

Susan A McDaniel University of Lethbridge

abstract Sociology of health and illness behaviour has been enlivened by increased understanding of the complex roles social factors and structures play in individual and societal health and well-being. New insights are simultaneously empirical and conceptual, leading to innovative approaches to analysis, as well as new conceptual frameworks. Three examples are: the social gradient of health, the population health perspective and the salience of social fabric to both individual and societal well-being. Nonetheless, puzzles remain such as how social inequalities get under the skin, why socioeconomic improvements do not always yield life expectancy gains and how to reduce health disparities and inequalities.

keywords health ♦ health disparities ♦ population health ♦ well-being

Thinking sociologically about health and illness behaviour is the focus of this article. Other specialties in medical sociology such as sociology of health care or medicine, and sociology of health policy can be addressed in separate essays. Several journals focus specifically on sociology of health and illness behaviour including *Social Science and Medicine*, *Sociology of Health and Illness*, *Journal of Health and Social Behavior* and *Health Sociology Review*, to name just a few. As well, many other sociology and social science journals have specific foci that include health behaviour, such as gender and health, ageing and health, among others. Because health and its determinants range widely, sociological insights have infused, and been infused by, among others, allied disciplines such as public health, global health, community health, epidemiology and health economics.

Sociological thinking about health and illness behaviour has experienced intellectually exciting renewal in recent decades with vastly increased understanding of the complex roles social factors and structures play in health and well-being of individuals and of societies (see Rosich and Hankin, 2010 for a summary of what is known from the US perspective; and Hall and Lamont, 2009 for a more international perspective). A compelling dimension of the major new insights is that they are simultaneously empirical and conceptual, leading to innovative approaches to data and analysis (see Avison, 2010; Halfon and Hochstein, 2002; Jenson, 2009, for example), as well

as compelling new theoretical frameworks with immediate potential applicability to both individual lives and to policies (Evans et al., 1994). Three such examples are: the social gradient of health, the population health perspective and the growing saliency of the social fabric to both individual and societal well-being.

Theoretical approaches

A sociological approach to health and illness probes the intricacies of the relations of societal structures, culture and inequalities to health beliefs, behaviours and outcomes. It looks at the how and why of these relations and their changes.

Health did not emerge from the shadows of history as a viable concept for a very long time. In most of human history, health was elusive and virtually unrecognizable as an experience or an ideal. Only after health came to be seen as the absence of disease did the sociological study of health and illness begin. The focus on what contributes to well-being and keeps individuals and societies healthy is a relatively new sociological endeavour.

Not surprisingly, when sociologists made early forays into understanding medicine (not health in the early days) in the 1950s and 1960s, these took place within the dominant theoretical paradigm of the day, structural functionalism. Society, in this perspective, is

viewed as an orderly array of functioning social institutions that articulate with each other. Individuals in social institutions play roles prescribed by society and learned through socialization. Illness, then, was seen as a 'sick role' which encompasses both rights and duties (Parsons, 1951). The sick person was exempt from normal role responsibilities but had a duty to work to get well and, in doing so, to seek appropriate professional help. The concept has been soundly critiqued on the grounds that its normative presumptions fail to address issues of power and conflict, that its preoccupation with restoration to health does not address chronic illness or disabilities, and that it overestimates the power of medical professionals. Nonetheless, the 'sick role' concept in 21st-century guise is making something of a return as 'personal responsibility' for one's health in healthy eating, weight control and avoidance of risky health behaviours such as smoking. There is even some movement not to cover health care costs for those who are perceived as not taking personal responsibility for their own health. This, of course, penalizes people who took up smoking, for example, when it was almost normative and not known to be linked to serious health problems, or those who may be deemed irresponsible because of HIV/AIDS infections.

Early medical sociology tended to focus on social and social psychological factors thought to result in illness and to affect medical care. Straus (1957) made the distinction between sociology *of* medicine, the study of issues of interest to medical practitioners, and sociology *in* medicine, a more critical analytical stance intended to enhance sociological knowledge. The latter has produced important findings in several realms: on the distribution of illness/disease among subpopulations, on the social patterns of illness behaviours and responses, on various social means by which illness is dealt with and on the social organization of health services beyond medical practitioners. The foundation was laid for future research and the emergence of new theoretical paradigms.

What is studied and how, about health and illness is largely a question of the theoretical lens chosen. Conflict and power theoretical stances include Marxist theories, political economy approaches as well as gender/feminist and race-centric perspectives. All of these, in varying ways, focus attention on differential power and access to resources. The dominance of medicine in defining health and in exerting control is a major theme in these theoretical perspectives. Capitalism and power relations, of course, are a principal theme in this theoretical stance. Gender, race and gay/lesbian/bisexual/transsexual (GLBT) approaches have positioned gender, race and sexual orientation as fundamental to societal power rela-

tions, and hence the ways in which master narratives about health and illness are imposed.

Michel Foucault (1994 [1973]), in extending conceptualizations of power, has had significant influence on the sociology of health and illness. He sees power as diffused and embedded in social relations whereby people internalize professional models and act as willing subjects. This occurs not only in our relations with medical and other professionals, but also in our relations to our own health and illness, and to our own bodies. 'The medical gaze' extends beyond patient–doctor relations to structure how we understand, regulate and experience our bodies and their symptoms. His work opened the door for the creation of a new subdiscipline, 'sociology of the body' (Turner, 1997), which looks at the body as a social and cultural construct.

Social psychological approaches focus on human agency, or the actions or behaviours of individuals with respect to health and illness. This is not a new theoretical stance in sociology of health and illness, but has seen a resurgence with more attention by postmodern theory on the role of agents in making their own lives. This focus does not mean, however, that social structural factors are thought not to matter. Rather, there is interest among some who favour a social psychological perspective to examine how and why individuals and groups behave as they do within social structures, particularly within structures of social inequality. Social psychological perspectives including symbolic interactionism, phenomenology, ethnography and interpretative enquiry share an interest in how we construct meaning and interpret the world through social interactions. How we construct and maintain beliefs about health would be an example of this approach.

Newer theoretical approaches in sociology of health and illness include the life course perspective, disability theory and structuration. Life course theory (Elder, 1975) focuses on the intersection of individual biographies with historical events. Life course theory is widely used in sociology. In sociology of health and illness specifically, it brings attention to how early experiences, present circumstances and the timing of various historical events in lives can all work together to affect health and well-being. Life course theory has also been used as a therapeutic modality.

Disability theory emerged from multiple critiques, including those by Foucault and his followers, which saw social restrictions for disabled people as emanating from their bodily impairments. Instead, the social model of disability sees disability as a social construction and a product of social organization. Impairment is seen as a bodily dysfunction while disability is produced through

processes of social exclusion. Despite its utility in mainstreaming previously excluded populations – witness the Para Olympic phenomenon – the social model of disability has come under criticism for its emphasis on structural constraints, and its separation of bodily experiences from social life. The argument is proffered that the impaired body should be seen as part of history and of culture, having meaning not only as a biological entity of interest to medicine. More recent theorists focus fruitfully on the reflexive relationship between the bodily and the social.

Structuration theory, the brainchild of Anthony Giddens (1979), relies on the duality of agency and structure in analysing social action. Focusing neither on individual experiences nor on structure per se, but on social practices across time and space, structuration theory is useful in understanding health and illness behaviour sociologically. It can reveal how we behave in ways to which we are habituated but which may not be taken for granted, such as eating habits or activity levels. As individuals, we can make choices, however, about those practices to which we have been socialized.

Bourdieu (1977, 1984), by contrast, solidly favours structure over agency. He sees each of us situated in social space with differential amounts and kinds of capital (social, cultural and symbolic). We act in accordance with a set of acquired dispositions called *habitus*, which are essential to social reproduction and social regulation. Bourdieu moves sociology of health and illness behaviours away from the body as an object of scrutiny to the body as an integral part of the social actor and the social structure, a source and site of knowledge and intention. The embodied agent both produces society and is produced by it. In sociology of health and illness, from this perspective, body, mind, spirit and society are inextricably intertwined.

Empirical evidence and assessment

Insights in sociology of health and illness have been simultaneously enabled by new theoretical/conceptual approaches and new empirical analyses. We shall first summarize some of the major empirical findings over the history of this subdiscipline, and then focus specifically on three new arenas of insight: the social gradient of health, the population health perspective and the saliency of the social fabric to both individual and societal well-being.

Sociological research on health and illness has empirically found in studies too numerous to cite, the multiple and complex ways in which social contexts and conditions affect health and illness. This is found at the micro-level where ‘the greatest threats to

the health and well being of individuals stem largely from unhealthy life-styles and high risk behavior’ (Cockerham, 2010: 21), an argument that some but not all conflict analysts might contest. Complementing this finding at the macro-level is extensive sociological research that reveals the immense disparities in health by social factors and structures such as class, race, ethnicity, gender, sexual orientation and immigration status.

Significant empirical evidence exists about the persistence of health inequalities in societies whereby the poor and vulnerable suffer worse health and die younger than better-off groups. One explanation, the theory of fundamental causes (Link and Phelan, 1995; Phelan et al., 2004), argues that as intervening mechanisms between socioeconomic status (SES) and health outcomes such as poor sanitation or infectious diseases lessen, new mechanisms arise by which the advantaged benefit. Among these are knowledge, power, money and social connections. Thus, SES is seen as a fundamental cause of illness. This theory implies that efforts to improve the overall health of populations by interventions in individual risks will be ineffective because socially unequal conditions remain. The view that unhealthy lifestyles and choices are the cause of most health disparities parallels fundamental cause theory in seeing lifestyle choices as deeply determined, or minimally affected by social structures, particularly structures of inequality. In a subsequent study, Phelan et al. (2004) found support for the hypothesis that in the US less preventable diseases are less strongly associated with SES than more preventable diseases.

Further empirical research on the ‘fundamental causes’ theory compares the US with Canada (Willson, 2009). Canada differs from the US in its lower levels of economic inequality and its publicly funded health insurance system, making for a natural experimental design. Willson finds that lower SES increases the odds of experiencing a highly preventable disease in the US but not in Canada. This suggests that Canadian policies may be more effective than those in the US in altering the social conditions that affect health determinants through SES. Additionally, lower levels of socioeconomic inequality, as exist in Canada, may possibly buffer the relationship between socioeconomic resources and health risks.

Substantial empirical research has been devoted to understanding how social stressors impact health (Thoits, 2010). Crucial findings reveal how major life events such as death of a spouse, job loss, eviction, or chronic stresses such as insufficient income, the demands of caring for someone who is disabled, or living in a dangerous neighbourhood, can damage health and well-being in measurable ways. The

effects on health vary by social groups, which connects with the concept of social resiliency. Minority groups, for example, based largely on US studies of African Americans, have been found to have negative health effects from the stresses of discrimination, a stressor that is significantly related to health problems, including major depressive disorders (Pearlin, 1989). However, a recent study in South Africa (Jackson et al., 2010) finds that the term 'minority group' may not apply equally to all those who are non-white. Fewer health differences were found between those who classify themselves as Indian in South Africa and those who self-classify as white, but large differences are found in anger and hostility between those who self-classify as 'coloureds' and all other groups. The relationship of minority status to health may need re-examination and recalibration in contexts outside the US.

The 1960s saw growing interest by sociologists of health and other academics in health inequalities. Many believed that health outcome inequalities could be explained and addressed by providing more equitable access to health care. The Black Report in the UK commissioned in 1977, and finally seeing the light of day in 1980, demonstrated clearly for the first time that although overall health had improved since the introduction of the welfare state ensuring more equal access to health care, widespread health inequalities remained. The main cause of these inequalities was found to be economic inequality. The report showed that the death rate for men in the lowest social class was twice that for men in the top social class, and that the gap between the two was increasing, not reducing as was expected. In the same period Blaxter (1981) found something similar among children in path-breaking research. Both Blaxter and the Black Report faced challenges getting into wide publication, however.

Although it slowly has become conventional wisdom that socioeconomic inequalities are a chief contributor to health inequalities, there is still research being done on the mechanisms by which inequalities get under the skin. It is among the most fertile areas of study by sociologists of health and illness. There remains as well some resistance to the existence of a link. One foundational contribution to the understanding of social inequalities to health outcomes is the Whitehall study (Marmot and Theorell, 1988). In this impressive study design, 10,000 British civil servants were followed for almost two decades. A wide array of detailed information on each person was collected. That the data are individual (person specific) and longitudinal enables a corrective to some earlier research that took only group averages at one point in time. The findings were nothing short of astounding. Mortality, age-standardized,

among those in clerical or manual grades was three-and-a-half times higher than among those in senior administrative grades. But, the story does not end there.

What Marmot and Theorell found was a sharp and clear gradient in mortality from top to bottom of the hierarchy. In each gradient, clearly measurable in the civil service ranks, down from the top, mortality increased. It must be remembered that no one in this study was impoverished in any way; all had jobs and relatively low risk work. Many, if not most, were more secure in their jobs than the general workforce/population, and likely better paid overall. Standard explanations of the relationship of socioeconomic inequalities and health outcomes just did not work in the Whitehall study. The poor were thought to be deprived of nutritious food, good living conditions, and suffer from crowding at home and risks of infectious illnesses, all leading to poor health outcomes. None of these factors are operative among civil servants, who were not poor or materially deprived, even at the bottom levels. The power of the Whitehall study findings is that there is something about social hierarchy per se that powerfully affects our health. And that something operates not on an underclass which is deprived, but on all of us.

Puzzles remain in the social gradient of health, however, particularly when focusing on specific mortality causes. A social gradient was found in the Whitehall study for most, but not all causes of death. The gradient was pronounced for smoking which, of course, is correlated with a variety of diseases: people in the top levels smoke hardly at all, while those in the lower levels smoke more commonly. Even among those in the top levels of the civil service, those who do smoke are much less likely to die of smoking-related diseases. The smoking gradient is likely less related to choice, as is often argued, than to social environments and has spawned a virtual industry of research on smoking in sociology of health and allied disciplines.

When relative risks of coronary heart disease are examined closely with the Whitehall data, it emerges that the 'usual suspects', i.e. the triad of smoking, blood pressure and cholesterol, only in small part explain the gradient. Huge unexplained factors remain and the degree of the unexplained mortality risks increases with each level one moves down. This and other similar findings lead Marmot and colleagues, as well as others who have subsequently analysed the Whitehall data, to suggest that an underlying causal process may exist that is correlated with hierarchy but which somehow expresses itself through different diseases. Diseases then, seen through this lens, may be pathways or mechanisms rather than actual causes. Postponement of death

seems to be a privilege given to those who are higher in the social hierarchy.

One puzzle to researchers has been the persistence of the association of years of schooling, one indicator of SES, with reduced risks of dementia in old age. Some have seen years of schooling as a confounding variable, with those who are better educated being better able and more motivated to mask their symptoms in examinations. Newer interpretations, however, are suggesting alternatively that education may actually 'condition' the brain in such a way that the physiological processes of deterioration are resisted (Hertzman et al., 1994). If so, it is speculated that serious mental diminishment in old age may be reflective of social and educational policy failures in earlier lives of those elderly today, a life course perspective.

Policy has been found to matter greatly over the long run in the approaches to infectious illnesses such as tuberculosis (Feldberg, 2003). Fascinating historical research that compares the US and Canada on tuberculosis policies finds that the return of TB in the AIDS era in the US may be best understood in the contexts of decisions in the 1930s to try to prevent the disease through improved hygiene and medical treatment, rather than vaccinations and poverty amelioration as was done in Canada. Feldberg concludes that the American policy approach worked to cultivate middle-class values of self-reliance, while defining those who got TB as people who did not know how to look after themselves. Understanding the aetiology of illness and disease necessitates a political as well as a sociohistorical analysis.

The discovery of the social gradient of health opened a barn door for rethinking the relationship of social inequalities and social hierarchy to health outcomes. If social hierarchy gets under our skins so profoundly, then social factors and policies may matter more deeply to health than was previously imagined. This insight has led to the realization of the sensitivity of us all, not only those who are disadvantaged, to our social environments. The result has been nothing short of a quest to understand better the social determinants of health (Commission on the Social Determinants of Health, 2008; Labonté et al., 2009; World Health Organization, 2003). Every social 'stone' imaginable is being examined for its influence on health: stress, early life, social exclusion, work environment, unemployment, social support, addictions, food, transport, the list goes on.

The Commission on the Social Determinants of Health (2008) refers to health inequities that are amenable to remedy now that we have accumulated sufficient evidence on how social environments and factors contribute to health outcomes. They note unequivocally that 'social injustice is killing people

on a grand scale' (2008: 2). The Commission then sets out a series of clear recommendations to ameliorate health inequities within a generation. Among them, are improvements in the daily living situations of girls and women known to connect to overall population health betterment, reductions in inequalities in distributions of power, resources and wealth, and continuing improvements in the measurement of health and health inequities.

The population health perspective takes the view that social structures, such as socioeconomic inequalities, have an effect on overall health of populations independent of any individual-level relation to social hierarchy or pathways. That more egalitarian societies, regardless of their level of socioeconomic development, have better overall health and greater life expectancy, has been found in repeated studies (Wilkinson and Pickett, 2006). That said, many remain sceptical about whether income inequality has any implications for population health, and others have argued that empirical evidence does not support the relationship. Without engaging that debate here, it must be noted that the population health perspective focuses attention on macro-forces and factors that link societal health with economic contexts. In that, it offers a fresh perspective on the historical, individualistic perspective of sociology of health and illness.

The mechanisms by which socioeconomic inequalities link with population health are still being theorized and studied empirically across the world. It may be that larger socioeconomic or class differences simply result in a sharper social gradient of health. But, it is speculated that more unequal societies may be characterized by greater status competition and class awareness, which results in more widespread health disadvantage. As mentioned above, it is now well established that health disadvantage is not confined only to the poor in society.

More unequal societies tend to have higher rates of violence and lower degrees of trust than more egalitarian societies (Wilkinson and Pickett, 2006: 1776). This suggests that psychosocial pathways may exist by which inequality seeps into societies as a socially corrosive force, undermining the health of all to a degree (Willson et al., 2007). In more unequal societies, of course, the lower social status is lower than in more equal societies. This may mean that people at the very bottom may be made to feel looked down upon, and seen as inferior. They will also have less control over their lives, a known stressor. As well, because of their poor living conditions, those at the bottom are more susceptible to infectious illnesses, which can spread to those in other classes through schools, streets and other means.

The salience of the social fabric to health and

well-being is an empirical finding emanating from the work of well-being researchers largely in epidemiology and psychology, but also in economics (Helliwell, 2002). This research is inherently sociological but the empirical momentum has begun in other disciplines. Based on multivariate analyses of three waves of the World Values Survey from the early 1980s to the late 1990s of 50 countries, it is found that the quality of norms and social institutions in a country has strong well-being effects, even larger than those previously found to flow through better incomes. Indeed, it is found to be misleading to focus on productivity and income enhancements to increase well-being. Research on well-being strongly suggests the great importance of the social fabric. '[T]o the extent that a trade-off is seen between sustaining the social fabric and increasing incomes', argues Helliwell (2002: 87), 'the former now appears to have a larger and faster-growing importance than was thought.'

Growing areas of interest

Gendered dimensions of health and illness behaviours are a growth area in understanding health and illness sociologically. Gender is a crucial vector of structural inequality in all societies, some more than others. Gender, for example, is known to be a major factor in survival following a heart attack or stroke in North America and Europe. Women's probability of dying from such health events tends to be greater than men's. And yet, on average, in the developed parts of the world, women outlive men. Women's and men's health is increasingly understood to be the product of a socially stratified gendered world. Research on gender and health behaviours is rich, complex and growing.

Some glimpses of that research are provided here. It is not possible to do justice to the entirety of the gender and health literature in this overview essay.

The gender gap in longevity is clear and consistent across almost all societies. The exceptions are those where female infanticide is practised or where maternal mortality (death in childbirth) tends to be very high. Women outlive men, although the gap is narrowing in some parts of the world, largely due to a decline in male death rates. Women, however, live longer with disabilities and chronic illnesses than men. This, of course, becomes an important policy challenge with population ageing.

Gender is key as a social determinant of health. Gender stratification, the unequal distribution of power, opportunity, wealth and privilege between men and women, affects health and well-being. Factors such as caring for families as well as working

in the paid labour market have implications for women's health, while behavioural choices such as tobacco and alcohol consumption are more important in men's health and well-being. Also important is that social determinants of health are themselves gendered constructs. Labour market rewards such as promotions or pay increases have different meanings for women and men, and therefore different implications for health by gender (McDonough et al., 1999). Future research on gender and health is likely to move into understanding the intersecting axes of inequalities that affect health.

Another growth area in understanding health and illness behaviour sociologically is through the lens of social capital. Kawachi et al. (2008) argue that any issue of the major journals in sociology of health will have something on social capital. As may be expected, no new concept in a field is without critiques and contestations, which we will not consider here. In brief, social capital in the health literatures is seen as those aspects of society such as interpersonal trust and norms of reciprocity or mutual aid that constitute resources for people. Having social capital is found to produce good health at various levels from societal to physiological in arenas as diverse as tobacco and alcohol consumption, sexual behaviours, mental health and stress. The causal processes involved differ and some still need specification and theorization. One fruitful area of research has been on the importance of community and neighbourhood contexts and the role of community social capital in health and illness.

Future directions

New directions in the sociology of health and illness behaviours, or perhaps what now should be termed the sociologies of health and illness behaviours, are many. Increasing interdisciplinarity, not only among the social sciences as we have seen above, but of social science with medical and various health sciences, has the potential to produce new insights. Examples of the possibilities abound. Note the above discussion of how education may reshape biochemical brain function to prevent or diminish the likelihood of dementia, or of how higher class can prevent the devastating health effects of smoking to a degree. Increased infusion of theory is a likely future direction for sociology of health and illness, as in the development of theoretical frameworks portraying the pathways by which social inequalities link to population health. Reliance on life course perspectives of both individuals and societies, particularly of social policies over time, can deeply enhance understandings and ramp up explanatory power.

Use of multiple methods to study phenomena of health and illness is increasing in popularity and likely to continue to expand. Combinations of meta-analyses, international comparative data, case studies, focus on particular illnesses, etc. all open doors to greater insights. Longitudinal analyses and the increasing availabilities of longitudinal micro-level data in many countries expand greatly what we can know (see Wister, 2005, for example). Following individuals over time, as clearly evidenced in the Whitehall study, enables researchers to understand at a deep level the factors that matter to health. Is it the gravity of being born in a lower class, or working in a lower level job, or living in substandard housing? Is it the path dependency of lowered opportunities and lowered expectations and control over one's life that leads to poorer health outcomes? Or is it shocks such as economic recessions, wars, crime, or loss that affect health more?

The sociology of bodies has opened new conceptual avenues for research on sociologies of health and illness. Seeing physiological bodies as social constructions enables new insights. We no longer ask, from this perspective, how the social enters the body, because the body literally is conceptualized as embodying the social. Similarly, new research on the relation of globalization to health and well-being opens opportunities to see how macro-level forces and changes affect population health.

Annotated further reading

Hall PA and Lamont M (eds) (2009) *Successful Societies: How Institutions and Culture Affect Health*, New York: Cambridge University Press.

This much acclaimed edited book brings together top social health scholars from different disciplines to contemplate with fresh eyes, data, new and old, together with new theoretical frameworks what defines successful and healthy societies and what social conditions sustain them. The focus is on population health and contemporary puzzles such as why life expectancy gains have not been sustained in some countries, why socioeconomic changes improve population health in some places but affect it negatively in others, and what explains the differential success of AIDS prevention among African countries.

Helliwell JF (2002) *Globalization and Well-Being*. Vancouver: University of British Columbia Press.

This short, award-winning, accessible book reveals the pluses and minuses of globalization with respect to health. The reasoned conclusion, empirically based, is that the social fabric matters more to well-being than income, with the importance of the social fabric growing at a faster rate than had been thought.

Townsend P and Davidson N (eds) (1982) *Inequalities in Health: The Black Report*. Harmondsworth: Penguin.

'The Black Report' was the first acclaimed study to reveal, unequivocally, that women and men in the lowest occupational groups experience higher rates of mortality and morbidity (illness and disease) than those in higher occupational groups. Those in the lower occupational groups were approximately 2.5 times more likely to die before reaching retirement age than those in the highest occupational groups. Since this report, numerous studies, relying on different conceptualizations of both health and class and different methodologies, have found a similar pattern, now known as the 'social gradient of health'.

References

- Avison WR (2010) Incorporating children's lives into a life course perspective on stress and mental health. *Journal of Health and Social Behavior* 51(4): 361–375.
- Black Report (1980) *Inequalities in Health: Report of a Research Working Group*. London: Department of Health and Social Security. Available at: www.sochealth.co.uk/Black/black.htm.
- Blaxter ML (1981) *The Health of Children: A Review of Research on the Place of Health in Cycles of Disadvantage*. London: Heinemann.
- Bourdieu P (1977) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.
- Bourdieu P (1984) *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge.
- Cockerham W (2010) *Medical Sociology*. Upper Saddle River, NJ: Pearson.
- Commission on the Social Determinants of Health (2008) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization.
- Elder GH Jr (1975) Age differentiation and the life course. *Annual Review of Sociology* 1: 165–190.
- Evans RG, Barer ML and Marmor TR (eds) (1994) *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Aldine de Gruyter.
- Feldberg G (2003) *Women, Health and Nation: Canada and the United States since 1945*. Montreal: McGill-Queen's University Press.
- Foucault M (1994 [1973]) *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. AM Sheridan Smith. New York: Vintage.
- Giddens A (1979) *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*. Berkeley: University of California Press.
- Halfon N and Hochstein M (2002) Life course health development: An integrated framework for developing healthy policy and research. *Milbank Memorial Fund Quarterly* 80(3): 433–480.
- Hall PA and Lamont M (eds) (2009) *Successful Societies: How Institutions and Culture Affect Health*. New York: Cambridge University Press.
- Helliwell JF (2002) *Globalization and Well-Being*.

- Vancouver: University of British Columbia Press.
- Hertzman J, Frank J and Evans RG (1994) Heterogeneities in health status and the determinants of population health. In: Evans RG, Barer ML and Marmor TR (eds) *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Aldine de Gruyter, 67–92.
- Jackson PB, Williams DR, Stein DJ, Herman A, Williams SL and Redmond DL (2010) Race and psychological distress: The South African stress and health study. *Journal of Health and Social Behavior* 51(4): 458–477.
- Jenson J (2009) Making sense of contagion: Citizenship regimes and public health in Victorian England. In: Hall PA and Lamont, M. (eds) *Successful Societies: How Institutions and Culture Affect Health*. New York: Cambridge University Press, 201–225.
- Kawachi I, Subramanian SV and Kim D (eds) (2008) *Social Capital and Health*. New York: Springer.
- Labonté R, Schreker T, Packer C and Runnels CV (eds) (2009) *Globalization and Health: Pathways, Evidence and Policy*. New York: Routledge Taylor Francis.
- Link BG and Phelan J (1995) Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior* 35: 80–94.
- McDonough P, Williams D, House J and Duncan G (1999) Gender and the socioeconomic gradient in mortality. *Journal of Health and Social Behavior* 40: 17–31.
- Marmot MG and Theorell T (1988) Social class and cardiovascular disease: The contribution of work. *International Journal of Health Services* 18: 659–674.
- Parsons T (1951) *The Social System*. New York: Free Press.
- Pearlin LI (1989) The sociological study of stress. *Journal of Health and Social Behavior* 30: 241–256.
- Phelan JC, Link BG, Diez-Roux A, Kawachi I and Levin B (2004) ‘Fundamental causes’ of social inequalities in mortality: A test of the theory. *Journal of Health and Social Behavior* 45(3): 265–285.
- Phelan JC, Link BG and Tehranifar P (2010) Social conditions as fundamental causes of health inequalities: Theory, evidence and policy implications. *Journal of Health and Social Behavior* 51(Suppl): S28–S40.
- Rosich KJ and Hankin JR (2010) What do we know? Key findings from 50 years of medical sociology. *Journal of Health and Social Behavior* 51(Suppl November): S1–S9.
- Straus RR (1957) The nature and status of medical sociology. *American Sociological Review* 22: 200–204.
- Thoits PA (2010) Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior* 51(Suppl): S41–S53.
- Turner B (1997) *The Body in Society: Explorations in Social Theory*, 2nd edn. London: Sage.
- Wilkinson RG and Pickett KE (2006) Income inequality and population health: A review and explanation of the evidence. *Social Science and Medicine* 62: 1768–1784.
- Willson AE (2009) ‘Fundamental causes’ of health disparities: A comparative analysis of Canada and the United States. *International Sociology* 24(1): 93–113.
- Willson AE and Erfani A (2009) Socioeconomic history and preventable disease: A comparative analysis of fundamental cause theory. Conference on Health over the Life Course, London, Ontario.
- Willson AE, Shuey KM and Elder GH (2007) Cumulative disadvantage processes as mechanisms of inequality in life course health. *American Journal of Sociology* 112(6): 1886–1924.
- Wister, AV (2005) *Baby Boomer Health Dynamics: How are We Aging?* Toronto: University of Toronto Press.
- World Health Organization (2003) *The Social Determinants of Health: The Solid Facts*, 2nd edn. Copenhagen: World Health Organization.

Susan McDaniel is a Canadian sociologist/social demographer with active research interests in international health and global issues. She is the Prentice Research Chair in Global Population and Economy and Professor of Sociology at the University of Lethbridge, Canada. Her current research is on well-being across the life course in comparative perspective, demographic ageing, generational relations, family change and care globally. [email: susan.mcdaniel@uleth.ca]

résumé La sociologie de la santé et de la maladie connaît de nouveaux développements avec une meilleure compréhension de la complexité des rôles que jouent les facteurs sociaux dans la santé des individus et de la société ainsi que dans le bien-être. Les nouveaux éclairages sont à la fois empiriques et conceptuelles, conduisant à des approches novatrices dans l'analyse, ainsi qu'à de nouveaux cadres conceptuels. Le gradient social de santé, la santé de la population, et l'importance du tissu social pour le bien-être de l'individu et de la société en sont trois exemples. Néanmoins, il reste à comprendre la façon dont les inégalités sociales deviennent sources de tensions, pourquoi les améliorations socio-économiques ne donnent pas toujours des gains en termes d'espérance de vie, et comment faire pour réduire les disparités et les inégalités en matière de santé.

mots-clés bien-être ♦ disparités de santé ♦ santé ♦ santé de la population

resumen La sociología de la salud y de la enfermedad ha sido vigorizada con mayor comprensión en las funciones complejas que juegan los factores sociales y estructurales en la salud y el bienestar del individuo y de la sociedad. Las nuevas revelaciones son simultáneamente empíricas y conceptuales, dando lugar a enfoques innovadores para el análisis, así como también nuevos marcos conceptuales. Tres ejemplos son: el gradiente social de la salud, la perspectiva de salud de la población y la prominencia del tejido social para el bienestar del individuo y de la sociedad. Sin embargo, quedan ciertas interrogantes tales como la forma en que las desigualdades sociales se vuelven establecidas, por qué el mejoramiento socio-económico no siempre proporciona aumentos en la esperanza de vida, y como reducir las disparidades y desigualdades de salud.

palabras claves bienestar ♦ disparidades de salud ♦ salud ♦ salud de la población