CHAPTER 1

# An Introduction to Social Sciences for Healthcare Professionals

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## How to Use This Book

This book provides an overview across its 20 chapters of the aspects of the social sciences most relevant to informing your practice as healthcare professionals now, and in the future. As a summary of some of the social sciences' largest bodies of work to date, crossing disciplines as diverse as Sociology, Psychology and Economics, this book provides readers with an overview of these disciplines work that has the most relevance to healthcare professionals in an accessible and easy to digest format. It is worth emphasising that all of these are large disciplines (and their sub-disciplines) and comfortably fill entire textbooks. As such, this book's chapters are intended as an introduction to some of the social sciences' most important contributions to health and healthcare. You can read this book's chapters in any order you like or you can start from **chapter 2**. A few of the chapters are particularly interrelated and we have highlighted these, both in this introduction and within the chapters themselves. In most of the chapters, we have provided opportunities to 'stop and think', and there are a number of case studies within this book that are intended to help you reflect on your own learning and relate the discussion and contents to your own practice and observations.

## What Are the Social Sciences?

### Sociology and Medical Sociology

Sociology is a scientific discipline that is concerned with the study of human societies, the institutions that as a society we build and the social relationships and processes that emerge from these (Giddens and Sutton, 2017, Scambler, 2018). A particular focus of sociology is understanding the unequal distribution of status, power and resources within a society that sees some having significant advantages and some having significant disadvantages, as well as the various social processes that influence and lead to such differences occurring (Giddens and Sutton, 2017).

Much of this applies to health too, and medical sociology (sometimes referred to as the sociology of health and illness) is simply the sociological study of health and illness (Allan, 2016, Barry and Yuill, 2022, Scambler, 2018). How health is constructed and seen in a society, as well as the health inequalities that exist between different individuals and groups, and the sometimes significant differences that exist relating to access to safe and effective healthcare (Scambler, 2018, Barry and Yuill, 2022). Medical sociology has also had a long interest in the healthcare professions, including the relative differences in terms of power and status afforded to different professional groups (Crinson, 2018), as well as how healthcare systems are seen and understood within a broader social system (Mays, 2018). Sociologies contributions to all of this, and more are considered throughout this book.

### Psychology and Health Psychology

Psychology, and in particular its sub-discipline Health Psychology, is another scientific discipline. As a broad discipline, it is generally most concerned with our minds, our thoughts, our behaviours, as well as how we make decisions (Gross, 2015, Marks et al., 2020, Ogden, 2023). Essentially, how we think, and how we behave (Gross, 2015, Marks et al., 2020,

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Ogden, 2023). This relates to and influences our health in several ways, many of which are explored throughout this book. For example, how we think can influence our behaviours and our behaviours can be influenced by those we are in contact with (Marks et al., 2020, Ogden, 2023).

This can affect the health-enhancing or health-harming behaviours we follow (such as drinking too much and smoking), and how we think about these behaviours, including whether we have the belief or motivation to change them (Marks et al., 2020, Michie et al., 2011, Michie et al., 2024, Ogden, 2023). It can also influence how we feel about our social relationships and the social contact that we have (Cacioppo and Cacioppo, 2018). From a health systems and organisational perspective, it can also shape how well we work with, or indeed how well we are able to lead others (Northouse, 2022, Salas et al., 2018a, Salas et al., 2018b), both of which are increasingly recognised as being important to healthcare delivery. Psychology's contributions to all of this, and more are considered throughout this book.

## Economics and Health Economics

Economics is the study of human behaviour, especially relating to the production, distribution and consumption of scarce resources – notably goods and services (Sloman et al., 2022). Health economics is also concerned with these, but in the context of health and healthcare provision for individuals and populations (Glied and Smith, 2011, Wiseman, 2011). Generally, we want people to consume healthcare when they need it, but as healthcare is generally seen as being finite (i.e. there are only so many hospital beds, healthcare professionals, drugs, etc. to go around), we do not want people to overconsume it when it is not needed (Glied and Smith, 2011, Koohi Rostamkalaee et al., 2022). With scarce goods, economic decision-making can be hugely important in determining what is and what is not funded, and economists are often concerned with how to maximise utility, by considering the tangible health benefits that arise through the consumption of healthcare, often when several alternative options exist (Feng et al., 2020, Glied and Smith, 2011, Rand and Kesselheim, 2021, Wiseman, 2011). The positive impacts of health consumption can of course relate to health outcomes, but can also relate to wider impacts on society, such as increased labour market productivity and reduced time off work, and these outcomes can have a reciprocal impact on health, as wider determinants (Dahlgren and Whitehead, 2021). Of course, all this consumption can impact on our planet, its resources and its ability to sustain life in a fair, just and equitable way (Raworth, 2017, Raworth, 2018).

As with psychology, economics is often also concerned with how people make decisions (especially decisions around consumption), particularly within behavioural economics (Glied and Smith, 2011, Sloman et al., 2022, Thaler and Sunstein, 2009). For example, much attention is often paid to how changing the price of products based on their harmful or helpful impacts on health may change patterns of consumption (known as elasticity), such as increasing the price of alcohol to deter consumption, or subsidising gym memberships to encourage uptake (Clements et al., 2022, Glied and Smith, 2011, Sloman et al., 2022). Economics' contributions to all of this, and more are considered throughout this book.

# So Why the Social Sciences?

Even outside of healthcare, your everyday experiences, and the experiences of those that you meet, are influenced by social, anthropological, psychological, economic and political influences. This book will introduce you to many of these and provide you with the underpinning social science knowledge to be able to make socially sensitive decisions in the care that you give, whatever healthcare role you do. As a healthcare professional, much of the care that you deliver will be shaped by these, and often in unexpected ways. Essentially, in your role as a healthcare professional, you must work within a set of complex and interconnected social conditions and structures that shape and influence how care is set up, organised and delivered.

So why is this all relevant to you, as a healthcare professional, or aspirant healthcare professional? Don't you just want to make people better? Isn't this largely a matter of biology and medicine? The short answer – no. This book provides a longer answer and will hopefully show that sickness and health are cultural and social experiences that are influenced by many complex and interrelated social processes. The delivery of healthcare is essentially a social activity that is determined by many of these processes across societies many layers.

# A Patient's Journey: The Social Sciences in Action

**Source:** Maskot/Adobe Stock Photos.

Barry is 58 and works in an office as a supervisor. He has recently divorced and lives on his own in a dank flat in the middle of town. Since his divorce six months ago, he has largely neglected himself and mostly just works. He has occasional contact with his sister, who is supportive, but apart from that he only really speaks to people at work (mostly his direct reports and his manager), as well as the local shopkeeper. It is a Friday, and Barry heads off to work, as he does every Friday.

Barry catches the 8:21 bus, which normally gets him to his office in about 20 minutes. Swiping his season ticket, he stands near the front of the bus next to another office worker who he occasionally speaks to; transactional, nothing too much. A 'hi' there, a nod here. Suddenly Barry begins to feel very funny and collapses into the aisle. A helpful bystander alerts the driver, the bus stops and Barry is tended too by bystanders. Someone calls an ambulance, and paramedics arrive at the scene and believe Barry to have had a stroke. They let the local Emergency Department know that they will be bringing Barry to hospital, under a blue light, and that they should expect to receive Barry in around 10 minutes. During the transit, the paramedics monitor his vital signs, pulse, blood pressure, levels of consciousness, etc. His levels of consciousness are poor, and he is slurring his speech, and tending to lean to one side. On arrival at the hospital, the paramedics transfer Barry's care to the Emergency Department team, who run through their various protocols and processes, and get him an urgent CT brain scan to determine if he has had a stroke, and what type of stroke he has had. This is an important information as it determines how Barry should be treated. Following this, Barry is diagnosed with an ischemic cerebrovascular accident (CVA), caused by a blockage to oxygenated blood flow to his brain. The decision is made to administer a drug delivered into his veins in the hope it will break down any clot that has caused a blockage, restoring blood oxygen flow to the affected areas of his brain. The treatment is partially successful, and in the weeks that follow, with the support of nurses, doctors, physiotherapists and occupational therapists, amongst others within the multi-disciplinary teams across the hospital, and with input from various community healthcare teams, Barry is ready to be discharged home to his flat. Whilst Barry is well enough to go home, the stroke has resulted in some damage to his brain, which has resulted in Barry having some physical, cognitive and sensory impairments that he will likely have to live with for the rest of his life. Three months later, Barry returns to work on a 'phased return'.

This is Barry's story. A story that many of you will be very familiar with.

So where are the social sciences and why are they relevant here? After all, wasn't Barry's recovery mostly through medicine? Wasn't it mostly healthcare professionals that put him back on his feet, got him home and back to work? All of these played a vital role, clearly, but this book will show you that Barry's story is actually incomplete; as too is the story of the healthcare professionals, healthcare system and wider society that provided his care. The social sciences can help us fill in the gaps in Barry's story, helping us understand, prevent and support Barry and his health, so that as a society, and in particular as healthcare professionals we are better placed to provide equitable care for all, and may even be able to prevent people like Barry collapsing on the bus in the first place. In the next section, we will step you through the book and how it will help you complete Barry's story.

# Completing Barry's Story

## Part 1: Understanding Health, Healthcare Systems and the Healthcare Workforce

In **chapter 2**, an overview of social theory and social research methods is provided. What you will see in this chapter, and alongside the rest of the book, is that social theory and social research methods are important to understanding how society works (Clark et al., 2021, Kislov et al., 2019) – and within the rest of this book, you will see diverse theories that have helped make sense of society and people's situations, as well as a range of methods that have been used to test or create these theories in many contexts with relevance to health. These can ultimately help us as a society to improve people's care and situations.

In **chapter 3**, we introduce you to the concept of 'health'. Barry, in his story, is clearly unwell. But defining health and disease is tricky, but nonetheless important, as it guides societies in thinking about who needs care, as well as how health is understood and delivered (Larsen, 2021, Leonardi, 2018, Schramme, 2023). It also guides what societies should prioritise or focus on (Larsen, 2021, Leonardi, 2018, Schramme, 2023). In fact, as we show in this chapter, how we think about health might even be relevant in preventing Barry from becoming unwell in the first place, and what aspects of Barry's care are seen as most important. This chapter also discusses the various ways health has been classified, and why classifications of health and disease matter (Clark et al., 2017, Harrison et al., 2021).

In **chapter 4**, we move on to consider health in the context of mental ill health. This chapter tracks the social changes that relate to mental ill health, including its identification and management (Rogers and Pilgrim, 2021), alongside the concept of deviance (something that sets someone apart) (Henry, 2018). Barry is presenting with a physical health issue, but poor mental health makes it more likely for people like Barry to find themselves in this position (Fiorillo et al., 2023, Kivimäki et al., 2020). In addition, experiencing a stroke makes it more likely Barry will experience poor mental health and poor well-being (Damsbo et al., 2020, Towfighi et al., 2017). The impact society has had on the various ways mental ill health has been viewed are considered, and how this might impact on how people like Barry are seen (Rogers and Pilgrim, 2021), alongside some prominent models in mental health practice (Beck and Fleming, 2021, Burns, 2020, Davidson, 2016, Middleton and

Moncrieff, 2019), and how these relate to the care that those presenting with mental ill health receive from a diverse range of backgrounds and experiences.

In **chapter 5**, we turn our attention to health economics, and the political economy, and consider in more depth the health systems that provide care to people like Barry. This chapter looks at some different healthcare systems that exist around the world and considers how these differences relate to how care is financed, what care people can access and what people like Barry must pay for it (if anything) (Anandaciva, 2023, Braithwaite et al., 2020, Britnell, 2015, Papanicolas and Cylus, 2015). The importance of countries working towards universal health coverage to ensure periods of ill health such as that experienced by Barry do not result in catastrophic healthcare expenditure is also considered (Wagstaff and Neelsen, 2020). In **chapter 6**, we move on to consider the healthcare professionals that work within these healthcare systems to care for people like Barry, highlighting some of the current challenges that exist relating to global healthcare workforce shortages (Boniol et al., 2022), and the relevance of this to meeting current and future healthcare needs. This chapter also considers how people end up in positions of care and what it means to be a 'healthcare professional'; how this has changed over time, as well as the differences in how professionals are seen and the differences in terms of the power and status that have been afforded to the different healthcare professions overtime (Saks, 2016).

## Part 2: Meeting Population Health Needs and Health Inequalities

Various demographic and epidemiological transitions have made Barry's situation more common in most societies. In **chapter 7**, these demographic and epidemiolocal transitions are discussed, alongside the challenges they present global healthcare systems with (Omran, 2005, Weisz and Olszynko-Gryn, 2010). These changes have meant that people are living longer, and more often with increased morbidity (Bury and Taylor, 2008, Taylor and Bury, 2007). The impact such changes are likely to have on health systems, and society more generally are considered, alongside the importance of people like Barry being supported to take on a greater role in the management of their own health once they have become unwell, alongside healthcare professionals (Bury and Taylor, 2008, Taylor and Bury, 2007).

Whilst anyone can find themselves in Barry's position, research consistently demonstrates increased early morbidity and mortality in those from lower socio-economic status groups (Bartley, 2017, Marmot et al., 2020). Differences in longevity and health outcomes are unequally experienced, and in **chapter 8**, readers are introduced to the social determinants of health (Dahlgren and Whitehead, 2021), and health inequalities (Marmot et al., 2020). Various explanations are considered that explain why those from lower socio-economic groups are more likely to experience early mortality and morbidity than those in higher-status groups (Bartley, 2017, McCartney et al., 2019, Wami et al., 2020). In **chapter 9**, bias and stigma are introduced as concepts that explain why some within a society experience various forms of disadvantage, including poorer care, based on their real or perceived differences (Hatzenbuehler et al., 2013, Phelan et al., 2008, Scambler, 2009, Tyler and Slater, 2018). These differences can result in people like Barry being more or less likely to receive emergency care, as well as influencing the quality of care they are able to access, and these differences can amount to discrimination, leading to poorer health outcomes, alongside reduced social and economic opportunities (Hatzenbuehler et al., 2013).

In **chapter 10**, some groups that are particularly vulnerable to being socially excluded are considered (Aldridge et al., 2018, Luchenski et al., 2018, Marmot, 2018, Tweed et al., 2022), alongside the consideration of how their needs can be better met by healthcare professionals, healthcare systems and society more generally. Those with a physical, mental, cognitive or sensory impairment are often excluded and disabled by society, and in **chapter 11**, the needs of those with impairments are considered, alongside the impact that society itself has on the lives of those living with such differences, often making it significantly (and unnecessarily) harder to participate fully in social and economic life, and access healthcare, through healthcare systems poorly accommodating the needs of those with impairments across their lives (Oliver, 2013).

## Part 3: Understanding Health Behaviours, Health Behaviour Change and Public Health

Of course, people like Barry can just be unlucky, and many of those who engage in unhealthy behaviours do not go on to have a stroke. However, global burden of disease studies consistently highlights the impact of health behaviours on non-communicable diseases and mortality (Afshin et al., 2019, Degenhardt et al., 2018, Katzmarzyk et al., 2022, Khan Minhas et al., 2024, Shield et al., 2020). **Chapters 12 and 13** consider why people engage in behaviours (such as drinking too much alcohol, smoking, being physically inactive or having a poor diet) that they know are unhealthy and that may lead to poor health outcomes, as well as how we can support individuals through various behaviour change techniques and interventions that seek to elicit change at the level of individuals. In this chapter, approaches that are particularly common in clinical practice, such as motivational interviewing and making every contact count are considered alongside their respective evidence bases (Frost et al., 2018, Nichol et al., 2024, Parchment et al., 2023, Rodrigues et al., 2024). These techniques may be effective in supporting people like Barry to change behaviours that could be harming their health. Of course, behaviours, including Barry's occur within a social context (Christakis and Fowler, 2013, Kickbusch et al., 2016, McCartney et al., 2019

Wami et al., 2020, WHO, 2023). This social context can make behaviour change difficult, especially where people lack the resources they need to change their behaviour and where behaviours are so often influenced by society, its institutions, as well as those within it. In **chapter 14**, we move beyond behaviour change at the level of individuals and consider how whole populations can be supported to change their behaviours through various population-level interventions, that may work to incentivise, disincentivise, restrict and even ban certain unhealthy behaviours. As part of this chapter, a whole systems approach to public health is considered (Danielli et al., 2023, Davey et al., 2022), alongside consideration of the relationship between our health and well-being and the health of our planet (Raworth, 2017, Raworth, 2018).

## Part 4: Social and Community Networks, Loneliness and Social Prescribing

Our social networks influence our health and lives in a number of ways across the life course (Christakis and Fowler, 2013, Granovetter, 1973, Rogers et al., 2014). They give us access to needed social, material and economic resources in good and bad health and also shape our health behaviours. In **chapter 15**, we introduce the life course approach and highlight the importance of earlier life stages on later life health and opportunities. Preceding Barry's stroke are a set of social network circumstances that are unique to him. How well supported he was in his early years relates to how well he is able to build and maintain relationships later in his life, as well as the economic resources that he is able to accumulate. His social network also has a significant impact on the health behaviours that he himself follows, with evidence consistently highlighting that unhealthy behaviours spread through social networks (Christakis and Fowler, 2008, Christakis and Fowler, 2013, Rosenquist et al., 2010). In **chapter 16**, the public health issue of social isolation and loneliness is introduced. Prior to the stroke, Barry's lack of social contact, especially if more contact was desired, may have actually increased his risk of becoming unwell (Cacioppo and Cacioppo, 2018, Holt-Lunstad, 2018). Of course, Barry's new situation also places him at an increased risk of experiencing social isolation and loneliness, with new impairments making it harder for him to reach out to maintain and connect with new social ties (Macdonald et al., 2018), and can also lead to poorer health, social and economic outcomes. In **chapter 16**, we turn to social prescribing as one approach that is being increasingly used to support those who are lonely, alongside those presenting with other social needs, through connecting people to a range of activities within their local communities (Chatterjee et al., 2018, Husk et al., 2020).

## Part 5: Leading Safe and Effective Care in Increasingly Changing Healthcare Systems

When Barry first accessed healthcare following his stroke, he was very vulnerable and was reliant on healthcare professionals like you being able to meet his needs safely and effectively. He was reliant on healthcare systems having safe work systems (Carayon et al., 2020, Holden et al., 2013) and strong leadership (Wu et al., 2024), and this is the focus of **chapter 18**. Barry's needs are complex and cannot be met by one healthcare professional working in isolation (Kerrissey et al., 2023, Sanford et al., 2024, Shuffler and Carter, 2018). Even just getting to a hospital involved the coordinated efforts of multiple healthcare professionals working within a multi-team system, where communication and other teamwork processes can have a significant impact on the quality and safety of care that Barry was able to receive (Salas et al., 2018b). It is the healthcare teams and teamwork processes that are the focus of **chapter 19**. Finally, Barry's care was reliant on healthcare professionals being able to use various health technologies effectively. In **chapter 20**, the place and importance of health technology and innovations are considered, alongside the importance of them being designed responsibly, and with the needs of intended users considered in their design to ensure that they can be used safely and effectively to enhance the care of people like Barry (Greenhalgh et al., 2017, Topol, 2019). Of course, Barry is just one person. The exact social influences and needs of those accessing care will vary from person to person, based on a range of complex and interrelated social processes and influences. This book is intended to help you give socially responsive care by considering social context, and across this book, you will have the opportunity to apply this learning to the diverse needs of a range of people across a wide range of settings and clinical contexts.

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