# Contents

List of Figures xiii  
List of Tables xv  
List of Boxes xvii  
Notes on Contributors xix  
Acknowledgements xxiii  
Introduction xxv  

_Graham Scambler_

## Part I  Social Aspects of Health and Disease  

1  **Society and Changing Patterns of Health and Illness**  
   
   *Ray Fitzpatrick and Ewen Speed*

   Introduction 3  
   Variation in Disease Patterns in Human Society 4  
   Explaining Changes in Disease Prevalence 6  
   The Historical Role of Medicine 10  
   Disease Rates and Social Factors in Modern Society 12  
   The Economy and Health Policy in Modern Society 17  
   Current Health Challenges 19  
   References 20

2  **Social Determinants of Health**  
   
   *Fiona Stevenson*

   Introduction 23  
   Principal Social Determinants of Health in the Twenty-First Century 24  
   Conclusion 35  
   References 35

3  **Globalization and Health**  
   
   *Judith Green*

   Introduction 39  
   The Processes of Globalization 40
## Global Health

- Global Health .................................................. 43
- The Globalized Health Care Workforce .............. 50
- Globalization and Health Care .......................... 52
- Conclusion ....................................................... 55
- References ....................................................... 55

## Part II  Social Factors in Medical Practice

### 4 Health and Illness Behaviour

*Fiona Stevenson*

- Introduction .................................................. 61
- Definitions of ‘Lay’ Perceptions of Health, Illness and Disease ..... 61
- Help-Seeking Practices ..................................... 65
- Different Health Care Systems .......................... 66
- Summary ...................................................... 71
- Conclusion .................................................... 72
- References ..................................................... 72

### 5 Doctor–Patient Relationships

*Myfanwy Morgan*

- Introduction .................................................. 77
- Historical Changes in Doctor–Patient Relationships .......... 78
- Current Models of the Doctor–Patient Relationship ........ 81
- Implementing Shared Decision-Making ..................... 84
- Variations in Relationships between Countries ............ 88
- Changing Context of Doctor–Patient Relationships .......... 91
- References ..................................................... 95

### 6 Long-Term Illness and Disability

*Sasha Scambler*

- Introduction .................................................. 99
- Sociological Approaches to the Study of Long-Term Conditions .......... 100
- The Role of Medicine, Self-Management and Empowerment .......... 101
- Understanding the Lived Experience of Long-Term Conditions .... 103
- Individual Stigma or Social Oppression? .................... 107
- Challenging the Personal Tragedy Model of Disability ........ 108
- Medical versus Social Models of Disability ................ 109
- The Middle Ground ......................................... 112
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contextualising Disability Oppression</td>
<td>114</td>
</tr>
<tr>
<td>Bridging the Gap and Moving Forward</td>
<td>115</td>
</tr>
<tr>
<td>References</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>7  Death, Dying and Bereavement</td>
<td>121</td>
</tr>
<tr>
<td><em>Graham Scambler</em></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>121</td>
</tr>
<tr>
<td>Changes in Life Expectancy</td>
<td>122</td>
</tr>
<tr>
<td>Talking about Death</td>
<td>124</td>
</tr>
<tr>
<td>Awareness Contexts</td>
<td>127</td>
</tr>
<tr>
<td>Stages of Dying</td>
<td>129</td>
</tr>
<tr>
<td>Place of Death</td>
<td>129</td>
</tr>
<tr>
<td>Patterns of Death and Bereavement</td>
<td>132</td>
</tr>
<tr>
<td>Trajectories of Dying</td>
<td>133</td>
</tr>
<tr>
<td>End-of-Life Decisions</td>
<td>134</td>
</tr>
<tr>
<td>Bereavement and Mourning</td>
<td>134</td>
</tr>
<tr>
<td>Conclusion</td>
<td>135</td>
</tr>
<tr>
<td>References</td>
<td>136</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Part III  Social Structure and Health</td>
<td>139</td>
</tr>
<tr>
<td>8  Social Class and Health Inequalities</td>
<td>141</td>
</tr>
<tr>
<td><em>Graham Scambler</em></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>141</td>
</tr>
<tr>
<td>Nineteenth-Century Accounts</td>
<td>142</td>
</tr>
<tr>
<td>Social Class and Proxies</td>
<td>142</td>
</tr>
<tr>
<td>Models and Explanations</td>
<td>145</td>
</tr>
<tr>
<td>Sociological Theory and Health Inequalities</td>
<td>150</td>
</tr>
<tr>
<td>Tackling Health Inequalities</td>
<td>152</td>
</tr>
<tr>
<td>Conclusion</td>
<td>156</td>
</tr>
<tr>
<td>References</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>9  Gender and Health</td>
<td>161</td>
</tr>
<tr>
<td><em>Sasha Scambler and Annette Scambler</em></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>161</td>
</tr>
<tr>
<td>Contextualizing Gender</td>
<td>162</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>164</td>
</tr>
<tr>
<td>Mortality</td>
<td>165</td>
</tr>
<tr>
<td>Explaining Gender Differences in Life Expectancy and Mortality</td>
<td>167</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Morbidity</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>Childbirth and Medicalization</td>
<td>169</td>
</tr>
<tr>
<td></td>
<td>Domestic Violence</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>A Global Picture of Women's Health</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>The Masculine Norm and the Construction of Womanhood</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>Men's Studies, Masculinity and Health</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>LGBT Health</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>176</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>176</td>
</tr>
<tr>
<td>10</td>
<td><strong>Ethnicity and Health</strong></td>
<td>179</td>
</tr>
<tr>
<td></td>
<td><em>Moira Kelly and James Nazroo</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>What are Race, Ethnicity and Culture?</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>Ethnic Diversity in the UK</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>The Health of Ethnic Minority Groups</td>
<td>185</td>
</tr>
<tr>
<td></td>
<td>Improving the Health of Ethnic Minorities</td>
<td>194</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>198</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>198</td>
</tr>
<tr>
<td>11</td>
<td><strong>Later Life, Health and Society</strong></td>
<td>203</td>
</tr>
<tr>
<td></td>
<td><em>Paul Higgs</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>203</td>
</tr>
<tr>
<td></td>
<td>Health, Disability and Illness</td>
<td>206</td>
</tr>
<tr>
<td></td>
<td>Activities of Daily Living and Frailty</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>Dementia and Old Age</td>
<td>208</td>
</tr>
<tr>
<td></td>
<td>Residential and Institutional Care</td>
<td>209</td>
</tr>
<tr>
<td></td>
<td>Use of Health Care Services</td>
<td>209</td>
</tr>
<tr>
<td></td>
<td>Older People and Society</td>
<td>210</td>
</tr>
<tr>
<td></td>
<td>Domestic Circumstances</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Women and Ageing</td>
<td>212</td>
</tr>
<tr>
<td></td>
<td>Sociology and Older People</td>
<td>213</td>
</tr>
<tr>
<td></td>
<td>Disengagement Theory</td>
<td>213</td>
</tr>
<tr>
<td></td>
<td>Structured Dependency Theory</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>Productive Ageing</td>
<td>216</td>
</tr>
<tr>
<td></td>
<td>Theory of the Third Age</td>
<td>216</td>
</tr>
<tr>
<td></td>
<td>Cultures of Ageing</td>
<td>217</td>
</tr>
<tr>
<td></td>
<td>The Fourth Age</td>
<td>219</td>
</tr>
<tr>
<td>Contents</td>
<td>ix</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>220</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>220</td>
<td></td>
</tr>
<tr>
<td><strong>Part IV</strong> Changing Forms of Medical Knowledge</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td><strong>12</strong> Health-related Deviance and Stigma</td>
<td>227</td>
<td></td>
</tr>
<tr>
<td><em>Graham Scambler</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>227</td>
<td></td>
</tr>
<tr>
<td>The Sociological Role of Labelling</td>
<td>228</td>
<td></td>
</tr>
<tr>
<td>Deviance and Stigma</td>
<td>230</td>
<td></td>
</tr>
<tr>
<td>Defining a Stigmatizing Condition as ‘Personal Tragedy’</td>
<td>232</td>
<td></td>
</tr>
<tr>
<td>Rethinking Stigma</td>
<td>235</td>
<td></td>
</tr>
<tr>
<td>Components of Health-related Stigma</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>Tackling Stigma and Deviance</td>
<td>238</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>240</td>
<td></td>
</tr>
<tr>
<td><strong>13</strong> The Shifting Boundaries of Medical Knowledge</td>
<td>243</td>
<td></td>
</tr>
<tr>
<td><em>Paul Higgs</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>243</td>
<td></td>
</tr>
<tr>
<td>Normal Science and Paradigm Shifts</td>
<td>244</td>
<td></td>
</tr>
<tr>
<td>Jewson and the Disappearance of the Patient from Medical Cosmologies</td>
<td>245</td>
<td></td>
</tr>
<tr>
<td>Social Constructionism</td>
<td>248</td>
<td></td>
</tr>
<tr>
<td>Medicine, Medicalization and Social Control</td>
<td>251</td>
<td></td>
</tr>
<tr>
<td>Medicine, Social Structure and Social Policy</td>
<td>254</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>259</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>259</td>
<td></td>
</tr>
<tr>
<td><strong>14</strong> Reconceptualizing Bodies</td>
<td>263</td>
<td></td>
</tr>
<tr>
<td><em>Nick J. Fox</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>263</td>
<td></td>
</tr>
<tr>
<td>Social Bodies</td>
<td>263</td>
<td></td>
</tr>
<tr>
<td>The Sociology of the Body</td>
<td>265</td>
<td></td>
</tr>
<tr>
<td>Bodies, Power and Knowledge</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>The Material Body</td>
<td>270</td>
<td></td>
</tr>
<tr>
<td>Materialism, Embodiment and Illness</td>
<td>272</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>274</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>275</td>
<td></td>
</tr>
</tbody>
</table>
15 Digital Health and Health Care  

*Deborah Lupton*

Introduction 277  
Telemedicine 279  
Patient Self-Care Technologies 280  
Search Engines and Health Information Websites 282  
Discussion Forums, Patient-Support Platforms and Social Media 284  
Conclusion 286  
References 288

Part V Organization of Health Services  

16 Health Care Systems  

*Nicholas Mays*

Introduction 293  
What Do We Mean by a ‘Health Care System’? 294  
The Emergence of the Concept of a ‘Health Care System’ 295  
Different Definitions of the ‘Health Care System’ 296  
Explanations for State Involvement in Health Care and the Historical Emergence of Health Care ‘Systems’ 300  
Principal Health Care System Activities 302  
Classifying Health Care Systems 310  
Trends in Health Care Systems – Are there Signs of Convergence? 312  
References 317

17 The Health Professions and Professional Practice  

*Iain Crinson*

Introduction 319  
Defining the Health Professions 320  
Systems of Professional Governance 323  
The ‘New Professionalism’ 328  
Collaboration in Health Care? 331  
Global Developments in the Role of Health Professionals 333  
Conclusion 336  
References 337
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Public Health and Health Promotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Judith Green</td>
<td>341</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>341</td>
</tr>
<tr>
<td></td>
<td>Public Health Systems and Functions</td>
<td>342</td>
</tr>
<tr>
<td></td>
<td>Health Promotion</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>Public Health and Social Values</td>
<td>351</td>
</tr>
<tr>
<td></td>
<td>Sociological Critiques of Public Health and Health</td>
<td>352</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>356</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>356</td>
</tr>
<tr>
<td>19</td>
<td>Measuring Health Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ray Fitzpatrick</td>
<td>359</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>359</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>Measures of Health Status and Quality of Life</td>
<td>363</td>
</tr>
<tr>
<td></td>
<td>Patient Satisfaction</td>
<td>370</td>
</tr>
<tr>
<td></td>
<td>Outcomes and Changing Health Services</td>
<td>372</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>373</td>
</tr>
<tr>
<td>20</td>
<td>Assessing Health Care System Performance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nicholas Mays and Ray Fitzpatrick</td>
<td>377</td>
</tr>
<tr>
<td></td>
<td>Introduction</td>
<td>377</td>
</tr>
<tr>
<td></td>
<td>Why Assess Health System Performance?</td>
<td>377</td>
</tr>
<tr>
<td></td>
<td>Objectives of Performance Measurement</td>
<td>379</td>
</tr>
<tr>
<td></td>
<td>Criteria for Evaluating Health Care Systems and Services</td>
<td>380</td>
</tr>
<tr>
<td></td>
<td>Approaches to Assessing the Performance of Health</td>
<td>388</td>
</tr>
<tr>
<td></td>
<td>Care Systems</td>
<td>392</td>
</tr>
<tr>
<td></td>
<td>Balancing Performance Criteria</td>
<td>392</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>395</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>395</td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td>399</td>
</tr>
</tbody>
</table>
Introduction

One of the most important recent developments in ideas about health care and illness has been the widespread recognition that social and economic conditions have a major effect on patterns of health, disease and death rates. A wide range of sources – historical, medical and sociological – have provided the evidence for such influences. This chapter considers how lines of influence from society and the economy can be traced to patterns of disease.

The starting point of this analysis is the dramatic variation to be found in death rates both in the past and at present. For example, the death rate per annum has virtually halved in England and Wales over the past 150 years: in 1851 it was 22.7 per 1000 population and by 2015 it had fallen to 9.9. Another way to express the difference over this period is in terms of the average number of years an individual could expect to live at birth, that is, life expectancy. A man or woman born in 1840 could, on average, expect to live to 40 and 43 years, respectively, whereas by 2015 life expectancy had risen to 79 and 83 years, respectively. However, such differences in overall mortality
rates disguise a more complex picture if we look at particular age groups. The higher death rates of the mid-nineteenth century were much more severe in particular age groups, especially in infancy and childhood.

The higher death rates and lower life expectancies are not of course simply a historical phenomenon. At present, many under-developed countries have much lower life expectancies than England; for example, in 2014, life expectancies for men and women in Swaziland were 49 and 48 years, and for Sierra Leone 50 and 51 years, respectively. Under-developed countries with higher death rates resemble nineteenth-century England and Wales in that infant and child mortality are one of the main reasons for lower life expectancy.

This evidence demonstrates that the country in which you live clearly affects how long you might live, but there is also a large variation within countries. In the UK, Scottish men on average live two years less than English men, and Bambra (2016) documents a 25-year gap in life expectancy between residents of the Iberville and Navarre suburbs of New Orleans, despite these areas being only 3 miles apart.

Variation in Disease Patterns in Human Society

The diseases encountered by humans have not remained the same over time. The history of humans might be viewed as a progressive victory over disease, but this is an over-simplification. Although some diseases are less important than in the past, others have become more important. Complex social and biological processes have altered the balance between humans and disease. A number of authorities (McKeown 1979; Powles 1973) now agree on three characteristic disease patterns in historical sequence.

Pre-agricultural disease patterns

Before about 10,000 BC, indeed for most of the evolution of humans as a distinct species, humans lived as hunter–gatherers, that is, without any form of settled agriculture for subsistence. Although conclusions based on such early evidence are somewhat speculative, anthropologists and epidemiologists have argued that the infectious diseases that were later to become major causes of illness and death were relatively uncommon at this stage of social evolution. Furthermore, diseases that are sometimes described as diseases of civilization, such as heart disease and cancer, were less common than at the present time (Powles 1973). It is likely that mortality in adults arose from environmental and safety hazards, for example hunting accidents and exposure.
1 Society and Changing Patterns of Health and Illness

Diseases in agricultural society

Knowledge of the diseases that plagued agricultural societies is more certain. These were predominantly the infectious diseases, which for purposes of discussion can be divided into the following:

1. Air-borne diseases, such as tuberculosis
2. Water-borne diseases, such as cholera
3. Food-borne diseases, such as dysentery
4. Vector-borne (i.e. carried by rats or mosquitoes) diseases, such as plague and malaria

In England and Wales, and in Europe generally, the plague was a particularly important cause of death and at its most virulent, in the Black Death of 1348, it killed one-quarter of the English population. It last occurred on any large scale in England and Wales in 1665, and disappeared from Europe shortly after. The plague was spread by the fleas carried by black rats. Its disappearance was due to the replacement of the black rat by the brown rat, which was much less prone to infest human habitations.

Malaria was never as great a health problem in England and Wales as it has been in the tropics, where conditions are ideal for the natural life cycle of both vector and parasite. By the mid-nineteenth century, when reliable vital statistics were available in England and Wales and the country’s economy was changing from agricultural to industrial, the major causes of death were tuberculosis, bronchitis, pneumonia, influenza and cholera.

The modern industrial era of disease

By the mid-twentieth century, infectious diseases had become relatively unimportant causes of death in England and Wales and in the western world in general, although some infectious diseases, such as influenza, remained common causes of death, particularly in the elderly. The infectious diseases have been replaced as major causes of death by the so-called degenerative diseases, cancer and cardiovascular disease.

The most striking feature of modern industrial society is the continued and dramatic increase in life expectancy. Since 1840, life expectancy has improved linearly at an extraordinary three months per year without any apparent sign of slowing or stopping (Oeppen and Vaupel 2002). Until the 1920s the majority of this improved life expectancy was due to increased survival at infancy and...
Sociology as Applied to Health and Medicine

childhood but since then improved life expectancy was more due to improved survival at later ages. As a result, most babies born since 2000 will live to their hundredth birthday.

By contrast, this period has seen a steadily increasing prevalence in industrial societies, especially in older ages, of chronic diseases, such as heart disease, arthritis, and diabetes. At least some of this increased prevalence may be due to improved recognition rather than changes in underlying prevalence, but not all is so explained. A third and important aspect to the overall picture of health alongside life expectancy and disease prevalence is disability. Here the evidence of trends in industrial societies is positive with steadily improving levels of disability as expressed in surveys of self-reported mobility and self-care such as bathing and dressing. The extent of improvement over time depends on the country in question and the exact methods of self-reported disability, but some evidence suggests a consistent pattern of over 1% per annum rates of improvement in disability (Christensen et al. 2009; see also Chapter 6).

An important question can be asked of these different trends: overall are we living longer lives but in poorer health? This requires combining relatively straightforward data on life expectancy and more complex data on health status and disability and as a result, trends over time are complex and interpretations contested. However, one reasonable summary of trends in modern industrial societies is that we are living longer lives, especially with improved survival at older ages, with more chronic disease, but reduced disability from that disease. Economic conditions and health care favourably impact on survival and over time reduce the impact on daily life of chronic disease; overall length but also quality of that life is improving over time.

Explaining Changes in Disease Prevalence

It would be all too easy to regard changes in disease patterns as the inevitable consequences of medical and technical progress without further explanation. Close examination of the major influences on disease patterns, however, uncovers a complex picture that is increasingly recognized as important for the understanding of disease in the contemporary world. The study of how disease patterns have changed indicates the pervasive influence of social and economic factors on disease prevalence.

Three main factors seem important in the changes in disease patterns that followed the transition from nomadic hunting and gathering to agricultural life. First, the development of cereals such as wheat allowed
agricultural societies to feed more mouths and hence support higher population densities. Evidence from epidemiological studies, however, shows that many infectious organisms thrive when human populations grow above certain densities. Second, agricultural work necessitated permanent settlement, whereas hunter–gatherers moved settlement periodically in search of fresh food sources. However, in the absence of sanitation and awareness of its importance, permanent settlement often led to the contamination of water supplies by waste products, which increased the risks of infection from a number of organisms. Third, the development of cereals as the major source of food, although supporting greater numbers of people, paradoxically narrowed the range and quality of diet, a factor that crucially reduced resistance to infection.

More careful examination is needed to explain the remarkable changes in death rates and the decline in significance of mortality from infectious disease that occurred with the transition from agricultural to industrial economies. The victory over death and diseases in the nineteenth and twentieth centuries still represents the most dramatic improvement in health in the history of humankind. Death rates for the various infectious diseases did not decline simultaneously. Tuberculosis, the most common cause of death in the nineteenth century, began to decline in the first half of that century, as indicated in Figure 1.1.

![Figure 1.1 Pulmonary tuberculosis: annual death rates for England and Wales, 1838–1970](source: Reproduced with permission from McKeown (1979))
There are a limited number of possible explanations for such a marked decline in mortality from an infectious organism. Box 1.1 shows the competing explanations that have been offered, not only for the decline of tuberculosis but for the wide range of infectious diseases for which mortality rates declined dramatically in the course of the nineteenth century in Britain and other parts of western Europe. It is possible that a change occurred in the virulence of the organism itself or that the genetic immunity of the population improved. Both of these possibilities are generally discounted. There is no theoretical reason why the organisms responsible for tuberculosis and several other infectious diseases should fortuitously change in their virulence at approximately the same period. It is very unlikely that genetic immunity could improve in such a short time as the selection processes implied would require dramatic increases in mortality rates across a range of diseases. For these reasons, the first and third explanations in Box 1.1 are normally rejected as unlikely.

The most convincing explanation for the decline in mortality from tuberculosis and, later in the century, from air-borne diseases such as pneumonia, is that of greater acquired resistance. An increased resistance to infection resulted from improvement in nutritional intake as agricultural techniques improved and transportation of produce became faster and more efficient. Much of the nineteenth century also saw unprecedented increases in real wages and the standard of living in Britain. It is also possible to argue for

**Box 1.1 Possible Explanations for the Decline of Mortality from Infectious Disease in Britain in the Nineteenth Century**

- Decline in virulence of organisms: organisms responsible for diseases, for example tuberculosis and bronchitis, became less lethal as a result of changes in their biological properties
- Reduction in exposure of humans to infectious organisms: for example, through changes in domestic housing and urban planning or through reduced contamination of food and water supplies
- Genetically induced increase in resistance of humans to infection: human genes associated with resistance to infection might be favoured by Darwinian selection processes and thus individual and population resistance increased over time
- Acquired resistance of humans to infection: general fitness brought about by improved nutrition resulted in greater resistance in terms of probability of: (1) being infected; and/or (2) recovering from infection
- Specific medical interventions: rates of recovery from infectious diseases were improved by developments in medical treatment and therefore mortality rates were reduced
the significance of nutrition with contemporary evidence. In many developing countries today, diseases such as measles or tuberculosis have a much higher fatality, especially among the very young in populations whose resistance is reduced by malnutrition. McKeown cites the conclusion of the World Health Organization (WHO) report that one-half to three-quarters of all statistically recorded deaths of infants and young children are attributed to a combination of malnutrition and infection (McKeown 1979). However, the role of the second possible explanation in Box 1.1 – reduced exposure to infectious organisms – is also of importance. The incidence of illness and mortality from water-borne diseases such as cholera declined somewhat later in the nineteenth century, largely as the result of concerted efforts by the public health movement to prevent the contamination of drinking water supplies by sewage; gastroenteric infectious diseases came under control by the beginning of the twentieth century, resulting in a dramatic impact on infant mortality. The sterilization and more hygienic transportation of milk in particular, and improved food hygiene in general, constitute another form of environmental change that produced the decline in infectious disease mortality.

Thus, most of the decline in death rates achieved in Britain and in the western world generally by the Second World War can be attributed to environmental factors such as improvements in food and hygiene, which were the products of economic development. Other social changes, such as the decline in the birth rate, reduced the demand for food and housing resources. Improved housing and better personal hygiene also played their role in reducing mortality rates.

Historians still dispute the precise nature of the changes that brought about the decline in mortality rates just described. The nature of that debate can, with some simplification, be termed one between the ‘public health’ form of explanation and the ‘invisible hand’ version of events (Box 1.2). The debate is of more than purely historical interest because it mirrors and has implications for current debates. Even now, some would argue that improvements in the economy and wealth are the most effective ways of producing improvements in the health of modern populations – ‘the invisible hand’ (Guha 1994). Others would argue that more direct and political intervention is required by a modern public health movement to address the ills described later in this chapter (Szreter 1988). This question of whether ‘public health ends are better served by targeted interventions or by broad-based efforts to redistribute the social, political, and economic resources that determine the health of populations’ (Colgrove 2002) is a fundamental one, and it is one that is still up for debate. Box 1.2 shows how difficult it is to disentangle claims, even with historical hindsight!
The Historical Role of Medicine

To this point nothing has been said about the role that medical intervention (the last possible explanation listed in Box 1.1) has played in the relationship between humanity and disease. At first glance, this might seem an important omission, given that medical knowledge was accumulating throughout the period and that hospitals had grown in number since the latter part of the eighteenth century. The evidence that McKeown and others have gathered, however, suggests that very little of the decline in mortality rates can be attributed to improvements in medical care. They cite a range of evidence against the role of specific medical interventions having a substantial effect on mortality:

Hospitals and surgical interventions were actually harmful. When Florence Nightingale began to reform the hygienic conditions in hospitals, it was widely thought that hospitals constituted a risk to health; in other words, one stood a high risk of cross-infection – contracting a disease from other patients – because wards were unsegregated as well as unhygienic. Similarly, despite the advances in surgery made possible by the development of anaesthetics, there is little evidence that surgical procedures made any impact on life expectancy in the nineteenth century.

Drugs were largely ineffective. Before the twentieth century a large armoury of medicines appears to have been available to the Victorian doctor.

Box 1.2 The Debate Between ‘Public Health’ and ‘The Invisible Hand’ to Explain Improved Life Expectancy in Nineteenth-Century Britain

The ‘public health’ explanation emphasizes deliberate government interventions:

- The public health movement improved water supplies, housing standards and regulation of food sold to public
- Increased income of working classes sometimes coincided with deteriorating death rates because of migration into more unhygienic industrial towns

‘The invisible hand’ explanation emphasizes benefits of rising incomes:

- Some areas of London enjoyed improved death rates in the nineteenth century before reforms to water supplies
- Studies of claims to insurance societies show that while working-class sickness rates due to infectious disease were stable, deaths from the same causes declined
- In some nineteenth-century towns, such as Mansfield, deaths from infectious disease remained high despite excellent water supplies
- The greatest benefit of improved diet is upon the capacity of infants and children to survive infectious disease
However, only a few, such as digitalis, mercury and cinchona, used in the treatment of heart disease, syphilis and malaria, respectively, would be recognized by modern standards as having specific efficacy and, in any case, dosages were unlikely to have been appropriate.

The first drugs that can be shown to have influenced mortality rates did not appear until the end of the 1930s. Antibiotics, which are used in the treatment of a wide range of bacterial infections, were developed in the 1930s and 1940s. Prophylactic immunization against such diseases as whooping cough and polio dates from the 1950s. In the case of these medical breakthroughs, however, it is easy to overstate the contribution that they made to mortality rates. The decline in mortality for most infectious diseases took place before the introduction of antibiotics. The period of decline for tuberculosis can be seen in Figure 1.1, and the mortality rates for bronchitis, pneumonia and influenza are shown in Figure 1.2. Moreover, it is difficult to distinguish between the improvements in disease mortality that can be attributed to the introduction of treatment or immunization and those due to the continuing influence of improving social and economic conditions. The immunization programmes for diphtheria and polio most likely brought about the greatest improvements that can be attributed to specific medical intervention.

Figure 1.2  Bronchitis, pneumonia and influenza: death rates for England and Wales, 1848–1971

Source: Reproduced with permission from McKeown (1979)
Disease Rates and Social Factors in Modern Society

Global burden of disease

There are two major difficulties in understanding contemporary patterns of ill health and possible social and environmental causes. First, we have to recognise the extent of global diversity of health between societies; health status is clearly more favourable in North America and Europe compared to low-income countries such as in sub-Saharan Africa. Second, we have to recognise the very complexity of health in modern society, taking account of both death rates and causes of death and patterns of ill health among the living. These are serious scientific challenges. A major initiative known as the Global Burden of Disease Study (GBD 2013 Risk Factors Collaborators 2015) helps us to address these challenges (see Chapter 3 for a discussion of globalization and health).

The Global Burden of Disease Study begins by producing a novel form of health measure that combines into one expression the death and disability rates prevailing in any given population. Death rates are expressed in terms of numbers of years lost (compared to a reasonable estimate of life expectancy) and disability rates are expressed in terms of years living with disability in that same population. The two calculations are combined to produce one figure for each population – the Disability-Adjusted Life Year (or DALY). The next step is to assess all the best available evidence of modifiable (that is, potentially preventable) risk factors responsible for DALYs to produce overall estimates of the importance for health of different types of risk factors.

A summary of key results of the most important contemporary risk factors is shown in Box 1.3. The single most important risk factor globally in 2013 was high blood pressure, followed by smoking and high body mass index. The main risk factors studied contribute to explaining more than 57% of global deaths and more than 41% of global DALYs, underlining the enormous scope for prevention globally. This overall global picture clearly varies by region. Problems that are of less relative importance in other parts of the world, such as water sanitation, poor handwashing and household air pollution, make major contributions to ill health in some sub-Saharan African countries. The other powerful message conveyed by this study is the rate of change in risk factors for ill health in recent history. In 2000, childhood undernutrition, high blood pressure and smoking were the main risk factors for DALYs. Overall the majority of risk factors have been consistently important in that 13-year period.
A study of this scale of ambition inevitably raises questions about methods. The study acknowledges that many risk factors (for example, high body mass index and physical inactivity) are interrelated; they make the best effort they can to use best available quality epidemiological data to separate out the effects of different factors. The quality of data and hence of estimates may vary between regions of the world. Nevertheless it provides a powerful body of evidence for the risk factors that are as amenable to change as those revealed by historical analysis of reasons for improved health.

A focus on health, as constituted through a range of individual behaviours, leads to the identification of specific risk factors (such as smoking, drinking or obesity) that function to obscure or overshadow the social distribution of health across populations. From this, it then follows that interventions become concerned with reducing the prevalence levels of specific diseases, through individually tailored interventions targeted at specific health behaviours and lifestyle factors. The example of smoking (Box 1.4) illustrates the need to look beyond the individual to understand health behaviour. The emphasis on individual lifestyle and behaviours, notable across public health means, as Frohlich and colleagues (2001) argue, that lifestyle is used to denote ‘individual behaviour patterns that affect disease status’ (783) in a way that understates the role and impact of wider structural factors. Cockerham (2005) details how this reflects a dominant approach in public health and epidemiology that treats health behaviours and lifestyles as issues of individual
choice. However, there are clear social gradients for many of these behaviours which would challenge this individual-choice explanation. For example, obesity shows a well-established social gradient in terms of prevalence, with the most socioeconomically disadvantaged having the highest rates (Bissell et al. 2016). Debate about how best to explain this gradient is ongoing, but the simple fact remains that this social gradient cannot be explained simply through addressing issues of lifestyle and eating behaviour (see Chapters 2 and 8).

Link and Phelan (1995) propose a four-fold framework for identifying what they term a social cause of health inequalities. First, a social cause of health inequality will influence multiple disease outcomes, meaning that it is not limited to only one or a few diseases or health problems. This could be the reason why there are similar social gradients across so-called lifestyle behaviours, as many of these behaviours may have an association with socioeconomic disadvantage. Second, a social cause of health inequality will affect those disease outcomes through a range of different risk factors. Third, a social cause of health inequality is in part determined by differences in how people are able to gain access to resources that can be used to avoid risks or to minimize the consequences of disease once it occurs. People with more social, political, cultural or economic resources tend to be able to do more to avoid
or minimize the risk or consequence of a disease. Finally, the clear association between a social cause of health inequality and a person’s health status is ‘reproduced over time’, such that patterns of health inequality come to be evidenced as a social gradient. Link and Phelan attribute a primary role to socioeconomic status (SES) as the key determinant linking health inequalities to health status. They argue that SES is a ‘fundamental’ cause of health inequalities (see Chapter 8).

**Global health inequalities**

Evidence of health inequalities points to unfairness and patterns of ill health in populations that can in principle be addressed and resolved. The WHO set up a commission to examine evidence of health inequalities globally and produce authoritative, evidence-based solutions (Marmot et al. 2008). The Commission concluded that the large health inequalities that they observed between and within countries should be addressed within a generation by means of three principles:

1. Improve the conditions of daily life (i.e. the circumstances in which people are born, grow, live, work and age)
2. Tackle the inequitable distribution of power, money and resources (the structural drivers of those conditions of daily life) globally, nationally and locally
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about these determinants (Marmot et al. 2008).

These three broad principles were based on a series of more specific recommendations for which the Commission produced evidence. Thus, ‘improving the conditions of daily life’ will be achieved by a range of steps, including action to invest in children’s health and development from the start of life, eliminating slum housing by access to good-quality housing and shelter, clean water, and sanitation, full and fair employment, access to free health care and social protection (protected income during periods of disability or unemployment).

‘Tackling inequity of power, money and resources’ requires broader, more structural changes to society. A focus on health equity across all policies of government, for example, transport, education, housing, is required. Within countries more progressive taxation is needed. Between countries the level of funding of development aid from wealthy countries needs to be increased. Resources that are positive for health need to be universally
available regardless of ability to pay. Global governance of health issues such as tobacco, alcohol and processed food must be strengthened. Gender inequalities in all aspects of society have to be reduced. The public engagement of all social groups needs to be ensured. The research evidence for links between such changes and health improvement is complex and the kinds of country-level and global changes required hugely ambitious. The rationale of the Commission is that health inequality can in principle be eliminated.

**Obesity**

Obesity is a good example of a risk factor with clear, major global health consequences, requiring new ways of thinking about how to improve health. The problem has been increasing for over 40 years, so that now over 2 billion adults are judged to be overweight or obese worldwide. The health risks, especially for cardiovascular disease, cancer, diabetes, osteoarthritis and chronic kidney disease, are substantial. The causes of obesity are actually clear: chronic energy imbalance involving inappropriate dietary intake and physical inactivity. The challenge in terms of potential solutions is that they are bound to involve multiple, complex strata of society – for example, government policy, schools and the workplace, the food, advertising and retail industry, families and individual behaviours.

Interventions that have a strong basis in evidence are required, so that society can confidently invest resources to reduce obesity. Traditionally such evidence comes from well-designed randomized controlled trials, which mean that the benefits of interventions are likely to be reliable if applied in the real world and on a larger scale than in research studies. There are some interventions that qualify by such criteria – most notably bariatric surgery with gastric banding is highly effective, as is referral to weight-management organizations. However, the former in particular is not feasible or cost-effective on a large enough scale to address such a common problem. To find interventions that are feasible and cost-effective we have to resort to different types of evidence, evidence drawn from modelling the best available non-randomized data and which considers what works best within complex systems. If we do that, we find interventions such as taxes on unhealthy food and beverages, reduction of advertising of junk food to children, and ‘traffic light’ labelling of nutritional information on food packages that are highly cost-effective (Gortmaker et al. 2011). The problem is that, not only are such interventions based on a different kind of evidence, they require more complex changes to be implementable.
The Economy and Health Policy in Modern Society

Some of the most recent research on the relationship between the economy and health suggests that, even in modern societies, economic factors play the predominant role in determining patterns of illness, and that the role of health services is more modest by comparison. Four different views of how the economy generally, and patterns of employment and income in particular, can affect health are evaluated here.

Unemployment and health

The evidence that the involuntary loss of one’s employment is harmful to health is now substantial and has been observed in many societies with many different kinds of studies. A typical piece of evidence is a study by Granados and colleagues (2014) of over 12,000 individuals representative of the wider population of the USA. As with many other studies, they found that unemployment was significantly related to subsequent death. To make real the scale of effect they observed that the degree of additional risk of becoming unemployed was equivalent to being ten years older than actual age. The mechanisms whereby loss of job has adverse health effects are multiple; there are psychological costs through depression, loss of esteem and increased risk of suicide. There are lifestyle mechanisms, such as less access to adequate diet, housing and other essential goods, and also altered health behaviours and use of health services. The context, for example strength of a society’s social security system, can significantly mediate and reduce such effects.

Economic change, austerity and health

Because of adverse effects such as unemployment and fear of job loss and its deleterious impact on health, it is to be anticipated that events such as the major global crisis in 2008–9 and the subsequent period of austerity that hit the world economy would have negative health effects. This is indeed the case and the pattern of harmful effects follows those observed in relation to the Great Depression of the 1930s and the societal collapse that followed the fall of the Soviet Union. In the most recent economic crisis, negative effects on mental health have been observed in countries such as Greece, Spain and Portugal (Karanikolos et al. 2013).

Reeves and colleagues (2013) have explored the effect of austerity and unemployment on health. They report that austerity is likely to widen health
inequalities and increase levels of premature mortality, and that this happens
in two key ways. First, there is a very direct effect of austerity in that levels
of premature mortality increase as a result of cutting effective prevention and
treatment programmes. Second, more indirect effects of increasing austerity
related to levels of unemployment, poverty and homelessness (while the social
protection offered by the welfare state is reduced) mean that risk factors that
might previously have been mitigated no longer are. Reeves and colleagues,
while not directly stating that one caused the other, do highlight the concom-
itant increase between 2007 and 2009 in levels of unemployment and rates
of suicide.

Similar deleterious effects upon health of rapid economic growth have been
detected historically. Returning to the evidence of nineteenth-century Britain,
it can be argued that it was the disruption caused by rapid economic growth
that resulted in little or no overall increase in life expectancy in the middle
of that century. Mortality rates were particularly poor in the rapidly growing
industrial cities such as Manchester, Glasgow and Liverpool, indeed they are
still lower today in these old industrial heartlands than in other less indus-
trialized areas (for a slightly macabre but fascinating analysis of the geographi-
cal spread of mortality in Britain, see Shaw et al. 2008). Rapid economic growth
was associated with large-scale immigration of the rural poor into cities,
growing social divisions between rich and poor within cities, and a decline
in the willingness of those in power to fund environmental and public health
protection (Szreter 1999). Szreter argues that ‘the invisible hand’ of rapid
economic growth alone proved harmful to health and that only a deliberate
public health movement in the second half of the nineteenth century restored
the improving trends in life expectancy associated with economic growth.

So periods of rapid economic growth may also have adverse effects, through
stress and work pressures to overwork and disruption of social ties, networks
and social support, with ensuing harmful health behaviours such as alcohol
misuse. Paradoxically there is evidence that economic slowdowns reduce some
pressures and stresses leading to more healthy behaviours (Karanikolos et al.
2013).

Forms of employment and health

It is increasingly argued that the nature of work processes need to be examined
for possible health effects. According to the ‘job–strain’ model, individuals
who have very demanding jobs but who see themselves as having very little
control over their work, experience not only higher levels of stress than oth-
ers but also elevated cardiovascular disease. Kivimäki and colleagues (2012)
analysed the health outcomes of nearly 200,000 men and women who were free of heart disease at baseline. After adjusting for other risk factors, those who reported job strain at baseline were significantly more likely to develop cardiovascular disease. A related model—the effort–reward imbalance model—argues rather similarly that those whose work is demanding and stressful, but who perceive themselves as insufficiently rewarded for their efforts, are also more prone to distress as well as to cardiovascular disease (Siegrist et al. 1990). Rewards are not primarily monetary but include prospects of status enhancement or promotion. Both models, when tested on workforces, have been found to demonstrate the highest levels of risk in semi- and unskilled manual workers. It is now becoming increasingly clear that precarious employment, that is, work that is insecure and temporary, may also have serious adverse consequences (Julia et al. 2017; see also Chapter 8).

**Income distribution and health**

One final model of the effects of the economy on health is that it is the relative degree of inequality in incomes within a country that influences health. Evidence to support this model comes from international comparisons of countries where it is claimed that countries with the smallest spread and the least inequality of incomes from top to bottom (e.g. Japan and Sweden) have higher life expectancies than those with large income differentials (such as the USA and the UK) (Pickett and Wilkinson 2015). There are very contrasting interpretations of these effects, and these are examined in Chapter 8.

**Current Health Challenges**

Despite being unequal between and within societies, dramatic improvements in health have occurred over the last 150 years. The reasons for these improvements are many and complex and vary from one part of the world to another. It is nevertheless possible to identify four distinct contributions to improved health:

*Deliberate public health initiatives*, most obviously the water and sanitation reforms of the nineteenth century and public health campaigns against smoking in the twentieth and twenty-first centuries.

*Collateral benefits of social change*, particularly evidenced by improvements to health arising from improved nutrition, in turn due to economic changes.
Medical benefits to life expectancy delivered via the health care system, best illustrated by antihypertensive drugs.

Medical benefits to disability and quality of life delivered via the health care system, illustrated by joint replacement surgery to improve mobility and cataract surgery to improve vision and social function.

It is not possible precisely to separate out these four contributions; for example, the dramatic improvements in adult cardiovascular health are due to all four types of change.

The net result of these four kinds of impact is that all parts of the world actually or in principle are able to enjoy dramatically and continuously improving health. We nevertheless often characterize ‘improving health’ in terms of population ageing, with all its negative connotations of adverse consequences. Population ageing is reflected by the fact that for the world as a whole, and for the first time in history, those aged 65 or over will shortly outnumber children younger than five. As a result of improved survival, a higher proportion of the population will have multiple morbidities. In a survey of 314 general medical practices in Scotland, 23% of all patients were multi-morbid, and the majority of patients aged 65 or older had multiple morbidities (Barnett et al. 2012). This is challenging for the practice of medicine, mainly because medical research, education and best-practice guidelines are all based on thinking about solving problems from individual diseases. The typical patient now and in the future has multiple health problems (see Chapter 11).

The novel patterns of health problems of an ageing population and its associated multiple morbidities will require new types of services. The search for solutions from combinations of the same four types of intervention that were historically effective might be optimistic. The scope for continued improvement in health continues to be very substantial but our models of the relationship between illness, society and health services need continuously to evolve, to capture the observed complexities that will always challenge our understanding.

References


Index

The following suffixes appear on some page numbers:

\( b \) – box
\( f \) – figure
\( t \) – table

A
abnormality, 227, 253
abortion, traveling for, 52–53
Abualfaraj, R., 106
acceptance stage of dying, 130b
accessibility of care, 384
accountability as measurement objective, 379–380
accreditation of health care systems, 70–71
accumulation of risk life course model, 32
‘achieved deviance,’ 230–231
active listening, 83–84
‘activities of daily living’ (ADL), 207–208
acute respiratory disease, 34
adherence, 169, 370
admission of uncertainty disclosure strategy, 128
Affordable Care Act (Obamacare), 255–256, 302, 384
‘affordances’ of digital health, 284
Afghanistan, 360
Africa
access to medicine, 69
HIV/AIDS prevalence in, 26
immigrants in United Kingdom, 184–185, 184f, 187f, 235
traditional medicine in, 333–334
Against Method, 245
ageing populations, 20, 213–220
and ‘activities of daily living,’ 207–208
cohorts’ differing needs, 212–213, 218–219
consulting doctors, 210
cultures of, 216–219
and disengagement theory, 213–214
disability among, 206–207
fourth age of, 219–220
frailty of, 208, 219–220
in health care systems, 67, 209–210
in industrial societies, 213–214
influencing health care policy, 315–316
institutional care of, 209
interactions for, 20
‘mask’ of old age, 217
mental health of, 208–209, 219–220
‘middle’ vs. ‘old,’ 217
migration by, 54
multiple pathologies of, 208, 210
as overall percentage of population, 204–205, 205f
‘productive ageing’ approach, 216
retirement age of, 210–211
and self-care technologies, 282
self-reporting by, 207
social circumstances of, 210–212
and structured dependency theory, 214–216
third age of, 216–217
‘unsuccessful ageing’ among, 219
Copyrighted material – 9781137577375
'ageism,' 215
Aggleton, P., 237
agricultural period disease patterns, 5
AIDS. See HIV/AIDS
alcoholism, 13b, 16
changing norms of, 228
as public health issue, 347
stigmatization of, 231
Alexander technique, 67
Allen, D., 333
Alonzo, A., 234
alternative health systems, 70–71
Alzheimer’s disease, 165–166, 172f;
208. See also dementia; mental illness
Anderson, R., 104, 107
anger stage of dying, 130b
antenatal care, 147
antibiotics, 11, 254
‘anticipatory’ mourning, 134–135
anxiety, women reporting, 169
Aphramor, L., 353–354
Appiah, K.A., 198
Apple Watch, 268
apps. See also digital technologies
in health care systems, 277, 278,
286
in self-care regimens, 280–281
selling data, 287
Arches, J., 329
arenas of care. See health care sectors
Aries, P., 124, 129–130
Armstrong, D., 247, 344, 345
artefact explanation of health inequality, 145
arthritis, 6, 103
‘ascribed deviance,’ 230–231
‘aspirational medicine,’ 252
aspirin, 68
assemblage approach, 271
asset flows, 152
austerity. See also capitalism; economic conditions; financing; neoliberalism
and health, 17–18
health care systems under, 255–256
as ‘neoliberal epidemic,’ 152
Australia
avoidable deaths, 361
doctor-patient relationships, 90t,
372
gender and health, 169
health care financing, 313–314,
314t
health governance, 327, 328
increasing use of non-prescription drugs, 68
medical tourism, 53
online medical platforms, 285
Austria, 206. See also European Union (EU)
autonomy, and health, 29
avian influenza, 48–49
avoidable deaths, 360–361, 361b
awareness contexts of dying, 127–129,
127t
Ayurveda, 42, 70

B
bacterial infections, 11
Baker, P., 175
Bamba, C., 4, 41, 144, 152
Bangalore, 51–52
Bangladesh
fast food in, 33
immigrant populations in United Kingdom, 184–185, 184f;
188–189, 190f
mortality rate of immigrants, 187f
self-reporting by immigrants, 186,
188, 188f
bargaining stage of dying, 130b
bariatric surgery, 16
Barnes, C., 101
Bartley, M., 147, 148, 149
Batten disease, 104–105
Bauman, Z., 43
Bayer, R., 240
bedside medicine, 78, 245–246
behavioural and cultural approach to
health inequality, 147
Belgium, 206. See also European
Union (EU)
See also death and dying
‘anticipatory’ mourning and, 134–135
counseling, 125
patterns of, 132–133
Better Health Channel, 282
bewitchment, 63
Bill & Melinda Gates Foundation, 42
‘biographical disruption,’ 106, 232
biological death, 132–133
biological pathways, 28–29
biomarkers, 92
biomedical decision-making, 81t,
82–83, 105–106
biomedicine. See also health care
systems; medicine
as ‘aspirational medicine,’ 252
as dominant health system, 67, 70–71
‘dualism’ in, 247–248
globalization of, 42–43, 50
vs. indigenous systems, 66–67
integrating with traditional
medicine, 334–335
and the medicalization of bodies,
267
biophysical trajectory of disease, 234
biopsychosocial perspective, 80
‘biosecurity,’ 48
biosensors, 281
bipolar disorder, 105
birth asphyxia, 172f
birth trauma, 172f
‘black box epidemiology,’ 195
Black Carribean peoples, 184–185,
184f, 192–194
Black Death, 47
black Report, 26, 145–147, 148, 188
Black, D., 146
bladder cancer, 351. See also cancer
Blane, D., 149
blindness, 229
Bloom, L.R., 106
Bloor, M., 49–50
Boards of Health, 344
bodies, 263–275. See also embodiment
as assemblages, 271
biological definition of, 263–264,
270
capacities of, 271
dualism of, 247–249
importance of, 247
and knowledge, 267–269
managed through self-awareness,
268
materialism and, 270–272
medicalization of, 267
as metaphors, 264–265
and power, 267–269
social construction of, 249–250,
263–265
and social networks, 270–271
sociology of, 249–250, 265–266
bodily idiom, 250–251
body builders, 62
Boerma, T., 169
Bowser, D., 148
Bradby, H., 51
brain drain, 50f, 51–52
Brazil, 315, 333
breast cancer. See also cancer
awareness contexts of, 128
as cause of death, 166, 172f
continuity in treatment, 371
global rates of, 171–172
and life expectancy, 360
and shared decision-making, 84
breast-conserving surgery, 84
Bretton Woods Conference, 40
Bristol Royal Infirmary Inquiry, 257,
326
Britain. See United Kingdom
British Medical Association (BMA), 325
Broad Street water pump, 345
*Brocklehurst’s Textbook of Geriatric Medicine and Gerontology*, 208
bronchitis, 5, 11, 11f
Broom, A., 67, 124–125, 135
Brunner, E., 28
bubonic plague, 47
Buddhism, 122
Bunker, J., 382
Bunton, R., 352
Burris, S., 240
Burrows, R., 248
Bury, M., 103, 104, 106, 107

Capacities, 271, 273–274
Capitation payment mechanism, 306
Cardiovascular diseases. See also heart disease; hypertensive heart disease; ischaemic heart disease and class, 29–30
and employment, 18
incidents by gender, 29–30, 165, 171
in modern industrial period, 5–6 smoking interventions impacting, 351
care homes, 295
care pathways, 332–333
Care Quality Commission (CQC), 309, 390–391
assessment process, 393f
as composite measure, 392–394, 393f
caregiving
affecting women long-term, 212
and dying at home, 141
and long-term illness, 107
‘scripts’ for, 124–125
carotid endarterectomy, 385
Carrera, P., 53
Caribbean peoples, 187f, 188f, 190f ‘cascade of intervention,’ 170
Castles, S., 54
Castlight Health, 285
causation, 63. See also social causes
cell phones, as ‘therapeutic tools,’ 43
cerebral palsy, 53
cervical cancer, 166, 361. See also cancer
Chad, 360
Chadwick, Edwin, 142, 344
Chadwick, R.J., 170
Chan, K., 240
charities, 295
Chau, P., 122
child mortality. See infant mortality; maternal health
childbirth, 169–171, 251. See also pregnancy; women
childhood, health during, 148, 149
childhood undernutrition, 12, 13b.

See also nutrition

Chile, 169

China
female suicide rates, 167
health spending post-crisis, 315
immigrants, health of, 188f, 190f
immigrants in United Kingdom, 184–185, 184f
and medical tourism, 53
self-care regimens in, 281–282
stigmatization of sex workers, 240

chiropractic care, 70
cholera, 5, 345
Christianity, 122, 265
chronic disease. See also disability; long-term conditions
and embodiment, 266
managing pain of, 33
patient experiences of, 372
in quality of life instruments, 366–367, 367b
shared decision-making for, 86
chronic kidney disease, 195
chronic obstructive pulmonary disease (COPD), 123, 172f, 351
civil liability as oversight, 323
class. See social class
class/command dynamic, 151
Classification of Occupations, 142–143, 143r
cleft lip and palate, 103, 106
climatic change, 46–47
Clinical Commissioning Groups (CCGs), 93
clinical decision-making, 94, 182, 329
'clinical gaze,' 248–249, 267
Clinical Governance Framework, 324b
'clinical iatrogenesis,' 252
clinical trials, 91–92, 365, 378–379
clinics, 94, 192, 304–305, 308–309, 315, 324b
closed awareness of dying, 127–129, 127t
costigmas, 240

Coburn, D., 150–151, 156
Cockerham, W., 13
collaborations, 331–333, 389
collegiality, 'logic' of, 310
colon cancer, 172f, 360. See also cancer
colonialism, 183, 334, 335
command mode of governance, 324b
'commercial therapeutic sector,' 68–69
Commission on Social Determinants of Health, 153, 154t, 155
'commissioners' of health services, 312
commodification. See also consumerism
of ageing, 216–218
of death and dying, 135
of health, 53, 62, 228
of health data, 283–284, 287
of medicine, 68–69, 228

communication. See also doctor-patient relationships; health promotions; patients
'bodily idiom' as, 250–251
by digital technology, 277, 278
disclosure strategies, 128
doctor-patient, 77
about dying, 124–126, 126r
globalization of, 42–43
as health determinant, 195f, 196
in hospices, 132
models of, 82, 83–84
and patient satisfaction, 370–371, 372
in shared decision-making, 85–86
in telemedicine, 279–280

communion mode of governance, 324b

communities
cultures as, 181
dying within, 129–131
interventions by, 63
participating in promotions, 349–350
public health empowering, 343
competition, in health care systems, 312
competitive regulation, 309, 309r
complementary and alternative medicine (CAM), 67, 69, 71
concordance, 64, 87, 87b

conflict theory, 101–102

Connell, R.W., 174, 175

Conrad, P., 104, 232–233

constructionism, 101, 248–251

consumerism. See also commodification

ageing populations and, 211, 217–218

approach to health, 62, 257–258, 294, 310

and bodies, 101, 249–250, 258

and health care financing, 297–298, 298f

patients as consumers, 80, 81, 257–258, 329

and pharmaceuticals, 283

and surveillance medicine, 258

consumerist model of doctor-patient relationship, 81t, 83

consumption critiques of public health, 352

contexts

deviance in, 240

for disability oppression, 114–115

of doctor-patient relationships, 91–95

of dying awareness of, 127–129, 127f

of gender, 162–164

for help-seeking practices, 65–66

importance of, 29–30

of socioeconomic status, 149

continuity, importance of, 371

contraception, 147

contract mode of governance, 324b

Copernicus, 245

coping strategies for epilepsy, 232–233

‘coronary candidacy,’ 64

coronary heart disease. See also heart disease

in ethnic groups, 186

incidents by gender, 165

surgeries for, 368, 385–386

in surveillance medicine, 248

corporations, 40, 152, 155, 286

cosmetic surgery, 52

Crawford, R., 353

‘credentials’ of health professionals, 322–323

cremation, 135

Creutzfeldt-Jakob disease (CJD), 252

criminal law as oversight, 323

Crinson, Ian, 319–336

‘critical digital health studies,’ 278

critical gerontology, 215

critical periods model, 32

Croog, S., 368

‘cross-national’ health, 54

cultural/behavioural explanation of health inequality, 146

cultural competence, 179, 197–198

cultural distinctions, 227–228.

See also cultures; diversity; ethnic groups; immigrants

and ageing populations, 218

in death and dying, 121–122

and deviant conditions, 229

and doctor-patient relationships, 91

and ethnic health patterns, 188–189

importance of awareness, 197

in mourning, 134–145

‘cultural iatrogenesis,’ 252

cultural imperialism, 236b

cultures. See also cultural distinctions; ethnic groups; ethnicity; immigrants; migration; race of ageing, 217–219

as communities, 181

defining, 180–183

vs. ethnicity, 181

as health determinant, 195f, 196

cytotoxic chemotherapies, 367–368

D

Dahlgren, G., 195, 195f, 346

Davison, C., 64, 349
death and dying, 121–136. See also bereavement; life expectancy; mortality
awareness contexts of, 127–129, 127t
biological vs. social, 132–133
commodification of, 135
communication during, 124–128, 126t
within communities, 129–131
conditions influencing, 3–20
cultural definitions of, 121–122, 125
decisions regarding, 128, 134
in disability-adjusted life year (DALY) calculations, 12–13, 13b
gender difference in, 132–133, 165–167, 166f, 167f
as health outcome, 360–363, 361b
illness worse than, 368, 369t
‘invisible,’ 124
lay perceptions of, 63–64, 125–128, 126t
location of, 129–132
medicalization of, 130–131
patterns of, 132–133
vs. ‘permanent vegetative state’ (PVG), 122
quick vs. slow, 123, 124t, 133
rate of, 3–4, 8b
‘revival of,’ 125
stages of, 129, 130b
study of, 121–122
ten leading causes of, 123
trajectories of, 123, 133
‘death brokering,’ 126
decision aids, 86
decolonization, 183
degenerative diseases. See also diseases; illness; long-term conditions
in ‘dying trajectory,’ 123
in modern industrial period, 5–6
web of causation model for, 25
dementia, 208–209, 219–220. See also mental illness
incidents by gender, 165–166, 172f
democratization of health care systems, 301
denial stage of dying, 130b
Denmark, 206, 313–314, 314t. See also European Union (EU)
dentistry, 52, 250, 320
Department of Health, 100, 149
depression. See also mental illness
in ageing populations, 208–209
cause of disability, 114
and class, 29
stage of dying, 130b
women reporting more, 169
‘deritualization’ of mourning, 135
Descartes, Rene, 247
Desmond, N., 66, 71–72
deviance, 227–240. See also stigma
addressing, 238–240
definitions of, 230–231, 232b, 253
of HIV/AIDS patients, 233–234
illness as, 100–101, 227–229
importance of context, 240
as ‘personal tragedy,’ 232–235
psychiatry controlling, 254
vs. ‘sick role,’ 227–228
social factors in, 239–240
and stigma, 230–231, 232b
Dew, Kevin, 352
diabetes, 6. See also long-term conditions; Type 2 diabetes
as cause of death, 123, 172f
in ethnic groups, 186, 189, 195
from globalization, 43
lived experience of, 103
patient-centred care for, 81
self-treatment for, 69, 102, 281
diagnoses. See also doctors; medicine; symptoms; treatments
as cause for stigma, 229
doctors controlling, 82–83
transformed by telemedicine, 279–280
'diagnostic agents,' 280, 284
diarrhoeal diseases, 34, 123, 172f
diengagement theory, 213–214
diet, 7, 10b. See also nutrition
  health promotions for, 347
  in immigrant populations, 33, 55
  socioeconomic factors in, 147, 353
  in surveillance medicine, 248
digital technologies. See also internet;
  self-care technologies; social
  media
‘affordances’ of, 284
communication via, 277–280
in health care systems, 277–279
impact on health care, 286–288
for long-term conditions, 281
medicine perspective on, 278
patients using, 277, 281–282
privacy issues of, 287
sociological perspective on, 278
and telemedicine, 279–280
for testing, 277–278
diphtheria, 11
disability, 6, 99–116. See also long-term
  conditions
  activism, 285
  and ageing populations, 206–207
  ‘bodily idiom’ of, 250–251
  challenges of data collection,
    381–382
  challenging paradigms of, 235
  current framework for, 112–113,
    112f
  definitions of, 108, 110, 111
  environmental causes of, 110,
    111–112, 114
  lived experience of, 103–107, 113,
    114–115, 369
  models of, 109–112, 251
  modern significance of, 99–100
  moving forward with, 115–116
  and oppression, 114–115, 235–236,
    236b
  patient-centred care for, 81
‘personal tragedy’ model of, 108–109,
  232–235
  in quality of life instruments,
    366–367
  social disadvantages of, 103
  and stigmatization, 106
  welfare benefits for, 108
Disability Discrimination Act, 114
‘disability paradox,’ 369
disability-adjusted life years (DALY),
  12–14, 13b, 362–363,
  381–383
‘disablism,’ 235
discipline of bodies, 354–355
disclosure strategies, 128
discrete choice experiments (DCEs), 92
discrimination, 190–191, 236
discussion forums, 284–286
diseases. See also cancer; cardiovascular
  diseases; epidemics; illness;
  infectious diseases; long-term
  conditions; outbreaks; treatments
  biophysical trajectory for, 234
  causes of, 153, 154t, 345
  and ‘clinical gaze,’ 248–249
  conditions influencing, 3–20
  data sets via internet, 286
  degenerative, 5–6, 25, 123
  as ‘double burden,’ 355
  evolving understanding of, 344
  Global Burden of Disease Study, 12,
    13b
  managing outbreaks, 47–49
  in Marxist framework, 142
  medicine controlling, 254
  as Millennium Development Goal,
    355
  models of, 24–27
  non-communicable, 99–100
  patterns of, 4–16
  and public health, 346
  reducing stigmas, 238–239
  shared decision-making for, 86
dissimulation, as disclosure strategy, 128

   See also cultural distinctions; cultures; ethnic groups;
   ethnicity; race

divorce, 212
doctor as agent model, 83
doctor-patient relationships, 77–95.
   See also communication; doctors; patients
   barriers to, 91
   changing context of, 91–95
   and conflict theory, 101–102
   current models of, 81–84, 81t
   vs. ‘encounters,’ 94
   and geographic location, 88–91, 90t
   history of, 78–81
   increasingly egalitarian, 80
   and long-term illness, 105–106
   patient-centred care as, 79–81, 80b
   trust in, 93–95
doctors. See also doctor-patient
   relationships; health care
   workers; health professions
   ageing populations consulting, 210
   bias among, 182, 230
   in brain drain model, 51–52
   ‘club culture’ of, 326
   collaborations among, 331–333
   communicating with patients,
   64, 84–87, 126, 246, 371, 384–385
   constructing illness, 228–229
   in consumer society, 257–258
   controlling sexuality, 269
   controlling sick leave, 228
   and digital technology, 278–280,
   285–287
disclosure strategies, 128, 321–322
effects of micro-level assessment on,
   389
evolving role of, 78–79, 94–95,
   321–330
global distribution of, 50–51
   in health care system framework,
   298–299, 299f
   in hospital medicine, 246–247
   and integrated care pathways (ICPs),
   332–333
   and medicalization of bodies,
   267
   paternalistic behavior by, 82
   payment mechanisms for, 305–307
   self-regulation of, 319
   training of, 70, 322–323, 329
Dolan, A., 28
domestic violence, 171
Douglas, Mary, 249, 264
Doyal, L., 163
Dreyer, G., 195
drug abuse
   among LGB people, 176
   medicalization of, 253
   stigmatization of, 231
drugs. See also pharmaceuticals;
treatments
   commercialization of, 258
   costs, and globalization, 44
   efficacy, via shared decision-making,
   86
   elderly as ‘poly-pharmacy,’ 210
   increase in non-prescription, 68
   influencing mortality rates, 11
   public engagement with, 92, 93
dualism
   in biomedicine, 247–248
   in embodiment, 265, 270
   materialism reconciling, 271–272
   mind/body, 249
Duncombe, J., 266
dying trajectories, 123, 133. See also
deadth and dying; mortality
E
   East African immigrants, 187f
   ebola, 48, 335–336
economic conditions. See also austerity; income inequality; social class; socioeconomic status and global health inequality, 15–16 and globalization, 40–41 influence on health, 3–20 smoking as product of, 14b and social support, 31 education, 195f, 196, 298–299, 299f efficiency as performance criteria, 386–387 Ehrlich, Paul, 24 1848 Public Health Act, 344 1858 Medical Act, 325 Elias, N., 131 embodiment. See also bodies and duality, 265, 270 as focus of social control, 267 and gender, 265 holistic approaches to, 273 of illness, 264, 266, 268, 272–274 of ‘lived bodies,’ 265 materialist approach to, 270–272 of sexuality, 269 social context for, 266 sociological approach to, 264 vs. telemedicine, 279–280 emotions, social construction of, 266 employment, 17, 147. See also work and workplaces and disability, 114 and gender, 163–164 in health care systems, 295 as health determinant, 18–19, 28–29, 107, 195f, 196 and life expectancy, 142–145, 143t, 144t, 145t, 167–168 in neoliberal economies, 44, 151 in public health, 342–343, 342f Employment Equality (Sex Discrimination) Regulation, 164 empowerment. See also self-management and health policy, 349–350, 350f and health promotion, 349–350, 354 of patients, 101–103 reinforcing state systems, 103 end-of-life decisions, 134, 386 endoscopies, 385 Engels, F., 142, 152, 155 England. See also European Union (EU); Ireland; Scotland; National Health Service (NHS); United Kingdom; Wales conditional trust, 94 ethnic minority population, 184 life expectancy, 3–4, 204, 360 smoking, 351 English Longitudinal Study of Ageing (ELSA), 207, 211 entitlement, 303–304 environmental factors as ‘inverse housing law,’ 149 creating disability, 110, 112–113, 112f in disease modeling, 26–27 and disease patterns, 8b, 9 in epidemiological triangle, 24–25 and global health inequality, 15–16 health effects of, 147 and migration, 54–55 epidemics, 41, 47–49, 152. See also diseases; HIV/AIDS; outbreaks epidemiological triangle, 24–25 epidemiology, ‘black box,’ 195 epilepsy. See also disability; illness; long-term conditions ‘bodily idiom’ of, 250–251 coping strategies for, 232–233 interpretations of, 63 lived experience of, 103 as stigmatizing condition, 229, 232–233, 238–239 Equal Pay Act, 163 Equality Act, 109, 114
equity, as performance criteria, 388
ethnic groups, 185–194.
See also cultures; ethnicity;
immigrants; migration; race
and ‘black box epidemiology,’ 195
case study, 192–194
cultural competence for, 197–198
improving health of, 194–198, 195f
life course of, 191
morbidity among, 186, 188, 188f
patients in medical systems, 182
quality of care for, 191–192
‘respectful curiosity’ for, 197–198
and self-care regimens, 281–282
understanding health data of,
188–189
ethnicity. See also cultures; ethnic
groups; immigrants; race
vs. culture, 181
defining, 180–183
as health determinant, 186, 187f,
195, 195f, 196
moving beyond, 190
vs. race, 180–181
vs. social class, 153
Europe. See European Union (EU)
European Medicines Agency, 92
European Union (EU), 42. See also
individual countries
and brain drain model, 51–52
disability in, 109, 114
and globalization, 42
increasing use of non-prescription
drugs, 68
migration offsetting birth rates, 54
percentage of older population,
204–206
telemedicine in, 279
evasion, as disclosure strategy, 128
Evetts, J., 329
evidence-based guidelines, 94
‘Expert Patient’ programme, 102
exploitation, 236b
externalities, regulating, 308

F
Facebook, 285. See also social media
Faculty of Public Health, 343
failures of competition, regulating, 307
‘failure to rescue,’ 362
fast food, 33, 43
Featherstone, M., 217
fee-for-service payment mechanism,
305
feminism, 162, 174
‘feminization of poverty,’ 163
Feyerabend, P., 245
Field, C., 34
Field, M., 298
financial protection, as performance
criteria, 380, 386
financing, 297, 298f, 382. See also
health care systems
affected by economic crises, 315
based on quality-adjusted life years,
360
as cause for performance evaluation,
377–378
generated by governance, 300
by high-income countries, 313–314,
314t
and payment mechanisms, 305–307
as principal health care service
activity, 302–304
vs. productivity, 387
sources of, 302–303
Finland, 151. See also European Union
(EU)
Fitbit, 268
fitness, 258
Fitzpatrick, Ray, 3–20, 359–373,
377–395
‘Flags of Convenience,’ 49
flexibility, in shared decision-making,
85
flexible employment, 30
fluoridation of water, 352
folk sector, 71
‘food deserts,’ 353
Foss, C., 33
Foster, D., 170
Foucault, Michel, 258
and the ‘clinical gaze,’ 248–249, 267
construction of medical knowledge,
101, 248–249
public health as surveillance,
354–355
sexuality as construct, 269
sociology of the body via, 249, 265
fourth age theory, 219–220
Fox, Nick J., 263–275
frailty, 219–220
France. See also European Union (EU)
avoidable death in, 361, 361b
disability rates, 206
doctor-patient relationships, 89, 90t
health care financing, 313–314,
314t
health care system, 255, 301, 313
patient experiences, 372
World Health Report rating, 392
Freidson, E., 66, 228
Frenk, J., 298–299, 299f, 312
Frey, R.S., 34
Friedson, E., 322, 330
Frisina, L., 311
Frohlich, K., 13

G
G8, 42
Galen, 246, 249
Galileo, 245
Gastaldo, D., 355
gender, 16, 161–176. See also men;
  women
  and ageing, 210, 212–213, 214–215
  cardiovascular disease and, 29–30
  and caregiving, 107
  construction of, 162, 173–174,
    266, 269
  contextualizing, 162–164
  in doctor-patient relationships, 91
  and domestic violence, 171
  embodiment of, 265
  harassment impacting health, 164
  and health care systems, 67
  and life expectancy, 164–168, 165t,
    166f, 167f, 186, 187t
  medicalization of childbirth,
    169–171
  and migration, 54–55
  morbidity by, 168–169
  perceptions of health by, 62–63
  and self-care regimens, 69, 281–282
  and self-reporting, 168–169
  shifting norms of, 162–163
  and social class, 143, 144, 144t
  and suicide, 167
  toxicology studies, 163
General Household Survey, 207, 210
General Medical Council (GMC), 257,
  323, 325, 327
general practitioners (GPs). See doctors
general susceptibility theory, 25–26
 genetic differences, 180, 188–189
geographic location
  and doctor-patient relationships,
    88–91, 90t
  and health inequalities, 69, 144
  health policy shaped by, 41–42
  and HIV treatments, 26
  life expectancy by, 122–123, 123t
Gerhard, U., 227–228
geriatric hospitals, 209
germs theory, 24, 244
Germany. See also European Union
  (EU)
avoidable deaths, 361, 361b
disability rates, 206
doctor-patient relationships, 89, 90t,
  372, 384–385
health care financing, 313–314,
  314t
health care system, 294, 301, 306,
  309, 313, 388
home remedy acceptance, 70
hospitals, 305
and medical tourism, 53
percentage of older population, 206
Ghana, 43
Giddens, A., 252
Gilleard, C., 217–219
Gilmore, A., 351
Glaser, B., 127, 133, 135–136
Global Burden of Disease Study, 12, 13b, 363
Global Health, 43–45
pathways for, 44f
global health inequalities, 15–16, 45–46
global markets for health care, 52–53
global warming, 46–47
globalization, 39–41. See also
capitalism; economic conditions; financing;
neoliberalism
of biomedicine, 42–43
of communication, 42–43
creating ‘deprofessionalization,’ 329
diabetes caused by, 43
and ebola, 48
encouraging migration, 43
exacerbating health inequality, 45–46, 150–151
and food consumption, 33, 43
of health care, 33, 39–55, 299
health care workers in, 50–52
and income inequality, 40–41, 183
and infectious disease, 44, 47–49
obesity caused by, 43
and pharmaceutical prices, 44
processes of, 40–43
and public health, 347, 355–356
seafarers as case study, 49–50
and welfare states, 256
Goffman, E., 231, 232, 250–251
Goffman, I., 100
Google searches, 283, 284. See also
internet
Goraya, A., 152
Gorer, G., 135
Gorsky, M., 295, 296, 301
Gove, W., 230
governance. See also health care systems
analysis of, 300
definition of, 323–325, 324b
financing generated by, 300
in health care systems, 299–300, 299f
of health professions, 323
history of, 325–328
as measurement objective, 379–380
in public health, 354–355
‘govermentality,’ 258
governments, 295, 314–315, 390
GPs. See doctors
Granados, J., 17
Gray, A., 323–324
Gray, D., 233
Great Depression, 17
Greece, 17, 315. See also European Union (EU)
Green, Judith, 39–55, 341–356, 349
Gregson, S., 31
Guinea, 48

H
Hampshire, K., 43
handicap, definition of, 110
handwashing, 12
harassment, 164, 190–191
Haug, M., 329
healing, 42–43, 71
vs. indigenous systems, 66–67
health, 6, 61–63. See also health care;
health care policy; health care systems;
health inequalities; health outcomes;
health promotions; illness; medicine;
public health
and ageing populations, 20, 203–220
assemblages of, 273–274
health (cont.)

asset flows impacting, 152
attaching values to, 368–369, 369
bodily construction of, 250–251
as commodity, 53, 62, 257–258, 294
components of stigmatization, 236–238, 237
and conceptualizing disability, 112–113, 112
conditions influencing, 3–20
as criteria for performance, 380–383
determinants of, 195–196, 195, 343–344
empowerment as key to, 349–350
of ethnic groups, 185–198, 195
Foucauldian perspective on, 267–269
and gender, 161–176, 172
global economy influencing, 17–18, 33, 39–55, 155
and ‘govermentality,’ 258
instruments for measuring, 365–367, 366, 367
and life expectancy, 164–165, 165
and migration, 53–55, 191
normality vs. abnormality, 100–101, 227
occupational, 17–19, 28–29, 163–164
politics of, 255–256
rationalized into systems, 295–296
social determinants of, 23–35
socioeconomic status influencing, 14–15, 19, 146–148, 150
threatened by climate change, 46–47
traveling for, 52–53
utilities of, 368–369, 369
‘health-adjusted life expectancy’ (HALE), 362–363
health behavior, 61–72
health beliefs, 62–65
health care. See also doctors; financing;
health care policy; health care systems; health inequalities;
health outcomes; health
professions; patients; public
health; treatments
accessibility of, 384
adverse consequences of, 367–368
affected by payment mechanisms, 306–307
collaborations in, 331–333
and digital technology, 277–288
feasibility of, 379
in global economies, 52–55, 256
misuse of, 378
production and consumption of, 294, 387
randomized control trials (RCT) for, 378–379
relevance to health needs, 385
spending on, 293, 394–395, 394
structural impediments to, 67
technological vs. interpersonal, 370–371
health care managers, 314–315
health care policy
ageing populations influencing, 219–220, 315–316
economic influences, 41–42, 151, 152
and empowerment, 350, 350
and geographic location, 42
goals of, 153, 154
influencing trust, 94
in modern society, 17–19
patients engaging with, 92–93
and power, 255–257
and self-management, 101–103
and structured dependency theory, 214–216
upstream vs downstream, 351–352, 356
health care sectors, 71
health care systems, 293–317. See also
doctors; financing; health
care; health care policy; health
inequalities; health outcomes;
Index

health professions; health promotions; patients; public health
ageing populations using, 67, 209–210, 219–220
balancing criteria, 392–395, 393f, 394b
building blocks of, 296–297, 297f
composite measures of, 392–394, 393f
criteria for evaluation, 380–388
cultural competence for, 197–198
defined, 66–72, 294–295
development of, 68–71, 294–296, 300–301
digital technology in, 67, 277–280, 284
economics influencing, 94, 255–256, 293, 299
entitlement in, 303–304
evaluating treatments, 368–369, 369t
financing of, 297, 298f, 302–303, 312–314, 314t, 394
frameworks for, 296–300, 297f, 298f, 299f
and gender, 67
history of, 300–302
innovations impacting, 377–378
‘logics’ of, 310–311
measurement objectives, 379–380
patient-reported outcome measures (PROMs) for, 381–382
performance of, 377–395
principal activities of, 302–310
in public health, 342–343, 342f
reasons for assessing, 377–379
risk assessment in, 378
self-treatment in, 67
services covered by, 295, 302–303, 372
shared decision-making in, 84–88
as social control, 296
social structure supporting, 254–255
‘structured pluralism’ in, 312
task-shifting in, 335–336
trends of, 312–317, 314t
trust in, 93–95
types of, 67, 70–71, 310–313, 311t, 334–335
health care workers. See also doctors; health professions
and brain drain model, 51–52
communication by, 126, 128, 287, 384–385
and digital technology, 278–280, 285–287
globalization of, 50–52
in health care system framework, 298–299, 299f
hybrid roles of, 328–329
increasing expectations of, 251–252
and integrated care pathways (ICPs), 332–333
and patients’ emotions, 266
payment mechanisms for, 305–307
stereotyping by, 229
underestimating symptoms, 129
Health Direct, 283
health education, 238–239, 347–349, 348t
health inequalities. See also health care; health care policy; health care systems; health outcomes; illness; patients
comprehensive model for, 149
difficulties evaluating, 388
ethnic groups facing, 179, 191–192
and geographic location, 144
and globalization, 15–16, 150–151
historical record of, 142
and life expectancy, 122–123
models and explanations for, 145–149
reducing in systems, 388
and social class, 141–156
health inequalities (cont.)
sociological theories of, 150–152
tackling, 152–156, 154
health information websites, 282–284
‘healthism,’ 248
health outcomes, 359–373. See also
health; health care; health care policy; health care systems;
health inequalities; health promotions; public health; treatments
and changing health services, 372–373
death as, 360–363, 361
health-adjusted life expectancy as, 362–363
history of, 359
instruments for, 365–367, 366b, 367b
meso-level assessments, 390–391
patients’ feedback for, 370–372
and quality of life, 363–370, 364t, 366b, 367b, 369t, 370b
satisfaction vs. experience, 372
side effects as, 367–368
health professions, 319–336. See also
doctors; health care systems; health care workers
changing role of, 319, 321–323, 328–331
and ‘clinical autonomy,’ 322
‘credentials’ of, 322–323
defining, 320–323, 327
global developments for, 333–336
improving productivity, 387
‘logics’ of, 322
and managerialism, 327–328
‘new professionalism’ of, 328–331
‘social closure’ strategies of, 321–322
systems of governance, 323–328, 324b
traditional healing as, 334
health promotions, 341–356, 348t. See also health care policy;
immunization; interventions; public health; vaccination

community participation in, 349–350
defined, 341
and empowerment, 349–350, 354
governance in, 354–355
vs. health education, 347–349, 348
‘Heartbeat Wales’ example, 349
importance of information, 348–349
participation in, 349–350, 351–352
‘prevention paradox’ of, 349
sociological critiques of, 352–356
stigmatization and, 353–354
surveillance in, 354–355
and trust, 349
vaccination as, 348–349
health status, 363–370, 364t, 366b, 367b, 369t, 370b
healthism, 353–354
‘Heartbeat Wales,’ 349
heart disease, 4, 6. See also cardiovascular disease; hypertensive heart disease; ischaemic heart disease
health promotions for, 349
patient-centred care for, 81
stages of dying from, 129, 130b
help-seeking practices, 65–66
Hepworth, M., 217
Heredia, N., 313
heroin addiction, 253
Herring, J., 122
hierarchical regulation, 309, 309t
hierarchies, 27–28, 310
Higgs, Paul, 217–219, 243–259
high blood pressure, 12, 13b, 281
high body mass index as risk factor, 12, 13b
high fasting plasma glucose as risk factor, 13b
high-income countries. See also income inequality; low-income countries
changing focus of health care, 25, 304–305, 346
health care financing, 293, 301, 305, 312–315, 314t
income inequality in, 33
increasing health coverage, 88, 346–347, 361
life expectancy in, 45f, 171, 172f
migration to, 51, 54
Hinduism, 122
Hinton, J., 127–128, 132
HIV/AIDS. See also diseases; epidemics; outbreaks
as cause of death, 123, 172f, 173
lived experience of, 103
as Millennium Development Goal, 355
prevention via community groups, 31
risk environment for, 239
spread of, 26, 47–48
as stigmatizing condition, 229, 232–235, 237–239
value of NPCs in treating, 335–336
Hobson-West, P., 349
Hochschild, A., 266
holistic approaches, 131, 273
home births, 170
home blood pressure monitors, 69
home deaths, 129–131, 386
homeopathy, 70
Hopkins, A., 233
Horton, R., 194
hospices, 131–132
hospital births, 170
hospital deaths, 130–131, 361–362, 386
‘hospital medicine,’ 78–79
hospitals, 246–247. See also doctors; health care; health care systems; health care workers; medicine; treatments
ageing populations using, 209–210, 219
‘failure to rescue,’ 362
in health care systems, 304–305
improving productivity of, 387
institutional racism in, 182
medicalizing bodies, 267
waiting-time targets for, 384
‘weekend effect’ in, 362
household air pollution as risk factor, 12, 13b
housing, 9, 10b, 15
and health care systems, 298–299, 299f
as health determinant, 26, 195f, 196
and ‘inverse housing law,’ 149
in material explanations of health, 146, 147
in public health systems, 342, 342f
Howarth, G., 126, 131
Hunter, D.J., 342
hybrid health care systems, 312–313
hygiene, 345
hypertension, 64–65, 368, 369
hypertensive heart disease. See also cardiovascular disease; heart disease; ischaemic heart disease
as cause of death, 123, 361
women’s cause of death, 172f
hysterectomies, 88
iatrogenesis, 105, 252–253
Illich, I., 252
illness, 61–72. See also disability; diseases; health; health care systems; long-term conditions; morbidities; treatments
and ageing populations, 206–207
assemblage approach to, 272–274
construction of, 101, 228–229, 250–251
as deviance, 100–101
as ‘double jeopardy,’ 258
and embodiment, 264, 272–274
ethnicity as factor, 195–196, 195f
illness (cont.)
Foucauldian perspective on, 267–269
and help-seeking practices, 65–66
and health care systems
performance, 382
lay perceptions of, 63–64
and materialism, 272–274
online data sets, 286
patients evaluating, 368–369, 369t
as ‘personal tragedy,’ 232–235
in popular sector, 68–70
producing capacities, 273
in professional sector, 70–71
secondary deviation in, 229–230
shaping health education, 347–348
social and cultural norms, 227–228,
231
stigmatization of, 236–239, 237b
worse than death, 368, 369t
illness stories, 63
immigrants. See also cultures; ethnic
groups; ethnicity; migration;
race; See also individual
countries
access to health care, 194
demographics of, 184–185, 184f
health of, 18
life course of, 191
immunity, genetic, 8
immunization. See also health
promotions; vaccination
as health promotion, 348
and mortality rates, 11
socioeconomic factors in, 147
impairment, 110, 111, 116
income inequality, 19. See also health
inequalities; social class;
socioeconomic status (SES)
and diminished health, 33, 150
and ethnic health patterns, 189–190,
190f
exacerbated by neoliberalism,
45–46, 150, 151
and gender, 163, 173, 212
and globalization, 183
overreliance on, in models, 26–27
and premature mortality, 33
psychosocial effects of, 28
and structured dependency theory,
214
incomplete markets, regulating, 307
India
Ayurveda in, 42
health of immigrants from, 187f,
188f, 190f
HIV/AIDS stigma in, 235
hypertension in, 29–30
immigrant populations in United
Kingdom, 184–185, 184f
medical pluralism in, 67
and medical tourism, 53
migration from, 54
self-reporting by immigrants, 186,
188, 188f
indigenous healing, 66–67, 71
Indonesia, 315
infant mortality, 4, 34, 123, 204, 360.
See also childbirth; death and
dying; mortality
infectious diseases, 5, 7–9, 8b, 11
in dying trajectories, 123
epidemiological triangle of, 24–25
and globalization, 44, 47–49
and migration, 54–55
paternalist model for, 89
and social policy, 254
influenza, 5–6, 11, 11f
information asymmetries in health care,
307, 308
infrastructure, and help-seeking
practices, 66
insecurity as ‘neoliberal epidemic,’
152
Instagram, 285. See also social media
Institute for Fiscal Studies (IFS), 211
Institute of Medicine, 192, 378
institutional care, 219
institutionalized racism, 182, 192–194
Integrated Care Pathways (ICP), 332–333
intelligence, and health inequality, 148
Intensive Care National Audit and Research Centre (ICNARC), 390
‘intentional’ non-adherence, 86
International Classification of Functioning and Health (ICF), 112–113, 112f
‘International Classification of Impairment, Disability, and Handicap,’ 109–110
International Conference on Health Promotion, 350
International Labour Office Standard Classification of Occupations (ISCO-08), 320–321
International Monetary Fund (IMF), 40, 42
internet. See also digital technologies; social media
accessing medical information, 93, 282–284
and health care systems, 67
performance data via, 379
self-treatment via, 68
interventions, 13–14, 13b. See also health promotions; public health; treatments
for ageing populations, 20
cascading, in pregnancy, 170
ethnicity as factor, 195–196, 195f
evaluating, 80, 368–369, 369t
and health beliefs, 63
for long-term conditions, 105–106
in low-income countries, 91
for obesity, 16
randomized control trials (RCT) for, 378–379
with shared decision-making, 85, 88
in surveillance medicine model, 248
and web of causation model, 25
‘inverse housing law,’ 149
‘invisible hand’ version of events, 9, 10b, 18
Ireland, 187ff, 285. See also England; European Union (EU);
National Health Service (NHS); Scotland; United Kingdom; Wales
Irigay, L., 174
Irwin, A., 149
ischaemic heart disease. See also cardiovascular disease; heart disease; hypertensive heart disease
as cause of death, 123
and evaluating health care systems, 382
incidents by gender, 165, 166ff, 172ff
patient-centred care for, 81
Islamic Republic of Iran, 54
Italy. See also European Union (EU)
avoidable death in, 361b
disability rates in, 206
health spending post-crisis, 315
World Health Report rating, 392
Jacquet, J., 237, 237b
Jamaica, 193
Japan, 360
Jewson, N.D., 79, 245–248
Jha, P., 351
‘job-strain’ model of illness, 18–19
Jobling, R., 105
Johnson, S.E., 51–52
Kahn, R.C., 216
‘Kaiser’ model of care, 102
Kamerman, J., 135
Karnofsky Performance Index, 363–364, 364t
Keikelame, M.J., 63
Kelly, Moira, 179–198
Kennedy Inquiry, 326
Kessner, D., 383
Kickbusch, I., 350
kidney disease, 92, 106
Kivimäki, M., 18–19
Kleinman, A., 65, 68, 71, 72, 266
knowledge, in Foucauldian thought, 267–269
Koch, Robert, 24
Koku, E, 235
Kubler-Ross, E., 129
Kuhn, Thomas, 244–245

Labonté, Ronald, 41, 46, 355–356
laboratory medicine, 79, 247
Laennec, Rene, 247
Lalonde Report, 346
Landes, D., 151
Larkin, Philip, 213
Laslett, P., 216–217, 219
latency life course model, 32
later life. See ageing populations
Latin America, 312–313
Latvia, 206, 361b. See also European Union (EU)
Lavin, B., 329
Lawrence, Stephen, 182
Lawton, J., 63, 131–132
lay people, 61–67. See also patients; public
lay referral system, 66
Leach, M., 48
Lebanon, 54
Lees, S., 197
Legido-Quigley, H., 53
leprosy, 229, 232, 238–239
LGBT health, 175–176
LGBT Foundation, 176
Liberia, 48
life course
approach to health inequality, 149
of ethnic groups, 191
models, 31–32
'postmodernization of,' 217
life expectancy, 3–4, 164–165, 165t.
See also death and dying; mortality
and asset flows, 152
changes in, 122–123, 123t, 124t
and employment, 142–145, 143t, 144t, 145t, 167–168
and gender, 164–165, 165t, 167–168, 171
and geographic location, 122–123, 123t
and health inequality, 122–123
as health outcome, 360, 362–363, 381–383
improvement in, 5–6, 204
medicine influencing, 10–11
and quality of life, 207, 362–363
'rectangularisation of the survival curve,' 204
and socio-economic status, 18, 45–46, 45f, 156
'lifestyle drift,' 147
lifestyles. See also health promotions; interventions; public health
of ageing populations, 217
and fast food, 33
and health inequality, 147
patient-centred care changing, 81
and public health, 346–347, 346f
in public health interventions, 13–14, 14b
vs. social determinants, 33–34
Link, B., 14, 146, 153, 236–237
literacy, and shared decision-making, 91
Lithuania, 361b. See also European Union (EU)
Little, P., 67
'lived body' in narrative reconstruction, 266
lived experience of disability, 103–107
Local Government Association, 69
location. See geographic location
Lofland, L., 123, 124t
‘logics,’ 310–311, 322
Londoño, J.-L., 312
Loneliness of the Dying, The, 131
Long Term Conditions Questionnaire (LTCQ), 366–367, 367b
long-term care, 88–91, 90t, 295
long-term conditions, 99–116. See also
disability; illness
‘biographical disruption’ of, 106–107
and biomedical concerns, 105–106
creating ‘second class citizens,’ 100–101
digital technology for, 281
definition of, 100
and health care system performance, 381
lived experience of, 103–107, 369
modern significance of, 99–100
moving forward with, 115–116
and ‘narrative reconstruction,’ 106–107
patient-centred care for, 81
as ‘personal tragedy,’ 232–235
producing ‘expert patients,’ 102
self-management of, 101–103
social support for, 30–31, 31f, 107
sociological approaches to, 100–101
and stigmatization, 106
low fruit consumption, as health risk, 13b
low-income countries, 12. See also
health inequalities; high-income countries; income inequality
access to health care, 69, 255, 385
brain drain model, 51–52
doctor-patient relationships in, 82, 89
impact of climate change, 46–47
impact of neoliberalism, 40–41
innovations in health
professionalism, 319
interventions for, 91
mitigating financial risks, 386
patient-centred care (PCC), 91
self-treatment in, 69
smoking, 351
task-shifting, 335–336
traditional and complementary medicine (T&CM), 333–335
women’s health in, 171, 172f
lower respiratory infections, 123, 172f
lung disease. See also cancer; diseases
as cause of death, 123, 166, 172f, 360
in ethnic groups, 186
patient-centred care for, 81
and smoking interventions, 351
Lunt, N., 53
Lupton, Deborah, 170–171, 277–288, 353
Luxembourg, 315
Macdonald, S., 64
Macpherson Report, 182
macro-level performance assessment, 389, 391–392
Mainous, A.G., 68
Mair, M., 352
malaria, 34
in agricultural period, 5
as Millennium Development Goal, 355
treatment strategies for, 72
women’s cause of death, 172f
Malawi, 43
Malaysia, 62–63, 333
malnutrition, 12, 13b, 172f
‘managed pregnancy,’ 170
managerialism, 327–328
Mankoff, M., 230–231
‘manufactured uncertainty,’ 252
marginalization, 236b
marijuana, 228
market, as health care ‘logic,’ 310
Marmot Review, 147–148, 153, 155
Marmot, M., 27–28, 146, 148
Marsden, D., 266
Marshall, I.H., 64
Marxist theory, 215, 255–256
masculinity. See men
‘mask of ageing,’ 217
massage, 71
mastectomies, 84
material approach to health inequality, 147–148
materialism, 270–274
maternal health, 172f, 173, 355, 360
Mathieson, C.M., 101
Mayo Clinic, 283
Mays, Nicholas, 293–317, 377–395
McKeown, Thomas, 9, 10, 26, 254, 382
McKinlay, J., 329
McMichael, A.J., 46
measles, mumps, and rubella (MMR) vaccine, 252, 348–349
Médecins Sans Frontières, 42
medical knowledge, 248–251, 277
medical model of disability, 109–110
medical pluralism, 67
medical records, 93, 287
Medical Register, 325
Medical Research Council (MRC), 31–32
medical sociology. See also sociology as ‘frontier specialism,’ 23
and disease models, 24–27
importance of context in, 29–30
and life course models, 31–32
and self-management, 33–34
social and psychological factors in, 27–29
medical tourism, 52–53
medicalization, 251–254
of bodies, 267
and brain drain model, 51–52
of childbirth, 169–171, 251
of mental illness, 253–254
of sexuality, 269
of sociology, 107–108
medicine. See also doctors; health; health care; health care systems; public health
access, by geographic location, 69
‘aspirational,’ 252
as commodity, 68–69, 228, 258
creating ‘sick roles,’ 228
doctors controlling, 82–83
effect of algorithms on, 284
erosion of dominance, 319
history of, 10–11, 243–244
and iatrogenesis, 252–253
importance of social contexts, 244
Jewson’s history of, 245–248
masking stigma, 251
patients disappearing from, 245–248
in popular sector, 68–70
role of, 101–103
shifting boundaries of knowledge, 243–259
as social control, 251–254
and social policy, 254–258
and technology, 278, 330, 377–378
men. See also gender; women
and ageing, 212–213
domestic violence by, 171
causes of death, 165–167, 166f, 351
emotional responses of, 266
employment affecting, 167–168
as gender norm, 173–174
health gap in, 175
life expectancy of, 164–165, 165t
morbidity of, 168–169
suicide rates of, 167
men’s studies, 175
mental health social workers, 332
mental illness. See also dementia; depression
Index 421

caused by labelling, 230
collaborations among professionals, 332
in ethnic groups, 192–194
Foucauldian perspective on, 267–269
as secondary deviation, 230
and social control, 253–254
stigmatization of, 229, 232

Merleau-Ponty, M., 265–266
Merton, R., 246
meso-level performance assessment, 389, 390–391
Messing, K., 163
Mexico, 54
micro-level performance assessment, 389
Micronesia, 121
midwives, 170, 320
migration, 43, 183. See also cultures; ethnic groups; immigrants
access to health care, 194
of ageing populations, 53–54, 206
and brain drain model, 51–52
and ethnic diversity, 181, 183
health impacts of, 53–55, 191
between high-income countries, 51
in life course of ethnic groups, 191
and mental health risk, 193
as ‘professionalising project,’ 52
‘migration crisis,’ 194
Millennium Development Goals, 355
mind-body dualism, 247–248
Mishler, E.G., 82
Mishra, R., 256
mobile technologies, as ‘therapeutic tools,’ 43
modern death, 125–126, 126t
modern industrial disease patterns, 5–6
Monaco, 360
Monaghan, L., 62
monitoring technology, 277, 286
morbidity. See also diseases; illness
‘compression of,’ 219
among ethnic groups, 186, 188, 188f
and gender, 168–169
in Scotland, 20
and social class, 142–145, 144t, 145t
Morden, A., 33
Morgan, Myfanwy, 65, 77–95
mortality. See also death and dying; life expectancy
avoidable, 360–361, 361b
in ethnic groups, 185–186, 187t
gender differences in, 165–168, 166f, 167f, 171
and health care system performance, 381–383
as health outcome, 360–363, 361b
from smoking, 351
and social class, 142–145, 144t, 145t
motor neurone disease, 103, 229
mourning, 134–135. See also bereavement; death and dying
Mulkay, M., 132–133
‘multiple pathology’ of aged, 208
multiple sclerosis, 103, 229
Musculoskeletal Health Questionnaire (MSK-HQ), 365–366, 366b
mutual pretence awareness of dying, 127–129, 127t
Mwacalimba, K.K., 48

N
‘narrative disruption,’ 232
narrative reconstruction, 106–107, 266
nation vs. patients, 327–328
National Health Service (NHS)
collaborative teams in, 331–332
data via My NHS, 389
development of, 255, 294
doctos’ evolving role in, 325–328
financing of, 203, 312, 316
governance frameworks of, 309, 324–325, 327–328, 395

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Index

National Health Service (cont.)
  as hybrid system, 310
  inequalities of care in, 192
  managing productivity in, 387
  vs. national medical service, 327–328
  waiting-time targets for, 384
  ‘weekend effect’ in, 362
National Health Service and Community Care Act, 330
National Health Service Improvement Plan, 102
National Institute for Health and Care Excellence (NICE), 92–93, 170, 324b, 330, 395
National Joint Registry, 379
national protectionism, 183
National Service Frameworks (NSFs), 333
National Statistics Socio-economic Classification (NS-SEC), 143–145, 143t, 145t
Navarro, V., 153
Nazroo, James, 179–198
‘neoliberal epidemics,’ 41, 152
neoliberalism. See also austerity;
capitalism; economic conditions; financing;
globalization
  and employment, 44
  exacerbating inequality, 45–46, 150
  frustrating health reform, 155
  global health impacts of, 40–41
  and public health, 355
  weaponizing stigma, 238
nervous tics, 232
Netherlands. See also European Union (EU)
  disability rates in, 206
  doctor-patient relationships in, 90t
  equity in care in, 388
  health care financing in, 313–314,
  314t
  patient experiences in, 372
  payment mechanisms in, 306
  reducing health expenditures, 256
  Nettleton, S., 101, 248, 352
  new materialism. See materialism
  New Orleans, 4
  ‘new professionalism,’ 328–331
  ‘New Public Health,’ 346–347
New Zealand
  avoidable deaths, 361
  doctor-patient relationships, 90t, 372
  equity in care, 388
  gendered health, 169
  health governance, 327
  reducing health expenditures, 256
  regulatory instruments, 328
  ‘structured pluralism,’ 312–313
  non-adherence, 86, 87
  non-communicable diseases, 99–100
  non-physician clinician (NPC), 329, 335–336
  normality, 227, 253
Norway. See also European Union (EU)
  doctor-patient relationships in, 88–89, 90t
  patient experiences in, 372
  social democracy and health, 151
  nurse practitioner (NP), 329
  nurses, 50–52. See also doctors;
  health care workers; health professions
  nursing homes, 209, 219, 295
  nutrition
    and disease resistance, 8–9, 8b
    as health risk, 12, 13b, 172f

Oakley, A., 169
Obamacare, 255–256, 302, 384
obesity, 14, 16, 249
  globalization as cause, 43
  as ‘neoliberal epidemic,’ 152
  as public health issue, 347
  and stigmatizing strategies, 353–354
Index

in surveillance medicine, 248
'obesogenic' environments, 343–344
occupational health, 28, 163–164
Occupy Movement, 151
oesophagus cancer, 351. See also cancer
oestrogen as problem, 174
Office of National Statistics, 114, 212
old people's homes, 209
old-age dependency radio (OADR), 204–205
Oliver, M., 108–109, 111, 235
On the conduct of anatomy, 246
open awareness of dying, 127–129, 127t
oppression, types of, 235–236, 236b
‘oppression paradigm,’ 235
Organisation for Economic
Co-operation and
Development (OECD), 293, 312, 316, 391–392
organs, 134, 264
orthopaedic surgery, 52
osteopathy, 70
Ottawa Charter for Health Promotion, 350, 350t
Oudshoorn, N., 280
out-of-pocket payments, 303
outbreaks, 47–49. See also diseases; epidemics
outcomes. See health outcomes
ovarian cancer, 171–172. See also cancer
over-the-counter (OTC) medicine, 69
Overveen, E., 150

P
Pakistan
health, and economic status, 190f
immigrant populations in United
Kingdom, 184–185, 184f, 187f, 188f
self reporting by, 186, 188, 188f
pancreatic cancer, 360. See also cancer
Papadopoulos, I., 197
paracetamol, 68
Parent Advisory Groups (PAGs), 93
Parker, R., 237
Parkinson's disease
and biomedical concerns, 105
lived experience of, 103
measuring quality of life with, 366–367, 367b
Parsons, Talcott, 82, 227, 296, 321
partnership model, 83–84
Pasteur, Louis, 24
paternalist model, 81t, 82–83
patient decision aids, 86
patient experience, 384–385
Patient Opinion, 285
patient platforms selling data, 287
patient-centred care (PCC), 79–81, 80b, 91, 94–95
patient-doctor relationships. See doctor-patient relationships
patient-reported outcome measures (PROMs), 381–382
patient-supported platforms, 284–286
patients. See also doctor-patient relationships; health care; health care systems; health inequalities; health outcomes; health promotions; illness; public; treatments
accessibility of health care, 384
accessing medical information, 93, 282–284, 372, 389
agenda ideas of, 82–83
in bedside medicine, 246
characteristics determining treatment, 385
communication with health care workers, 126, 266, 280, 379–380, 384–385
concordance with doctors, 64
as consumers, 81, 83, 257–258, 329
decision-making by, 82, 86, 88
patients (cont.)
digital technology affecting, 278, 285, 287–288
disappearing from medicine, 245–248
doctors’ power over, 326
dying, awareness of, 127–129, 127t, 130, 133
empowerment of, 101–103, 281
engaging with medical information, 92–93, 285, 287, 329
ethnic groups as, 182
evaluating health care, 368–369, 369t, 373, 381–382
experiences of, 103–107, 265, 370–372
expertise, via chronic illness, 102
fourth age, 219–220
in health care system framework, 298–299, 299f
help-seeking practices, 65–66
HIV/AIDS, 233–234
in hospital medicine, 246–247
and iatrogenesis, 252–253
importance of continuity, 371
involvement in care, 80–81
measuring quality of life, 365–367, 366b, 367b
mitigating financial risks, 386
vs. nation in allocating resources, 327–328
perceptions of health, 61–67
pregnant women as, 170
role in governance framework, 323–324
and self-care technologies, 280–282
selling health data of, 287
patients’ rights, 80
PatientsLikeMe, 284–285
patriarchy, 174
payment mechanisms, 305–307
Peel Report, 170
peptic ulcers, 351
‘permanent vegetative state’ (PVG), 122
‘personal tragedy’ model, 232–235
person-centered approach, 79–81.
See also patient-centred care (PCC)
Personal Social Services Research Unit, 209
Petersen, A., 53
‘phallocentric logic,’ 174
pharmaceuticals. See also drugs; treatments
aged as ‘poly-pharmacy,’ 210
commercialization of, 258
impacting health care systems, 377–378
increase in non-prescription, 68
online advertising of, 283, 286
prices in global marketplace, 44
Phelan, J., 14, 146, 153, 236–237
physician assistant (PA), 329
Pinder, R., 105
Pinterest, 285. See also social media
plague, 5, 47
Plato, 264–265
pneumonia, 5, 11, 11f
Poland, 351
polio, 11
Popay, J., 147
popular sector of health care, 68–70
populations, susceptibility of, 25–26
Portugal, 17, 169, 315. See also European Union (EU)
postcolonial theory, 183
postmodern death, 125–126, 126t
poverty. See also economic conditions;
income inequality; social class; socioeconomic status (SES)
as ‘double jeopardy,’ 258
access to health care, 255
and disability, 99, 113, 114
and globalization, 45, 46, 155
illness causing, 384
in structured dependency theory, 214, 215
and women’s health, 163, 173, 212
power
  and bodies, 267–269
  and health care policy, 255–256
  and medical knowledge, 250
  and stigmatization, 236
powerlessness, 236b
pragmatic type of coping, 232–233
pre-agricultural disease patterns, 4
  'prebereavement mourning,’ 134–135
precarious employment, 19
pregnancy, medicalization of, 169–171.
  See also childbirth; women
premature mortality, 17–18, 33. See also
dead and dying; mortality
  See also drugs; pharmaceuticals;
treatments
preterm birth complications, 172f
prevention, 147, 347–348, 348t
  'prevention paradox,’ 349
primary care, 86–87, 192
Prins, S.J., 29, 30
private insurance, 295, 303, 310
private sector treatment, 69
privately owned provision, 305
privately-owned providers, 316
privatization, 155, 256
process indicators for performance, 382
processed food, 16, 43
‘productive ageing’ approach, 216
productivity as performance criteria,
  380, 386–387
professional practice in health care,
  319–336
professional sector of health care,
  70–71
Professional Standards Authority for
  Health and Social Care, 71
professionalism
  managerialism approach to, 328
  occupational vs. organizational,
    331–333
  traits of, 320–321
  'proportionate universalism,’ 153
prostate cancer, 166. See also cancer
prostatectomy, 88
protein-energy malnutrition, 172f
Protestant Reformation, 246
provision, 304–305, 316
psoriasis, 103, 105–106, 229
psychiatry
  controlling deviancy, 254
  controlling sexuality, 269
  institutionalized racism in, 193
psychosocial approach to health
ingquality, 148
psychosocial models, 27–28
psychotic illness among Black
  Caribbeans, 192–194
public. See also lay people; patients
  accessing medical information, 248,
    277, 282–284, 285, 287
demanding accountability, 377–378,
  394
and drug licensing, 93
evaluations by, 373
importance of engagement, 92–93
paying health costs, 315
role in research and policy, 92–93
Public Appointments Commission, 327
public goods, health care as, 308
public health, 341–356. See also
diseases; epidemics; health care
  policy; health care systems;
  health outcomes; health
  promotions; interventions;
  medicine; outbreaks
biological vs. political concerns, 345
defined, 341
employment in, 342–343, 342f
empowering communities, 343
frameworks for, 355–356
functions of, 342–347, 343t, 346f
and globalization, 347, 355–356
governance in, 354–355
health care systems in, 342–343,
  342f
history of, 344–345
public health (cont.)
  intergovernmental collaborations, 343
  vs. ‘invisible hand,’ 9, 10b
  and lifestyles, 346–347, 346f
  ‘nudge’ approach in, 354
  ‘rainbow model’ of, 346, 346f
  as religion, 352–353
  resurgence in, 19, 346–347, 346f
  and risk assessment, 354–355
  social causes of, 346–347, 346f
  and social values, 351–352
  sociological critiques of, 352–356
  specific targets of, 344–346, 351
  stigmatization in, 353–354
  surveillance in, 354–355
  upstream vs. downstream focus,
  346–347
  victim blaming in, 353
  public health systems, 342–347, 342f,
  343t, 346f
  publicly-owned providers, 305, 316

Q
quality-adjusted life years, 360,
  369–370, 370b
quality of care, 306–307, 378
quality of life. See also quality-adjusted
  life years
  affected by side effects, 367–368
  challenges of data collection,
  381–382
  dimensions of, 364, 366b
  as health element, 62
  Karnofsky Performance Index to
  measure, 363–364, 364t
  and life expectancy, 362–363
  measuring, 363–370, 364t, 366b,
  367b, 369t, 370b
  patients’ judgment of, 363, 364
  Quality Outcomes Framework (QOF),
  324b
quasi-liberated type of coping, 233
quick dying, 123, 124t, 133

R
race, 153, 180–183, 190. See also
cultures; ethnic groups;
  ethnicity; immigrants
  racism, 182
  affecting clinical decision-making, 182
  assessments leading to, 181
  and decolonization, 183
  as harassment, 190–191
  institutional, 182
  and mental health risk, 193
  ‘rainbow model’ of public health, 346,
  346f
  randomized control trials (RCT),
  378–379
  ‘rationalization’ of mourning, 135
  rationing, 94, 394–395, 394b
  Reagan, Ronald, 40
  reconceptualizing bodies, 263–275
  rectal cancer, 103, 172f. See also cancer
  ‘rectangularisation of the survival
curve,’ 204
  Reeves, A., 17–18
  refugees, 54
  regulation, 309, 309t
  evolving role of state, 325–328
  of health care systems, 307–310,
  309t, 319
  vs. self-regulation, 319
  of traditional and complementary
  medicine (T&CM), 334
  reiki therapy, 71
  ‘relative income hypothesis’ of health
  inequality, 150
  relevance of care to health needs, 385
  religion
  death and dying in, 122, 125
  and perceptions of health, 62–63
  public health as, 352–353
  Report on the Regulation of Herbal
  Medicines and Practitioners, 70
  reproductive health, traveling for, 52–53
  research
  communication facilitating, 43
gender in, 174
International Classification of
Functioning and Health (ICF)
for, 112–113
patient data sold for, 287
patients engaging with, 92–93,
363
residential homes, 209
‘respectful curiosity,’ 197–198
respiratory disease, 186
responsiveness, as performance criteria,
380, 384–386
retirement, 210–212, 214–217
‘retirement migration,’ 53–54
‘revival of death,’ 125
Reynolds, N., 234
rheumatoid arthritis, 104
Rhodes, T., 237, 239
risk assessment
in childbirth, 170–171
global risk factors, 12–13, 13b
and health beliefs, 64
in health care systems, 378
and ‘manufactured uncertainty,’ 252
and public health, 354–355
shaping health education, 347–348
in surveillance medicine, 247–248
Robertson, S., 175
robotic technology, 278
Roemer, M.I., 298
Rogers, A., 30, 105
Rose, Nikolas, 248
Rothgang, H., 295, 309–310, 311
Rowe, J.W., 216
Royal Colleges, 390
Royal Pharmaceutical Society of Great
Britain, 87
Russia, 46, 47, 54
Ryan, A., 69

S
Said, Edward, 183
salary payment mechanism, 306
sanitation and public health, 344–345
Saving Lives: Our Healthier Nation, 153
Scambler, Annette, 161–176
Scambler, Graham, 116, 121–136,
141–156, 227–240
Scambler, Sasha, 99–116, 161–176
Scharf, T., 212
Scheff, T., 230
schizophrenia, 105, 238–239
Schneider, J., 232–233
Scholte, J.A., 42
Schrecker, T., 41, 152
science, paradigm shifts in, 244–245
Scoones, I., 48
Scotland, 4, 20. See also England;
European Union (EU);
Ireland; National Health
Service (NHS); United
Kingdom; Wales
Scott, R., 229
seafarers, 49–50
Seale, C., 124, 134
search engines, 282–284. See also
internet
secondary care, for ethnic groups, 192
secondary deviation, 229–230
secret type of coping, 233
self-awareness, managing bodies by, 268
self-care technologies, 280–282. See also
digital technologies
self-esteem, 106–107
self-management. See also
empowerment
digital technology for, 277
and health care policy, 101–103
and ‘Kaiser’ model, 102
role of, 101–103
and social conditions, 33–34
self-regulation, 309, 309t, 319
self-reporting
by ageing populations, 207
among ethnic groups, 186, 188, 188f
in bedside diagnoses, 78
and gender, 168–169
<table>
<thead>
<tr>
<th>Term</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>self-treatment</td>
<td>67–69, 284</td>
</tr>
<tr>
<td>Sen, Amartya</td>
<td>34</td>
</tr>
<tr>
<td>sensitive periods life course model</td>
<td>32</td>
</tr>
<tr>
<td>‘sentimental mood’ of hospital wards</td>
<td>133</td>
</tr>
<tr>
<td>separation, in stigma</td>
<td>236</td>
</tr>
<tr>
<td>sexual harrassment</td>
<td>164</td>
</tr>
<tr>
<td>sexuality</td>
<td>249, 269</td>
</tr>
<tr>
<td>‘sexual revolution’ and ageing</td>
<td>212–213</td>
</tr>
<tr>
<td>Seymour, ?</td>
<td>130–131</td>
</tr>
<tr>
<td>Shakespeare, T.</td>
<td>116</td>
</tr>
<tr>
<td>shared decision-making, 84–88</td>
<td></td>
</tr>
<tr>
<td>communication in, 85–86</td>
<td></td>
</tr>
<tr>
<td>and concordant approaches, 87</td>
<td></td>
</tr>
<tr>
<td>costs of, 88</td>
<td></td>
</tr>
<tr>
<td>culture change for, 85</td>
<td></td>
</tr>
<tr>
<td>in doctor-patient relationships,</td>
<td>83–84</td>
</tr>
<tr>
<td>for end-of-life, 128, 134</td>
<td></td>
</tr>
<tr>
<td>flexibility in, 85</td>
<td></td>
</tr>
<tr>
<td>internet searches aiding, 284</td>
<td></td>
</tr>
<tr>
<td>and intervention rates, 88</td>
<td></td>
</tr>
<tr>
<td>and literacy, 91</td>
<td></td>
</tr>
<tr>
<td>patient preference for, 88</td>
<td></td>
</tr>
<tr>
<td>as performance criteria, 384–385</td>
<td></td>
</tr>
<tr>
<td>in primary care, 86–87</td>
<td></td>
</tr>
<tr>
<td>process of, 84–86</td>
<td></td>
</tr>
<tr>
<td>rate of, by country, 88–91, 90t</td>
<td></td>
</tr>
<tr>
<td>treatment via, 84</td>
<td></td>
</tr>
<tr>
<td>Sherry, M.</td>
<td>116</td>
</tr>
<tr>
<td>Shilling, C.</td>
<td>249</td>
</tr>
<tr>
<td>Shipman, Harold</td>
<td>257, 326</td>
</tr>
<tr>
<td>Short-Form 36-Item (SF-36) Health Survey Questionnaire, 365</td>
<td></td>
</tr>
<tr>
<td>sickness funds</td>
<td>295</td>
</tr>
<tr>
<td>‘sick role’ vs. deviance</td>
<td>227–228</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>4, 48</td>
</tr>
<tr>
<td>Silverman, D.</td>
<td>102</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>169</td>
</tr>
<tr>
<td>slow dying</td>
<td>123, 124t, 133</td>
</tr>
<tr>
<td>smallpox</td>
<td>47, 254</td>
</tr>
<tr>
<td>smartphones. See also digital technologies</td>
<td></td>
</tr>
<tr>
<td>in health care systems, 277, 278</td>
<td></td>
</tr>
<tr>
<td>impact of</td>
<td>286</td>
</tr>
<tr>
<td>in self-care regimens, 280–281</td>
<td></td>
</tr>
<tr>
<td>Smith, P.C.</td>
<td>380</td>
</tr>
<tr>
<td>smoking, 12, 13b, 14b</td>
<td></td>
</tr>
<tr>
<td>among LGB people, 176</td>
<td></td>
</tr>
<tr>
<td>changing norms of, 228</td>
<td></td>
</tr>
<tr>
<td>as public health issue, 347, 351, 369</td>
<td></td>
</tr>
<tr>
<td>socioeconomic factors in, 147</td>
<td></td>
</tr>
<tr>
<td>stigmatization of, 231</td>
<td></td>
</tr>
<tr>
<td>in surveillance medicine, 248</td>
<td></td>
</tr>
<tr>
<td>Snapchat, 285. See also social media</td>
<td></td>
</tr>
<tr>
<td>Snow, John</td>
<td>345</td>
</tr>
<tr>
<td>social acceptability of health care,</td>
<td>384–385</td>
</tr>
<tr>
<td>social bodies</td>
<td>263–265</td>
</tr>
<tr>
<td>social causes</td>
<td></td>
</tr>
<tr>
<td>of disease</td>
<td>28–29</td>
</tr>
<tr>
<td>of health inequality, 14–15</td>
<td></td>
</tr>
<tr>
<td>of public health, 346–347, 346f</td>
<td></td>
</tr>
<tr>
<td>social change</td>
<td>19, 33</td>
</tr>
<tr>
<td>social class</td>
<td>141–156. See also social inequalities; income inequality; socioeconomic status (SES)</td>
</tr>
<tr>
<td>social change</td>
<td>19, 33</td>
</tr>
<tr>
<td>of disease</td>
<td>28–29</td>
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<td>of health inequality, 14–15</td>
<td></td>
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<tr>
<td>of public health, 346–347, 346f</td>
<td></td>
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<tr>
<td>social change</td>
<td>19, 33</td>
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<tr>
<td>social class</td>
<td>141–156. See also social inequalities; income inequality; socioeconomic status (SES)</td>
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<tr>
<td>social conditions of health, 3–20,</td>
<td></td>
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<tr>
<td>24–35</td>
<td></td>
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<tr>
<td>and disability-adjusted life years (DALY), 13–14</td>
<td></td>
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<tr>
<td>slow dying</td>
<td>123, 124t, 133</td>
</tr>
<tr>
<td>smallpox</td>
<td>47, 254</td>
</tr>
<tr>
<td>smartphones. See also digital technologies</td>
<td></td>
</tr>
<tr>
<td>in health care systems, 277, 278</td>
<td></td>
</tr>
<tr>
<td>impact of</td>
<td>286</td>
</tr>
<tr>
<td>in self-care regimens, 280–281</td>
<td></td>
</tr>
<tr>
<td>Smith, P.C.</td>
<td>380</td>
</tr>
<tr>
<td>smoking, 12, 13b, 14b</td>
<td></td>
</tr>
<tr>
<td>among LGB people, 176</td>
<td></td>
</tr>
<tr>
<td>changing norms of, 228</td>
<td></td>
</tr>
<tr>
<td>as public health issue, 347, 351, 369</td>
<td></td>
</tr>
<tr>
<td>socioeconomic factors in, 147</td>
<td></td>
</tr>
<tr>
<td>stigmatization of, 231</td>
<td></td>
</tr>
<tr>
<td>in surveillance medicine, 248</td>
<td></td>
</tr>
<tr>
<td>Snapchat, 285. See also social media</td>
<td></td>
</tr>
<tr>
<td>Snow, John</td>
<td>345</td>
</tr>
<tr>
<td>social acceptability of health care,</td>
<td>384–385</td>
</tr>
<tr>
<td>social bodies</td>
<td>263–265</td>
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<td>social causes</td>
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<td>of disease</td>
<td>28–29</td>
</tr>
<tr>
<td>of health inequality, 14–15</td>
<td></td>
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<tr>
<td>of public health, 346–347, 346f</td>
<td></td>
</tr>
<tr>
<td>social change</td>
<td>19, 33</td>
</tr>
<tr>
<td>social class</td>
<td>141–156. See also social inequalities; income inequality; socioeconomic status (SES)</td>
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<tr>
<td>social conditions of health, 3–20,</td>
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<tr>
<td>24–35</td>
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<tr>
<td>and disability-adjusted life years (DALY), 13–14</td>
<td></td>
</tr>
<tr>
<td>slow dying</td>
<td>123, 124t, 133</td>
</tr>
<tr>
<td>smallpox</td>
<td>47, 254</td>
</tr>
<tr>
<td>smartphones. See also digital technologies</td>
<td></td>
</tr>
<tr>
<td>in health care systems, 277, 278</td>
<td></td>
</tr>
</tbody>
</table>
Index

and obesity, 16
and psychological factors, 27–29
self-management and, 33–34
social constructionism, 101, 248–251
of bodies, 264
of emotions, 266
of ethnicity and race, 180–181
of gender, 174
social control, 251–254, 296
social death, 132–133
social determinants of health, 23–35
social gradients, 14–15, 27, 144–145, 148
’social iatrogenesis,’ 252
social insurance health care systems, 310
social justice, 153, 343
social media, 284–286
’social medicine.’ See public health
social model of disability, 111–112, 251
social networks
breakdowns in, 148
and help-seeking practices, 66
importance of, 30–31, 31f, 211–212
social policy. See health policy
social position as ‘fundamental cause’ of
health, 146
social security, 298–299, 299f
social selection explanation of health
inequality, 146, 148
social stratification. See health
inequalities; income
inequality; social class;
socioeconomic status (SES)
social structure, 254–258
social values, and public health,
351–352
social workers, 332
socioeconomic position (SEP), 32
socioeconomic status (SES), 146–147.
See also health inequalities;
income inequality; social class
as cause for regulation, 308
contexts creating, 148, 149
and equity in health care, 388
of ethnic populations, 184–185,
189–190, 190f
and life expectancy, 156
and mental health risk, 193
in social cause framework, 15
socioenvironmental model, 26–27
sociology. See also medical sociology
of ageing populations, 213–220
approaches to long-term illness,
100–101
assemblage approach, 271, 272–274
of bodies, 249–250, 265–266
critiquing public health, 352–356
and development of health
professions, 321–323
focus on class as structure, 155–156
of long-term conditions, 115–116
materialist approach to, 270–272
medicalization of, 107–108
origin of health care systems, 296
of patients’ lived experience,
103–107
perspective on digital technology, 278
policy vs. critical, 152
role of labeling, 228–230
theories of health inequality, 150–152
Socrates, 264–265
Solar, O., 149
South Africa
cellular phones as ‘therapeutic tools,’
43
epilepsy in, 63
mortality rate of immigrants, 187f
racism in, 180
systematizing traditional medicine,
63, 334
South Asian immigrants, 189
South Pacific, 121
Soviet Union, 17. See also Russia
Spain, 17. See also European Union (EU)
avoidable death in, 361b
disability rates in, 206
health spending post-crisis, 315
Spain (cont.)
  retirement migration, 53–54
  World Health Report rating, 392
‘Spearhead groups,’ 144
Speed, Ewen, 3–20
spinal surgery, 53, 378–379
Sri Lanka, 70
Stam, H.J., 101

state
  patient empowerment reinforcing, 103
  public health as apparatus of, 355
  role in governance framework, 323–324
  vs. social class, 151–152
status loss, from stigma, 236
statutory insurance, 302–303
Stellman, J., 163
stem cell treatments, 52, 53
stereotyping
  affecting medical research, 189
  assessments leading to, 181
  as component of stigma, 236
  and deviant conditions, 229
Stevenson, Fiona, 23–35, 61–72, 67
Steward, W., 235
stewardship. See governance
Stiggelbout, A.M., 84, 94
stigma, 227–240. See also deviance; labeling
  addressing, 235–236, 236b, 238–240
  ‘bodily idiom’ of, 250–251
  components of health-related, 236–238, 237b
  and co-stigmas, 240
  definitions of, 231, 232b
  and deviance, 230–231, 232b
  of disability, 106
  enacted vs. felt, 233
  hidden distress model of, 233
  history of, 237
  importance of context, 240
  medicine masking, 251
  neoliberalism weaponizing, 238
  in public health, 353–354
  seven criteria for, 237, 237b
  structural factors in, 239–240
  trajectory of, 234
  and work capability assessment (WCA), 238
Stonewall, 175
stories shaping health beliefs, 63
Strauss, A., 127, 133, 135–136
Strauss, R., 106
stress, 18, 27–28, 148
stroke. See also cardiovascular disease; heart disease
  death resulting from, 123, 129, 130b
  in ethnic groups, 186
  Foucauldian analyses of, 250
  incidents by gender, 165, 172f
  patient-centred care for, 81
Stroope, S., 29–30
structural critiques of public health, 352
structural determinants
  of deviance, 239–240
  of health inequality, 34, 67, 149
structured dependency theory, 214–216, 218
Structure of Scientific Revolutions, The, 244–245
‘structured pluralism,’ 312
stuttering, 232
sub-Saharan Africa, 12, 51–52
Sudnow, D, 132
suicide
  in ageing populations, 209
  incidents by gender, 165, 167, 175
  among LGB people, 176
  unemployment increasing, 18
'supra-territorial' spaces, 42
surgery
  correcting stigmatizing conditions, 251
  Foucauldian analyses of, 250
  managing complications, 362
  traveling for, 53
surveillance critiques of public health, 352
surveillance medicine, 247–248
and consumerism, 258
and embodiment, 267–269
in public health, 354–355
Survey of Health, Ageing, and Retirement in Europe (SHARE), 206
susceptibility, 24–27. See also diseases; illness
suspected awareness of dying, 127–129, 127t
Swami, V., 62–63
Swartz, L., 63
Swaziland, 4
Sweden, 62. See also European Union (EU)
disability rates, 206
doctor-patient relationships, 88–89, 90t, 384–385
health care financing, 313–314, 314t
health care system, 151, 301
patient experiences, 372
payment mechanisms, 306
wait times, 384
Switzerland
disability rates in, 206
doctor-patient relationships in, 88–89, 90t, 384–385
patient experiences in, 372
symptoms. See also diseases; illness; morbidities; treatments
as historically secondary indicators, 78
iatrogenic, and long-term illness, 105
in quality of life instruments, 366–367
and shared decision-making, 86
as triggers for treatment, 65, 69
Szasz, T., 254
Szreter, S., 18
T
tablets, 277, 278. See also digital technologies
Tanzania, 66, 72
target-oriented frameworks, 94
tax-financed health care systems, 310
taxation as health financing, 302, 314
Taylor, K., 128
‘technological childbirth,’ 170
telemedicine, 277, 279–280.
See also communication; digital technologies
telemonitoring, 281
temporalized symptomatology, 65
tendency to monopoly, regulating, 308
terminal illness. See death and dying; long-term conditions; mortality
testing, digital, 277–278
tetanus, in low-income countries, 34
Tew, M., 170
Thatcher, Margaret, 40
third age theory, 216–218
Thomas, Carol, 116
Thomas, M., 65
thrush, 68
Tilki, M., 197
Timmermans, S., 126, 127
To Err Is Human: Building a Safer Health System, 378
tobacco, 16, 44. See also smoking
Tones, K., 349
toxic chemical exposure, 168
toxicology studies, 163
‘tracer’ conditions, 383
trachea bronchus, 123, 172f
trade unions, 295
traditional and complementary medicine (T&CM), 333–336
traditional death, 125, 126, 126t
Traditional Medicine Strategy 2014–2023, 334
transnational corporations, 40, 155
transnational politics, 41–42
transport systems, 343–344
traveling for health, 52–53
treatments. See also death and dying; diseases; health care; health care systems; health outcomes; illness; interventions; long-term conditions; morbidities; symptoms
accessibility of, 384
doctors controlling, 82–83
at end-of-life, 134
ethnicity as factor, 195–196, 195f
evaluating, 363, 368–369, 369r, 381, 385–386
and long-term illness, 105–106
measuring side effects, 367–368
men seeking, 175
patient-centred care for, 81
in popular sector, 68–70
randomized control trials (RCT) for, 378–379
and shared decision-making, 84
symptoms triggering, 69
Trinidad, 193
trust, 93–95, 148, 349
Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century, 326–327
tuberculosis, 7–8, 7f
in agricultural period, 5
as avoidable death, 361
lived experience of, 103
shared decision-making for, 91
stigmatization of, 232, 238–239
Tumblr, 285. See also social media
Tuohy, C.H., 310
Turkey, 54, 169
Turner, B., 265
23andMe, 287
Twitter, 285. See also social media
2008 Health and Social Care Act, 327
Type 2 diabetes. See also diabetes
cultural responses to, 64
self management of, 33–34
as ‘tracer’ condition, 383
typologies, of health care systems, 296–300, 297f, 298f, 299f
as ‘logics,’ 310–311
convergence of, 312–317, 314t
multidimensional, 311, 311t
U
Uganda, 69
United Kingdom. See also England;
 European Union (EU) Ireland;
 National Health Service (NHS); Scotland; Wales
ageing population, 203–206, 205f
availability of painkillers, 68
care pathways, 332–333
Care Quality Commission, 390, 392–394, 393f
communication, 279, 285, 372, 384–385
death and dying, 134, 135, 361, 361b
defining sexual harassment, 164
development of National Health Service, 255, 301
disability rates, 108, 206, 238
doctor-patient relationships, 88–89, 90t
drug advertising, 69
Equality Act, 109, 114
equity in care, 388
ethnic groups, 180–181, 183–185, 192–194
health care financing, 151, 203, 313–314, 314r, 315
health care spending, 310–311, 315
help-seeking practices, 65–66
home remedy acceptance, 70
hospitals in, 305
life expectancy by gender, 164–165, 165r, 167
long-term care in, 315–316
payment mechanisms in, 306
‘purchaser-provider split,’ 312
racism in, 182, 190–191
recruiting health care workers, 51
reorganization of National Health Service, 310–311, 327–330
responses to Type 2 diabetes, 64
retirement migration, 53–54
role of sick in, 228
wait times in, 384
UK General Medical Council, 84
uncertainty in long-term conditions, 104–105
Union of Physically Impaired Against Segregation, 111–112
United Nations, 54
Committee on the Rights of Persons with Disabilities, 108
United States
appropriateness of treatment, 385–386
commodification of health, 228
disability legislation, 109
disengagement studies, 214
doctor-patient relationships, 88–89, 90t, 279, 371, 384–385
financing of health care, 151, 293, 304, 313–314, 314t, 315
health care system, 53, 308, 310, 329, 330, 332–333
health determinants, 17
health inequality, 153, 191–192, 386
health promotions, 47, 353
hospitals, 305, 361–362
mental illness, 29, 230
migration offsetting birth rates, 54
mortality, 351, 361, 382–383
negative response to HIV/AIDS, 233–234
Obamacare, 255–256, 302, 384
online medical platforms, 285
patient experiences, 66, 88, 228, 372
payment mechanisms, 305, 306
racism in, 180, 190
randomized control trials (RCT), 378–379
self-care regimens, 281–282
‘structured pluralism,’ 312–313
unsafe sanitation as global risk, 13b
unsafe sex as global risk, 13b
unsafe water as global risk, 13b
‘unsuccessful ageing,’ 219
US Food and Drug Administration, 92
uterine cancer, 166. See also cancer

V
vaccination, 54–55, 348–349.
See also health promotions; immunization
Van Aerden, K., 30
Vassilev, I., 30
Viagra, 258
victim blaming, 353–354
Victor, C., 210, 212
violence, as oppression, 236b
Virchow, Rudolf, 142, 152, 155, 345
Virdun, C., 128
Vitals, 285

W
Wahlberg, A., 71
Waitzkin, H., 101–102
Wales. See also England; European Union (EU); Ireland; National Health Service (NHS); Scotland; United Kingdom
conditional trust, 94
ethnic minority population, 184
Heartbeat Wales promotion, 349
life expectancy, 3–4, 204, 351, 360
Walter, T., 125–126, 126t
water sanitation, 12
Watermeyer, B., 116
Waxler-Morrison, N.E., 70
web of causation model, 25
Weber, Max, 321
WebMD, 282–283. See also internet websites. See digital technologies; internet
‘weekend effect,’ 362
Weinstein, J., 378–379
welfare state, 255–256, 300–301
well-being. See health; quality of life
Wendt, C., 311
West African immigrants, 187f
wheat and climate change, 46
Whitehall II study, 27
Whitehead, M., 150, 195, 195f, 346
Wiitavaara, B., 62, 63
Wikipedia, 283. See also internet
Wilkinson, R., 146, 148, 150
Williams, G., 106–107
women. See also gender; men
accessing medical information, 283
and ageing, 212–213
causes of death among, 165–167, 166f, 167f
and domestic violence, 171
emotional responses of, 266
global picture of health, 80, 171–173, 172f
harrassment impacting, 164
life expectancy of, 164–165, 165r, 171, 360
and medicalization of childbirth, 169–171
morbidity of, 168–169
and shifting understanding of gender, 162–163, 173–174
suicide rates of, 167
Woodward, D., 43–44, 44f
work and workplaces. See also employment
and gender, 163–164
impacted by neoliberalism, 151
institutional racism in, 182
Work Capability Assessments (WCA), 108, 238
World Bank, 42, 49
World Health Organization (WHO)
building block approach to health care systems, 296–297, 297f, 298f
current disability framework, 109–110, 112–113, 112f
definition of health, 347
gender issues in health, 163, 169, 171, 173, 175
and global distribution of health care workers, 50
health care financing framework, 297, 298f
macro-level assessments by, 15, 91, 391–392
managing outbreaks, 47–49
promoting traditional and complementary medicine (T&CM), 333–335
and resource generation, 300
role in public health, 42, 153, 154t, 342
World Health Report, 391, 392
World Report on Disability, 114
world wide web. See digital technologies; internet
Y
Young, M., 235, 240
YouTube, 285. See also social media
Z
Zaman, S., 33
Zambia, 41, 48–49
Zimbabwe, 31
ZocDoc, 285. See also internet
Zola, I., 65