary applications of Durkheim's[31] theory of suicide in which individuals are protected by their close integration into society. His concepts of social solidarity and social facts are still applicable in illustrating how social capital is protective of the health of the individual[32]. Theories of social capital are of interest to medical sociologists because they can be a social mechanism linking inequality to health or, conversely, enhancing the health of people in neighborhoods and communities with high levels of it. The message of social capital research, however, is not to claim individual-level characteristics are unimportant or are superseded by such capital, but that structural variables like community networks can have a causal impact on health.

Neighornood disadvantage

A relatively new area of emerging research in health sociology is on 'neighborhood disadvantage' that investigates unhealthy urban living conditions. This research focuses on variables specific to neighborhoods, not individuals, such as the physical environment (e.g., quality of housing, water, air), availability of services (e.g., banks, police, fire, sanitation, health care), and social and cultural factors (e.g., social networks, single-parent families) that impair health through psychological distress or exposure to unhealthy living situations[33]. Neighborhoods have resources needed to produce good health or, conversely, harm it by being either health-promoting or health-damaging.

Health lifestyle theory

Health lifestyle theory is based on the initial formulation of William Cockerham[1,17], who provides the following definition: health lifestyles are collective patterns of health-related behavior based on choices from options available to people according to their life chances. A person's *life chances* are the probabilities that individual has in life to realize his or her choices. The higher the social class, the greater the probability, and the lower the class, the less the probability of obtaining what one wants or needs. This view incorporates the dialectical relationship between life chances and life choices proposed by Weber[34]. While health and other lifestyle choices are voluntary, life chances – which represent structure, especially class position – either empower or constrain choices as choices and chances work off each other to determine behavioral outcomes. That is, the person has the capability of choosing his or her lifestyle, but the choices are limited by what is possible and strongly influenced by the

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style common to one's class position, age, gender, and the like. The theory is therefore based on the premise that health lifestyles are not the uncoordinated behaviors of disconnected individuals, but rather are personal routines that merge into an aggregate form that are characteristic of specific groups and classes.

Weber had associated lifestyles not with individuals but with status groups, thereby showing they are principally a collective social phenomenon. Moreover, lifestyles are based on what people consume rather than what they produce. Therefore, for Weber, the difference between social classes did not lie in their relationship to the means of production as advocated by Marx, but in their relationship to the means of consumption. It is obvious to say that the affluent consume considerably more and higher-quality resources than the poor, including resources that promote health and ward off illness.

Weber's concept joins with Bourdieu's notion of the habitus as the centerpiece of Cockerham's[1,17] health lifestyle theory. Bourdieu[13] describes the habitus as a mental scheme or organized framework of perceptions that predisposes the individual to follow a particular line of behavior as opposed to others that might be chosen. These perceptions are developed, shaped, and maintained in memory through socialization, experience, and the reality of the person's class circumstances. While the behavior selected may be creative and even contrary to normative expectations, behavioral choices are typically compatible with the dispositions and norms of a particular group, class, or the larger society; therefore, people tend to act in predictable and habitual ways even though they have the capability to choose differently. Through selective perception, the habitus adjusts aspirations and expectations to 'categories of the probable' that impose boundaries on the potential for action and its likely form.

As for health lifestyles, Cockerham maintains that the dispositions that are generated by the habitus are either focused directly on health maintenance or include considerations of health in their adoption, or, conversely, give little or no thought to health outcomes and may even disregard such outcomes even though implications for health nonetheless exist. Consequently, health lifestyles are binary. That is, they usually fall into one or the other of two categories: good or bad. This binary characteristic means that the outcome generated from the interplay of choices and chances have either positive or negative effects on health. Positive health lifestyles are intended to avoid risk and are oriented toward achieving or maintaining one's overall health and fitness. Negative health lifestyles put one at risk for illness and earlier mortality. Virtually every study confirms that the lifestyles of the upper and upper-middle classes are the healthiest of any socioeconomic strata and progressively worsen the lower one descends the social ladder. More affluent classes have the highest participation in leisure-time sports and exercise, healthier diets, moderate drinking, little or no smoking, more physical checkups by physicians, and greater opportunities for rest, relaxation, and coping successfully with stress[1,17,35,36].

As shown in Figure 1, Cockerham suggests that four categories of (1) structural variables,

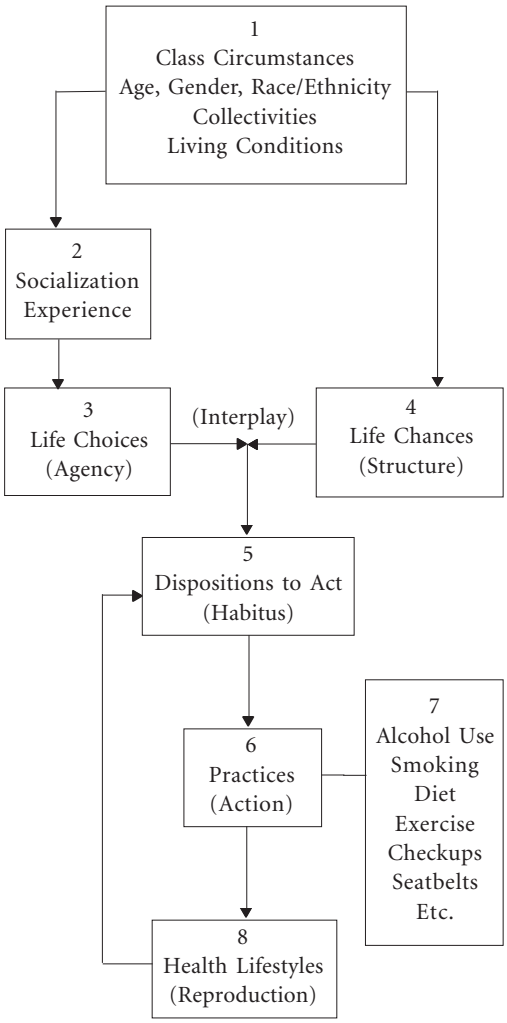

Figure 1. Health lifestyles.

especially (a) class circumstances, but also (b) age, gender, and race/ethnicity, (c) collectivities (e.g., religion, kinship), and (d) living conditions, provide the social context for (2) socialization and experience that influence (3) life choices (agency). These structural variables also collectively constitute (4) life chances (structure). Choices and chances interact and commission the formation of (5) dispositions to act (habitus), leading to (6) practices (action), involving (7) alcohol use, smoking, diet and other health-related actions. Health practices constitute patterns of (8) health lifestyles whose reenactment results in their reproduction (or modification) through feedback to the habitus. Hence, we see the ideas of a classical theorist (Weber) combining with a contemporary theorist (Bourdieu) to provide the basis of a modern-day neo-structuralist theory of the health lifestyle phenomenon.

Conclusion

The use of theory is flourishing in health sociology in the U. S. and this is particularly apparent in recent theories bringing structure back into prominence in explaining the social determinants of health and disease. This development, as noted, is materially aided by research methods providing measures of structural effects that were often absent or underdeveloped in the past. Structure needs to be accounted for in any social endeavor and contemporary medical sociology appears to be doing precisely that as part of the next stage of its development. While classical theories still influence some of the current work in the sociology of health, few contemporary theoretical "schools" of thought are linked to named theorists in what seems to be a characteristic of modern theorizing. Otherwise, the clear trend is toward the utilization of theories of the "middle range" that are specific to both particular substantive areas of study in health sociology and to this period of theoretical development and its corresponding methodological advances. The most prominent of these recent theories, as discussed, include fundamental cause, medicalization, social capital, neighborhood disadvantage, and health lifestyle theory. Each of these theoretical perspectives tends to take a neo-structural approach, thereby signaling a return to explanations of the effects of structural entities on health.

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