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Human Agency, Social Structure and Forming of Health Consciousness and Perception

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Abstract: The social context of an individual shapes the risk of exposure, susceptibility of the host, and disease's course and outcome, even if the disease is infectious, genetic, malignant, or degenerative. For example Conley at al. (2003) in their study among two groups of couples where one is high income and the other is low income group, along with each group has same 20 percent biological predisposition toward having a low-birth-weight baby finds that social variables can reverse the biological disadvantage. They found that the high income group has a very high probability of dealing with their biological predisposition through better nutrition and prenatal care. Their study shows that social factors can reverse the biological risk, for example by explaining how income translate into better education, living situation, jobs, quality medical care, and a good diet and other healthy lifestyle practices.

Keywords: Social Structure, Agency, Health, Consciousness

Whether it is human agency side or social structure side, before proceeding further it is important to clear the relationship between social variables and health. In literature usually social variables are characterized as distant or secondary influences on health and illness, not as direct causes (Cockerham, 2008). But Cockerham (2008) observes as expressed in the perceptions of people, social variables have much more direct and fundamental influence in inducing adversity or enrichment in health outcomes. That is, the social context of an individual shapes the risk of exposure, susceptibility of the host, and disease's course and outcome, even if the disease is infectious, genetic, malignant, or degenerative. For example Conley at al. (2003) in their study among two groups of couples where one is high income and the other is low income group, along with each group has same 20 percent biological predisposition toward having a low-birth-weight baby finds that social variables can reverse the biological disadvantage. They found that the high income group has a very high probability of dealing with their biological predisposition through better nutrition and prenatal care. Their study shows that social factors can reverse the biological risk, for example by explaining how income translate into better education, living situation, jobs, quality medical care, and a good diet and other healthy lifestyle practices. In addition among the low-income group the biological risk proceeds without any hindrance.

As social factors have direct relation with health, it is important looks into the pathways through which it works. Human agency is one way, which is the capacity of individual to freely select his or her behavior. It is the process by which individual influenced by their past but also oriented toward the future (as a capacity to imagine alternative possibilities) and the present, critically evaluate and choose their course of action (Emirbayer & Mische, 1998). As it is finally choosing the course of action, choice is important in agency oriented approach. In other words always there is a scope for individual actors to choose their behavior regardless

of structural influence. In addition individuals could have acted otherwise in a particular situation if he or she has chosen to do so (Cockerham, 2008). By explaining three elements of agency a) iteration, b) projectivity, and c) practical evaluation Mustafa Emirbayer and Ann Mische(1998) conclude that individual choose their behavior based upon their recall of past, imagining of future actions and critically evaluating their present circumstances. Similar to this symbolic interaction, a leading agency-oriented theoretical paradigm provides a social-psychological model of explanation to behavior. According to Blumer (1986) Symbolic interaction theory maintains that individual acts are based on their meaning-making to things around them through social interaction with other members in the society. It assumes that objects in the social environment do not possess meaning by its very nature, but it is the people who give meaning to them. Similarly, an individual's self is formed out of social interaction with other people, where other individuals in the interaction defining a person to himself. However, the crude denial of the role of structure and simply posing importance on agency alone or vice versa is not well accepted, instead of complete denial domination of the one over the other become dominant. In case of symbolic interaction, it emphasizes the dominance of agency over structure.

On the other hand conflict theory, with its roots in Marx, maintains that society is not held together by shared norms and values as discussed in agency oriented approaches, rather they are imposed by economically dominant groups. Marx held that they are imposed through the social process where people act on the external world by means or labour and through the production of material objects (Blaxter, 2004). This brings the class difference and its gradation of risk to health and longevity by social status, which in turn infers that the cures for ill health are change in the social structure rather than change in individual. In line with this, studies come up with findings like a poor start in life associated with poorer parental socioeconomic circumstances and vulnerability to illness, can be reinforced throughout childhood by poorer education and thus lower social class in adulthood, less healthy behavior, and poorer health (Wadsworth, 1991). On the one side people who believe in internal factors saw health and illness as the outcome of their own attitude and behavior, and therefore in their own hands. On the other side those who have believe in external factors saw them as the consequences of outside influence, and therefore require adjustment in the external environment. However this simple classification was soon seen as crude, nevertheless the internal / external, psycho social and behavioral / material distinction has been a very constant theme (Blaxter, 2004).

To this Max Webber added that social differences are based not only on economic factors, on relationship to the 'means of production', but also on status and other form of influence. Cockerham (2010) cites a theoretical background for these discussions in the writings of Weber through his two concepts: life conduct and life chances. Conduct represent agency or choice, the voluntarily direction in behavior. Chances represent class position, the boundaries within which people act according to their social situation. When lifestyle choices are explained by assigning complete freedom in individuals it fails to notice the boundaries placed on those choices by the social structure. Thus the interplay of both life conduct and life choice is the dominant theme in shaping lifestyle outcomes. But here it is not mean that people do not know that they are at least in a limited sense responsible for those behavioral risk factors which more likely make ill-health, but they also know that the risk they faced were part of their social conditions that are beyond their reach to make any change. This is not to say that considerations of agency should be minimized but agency is not the whole story. In many situations agency is not the dominant player and in some cases it can even be just a passive role. However, structure always has a role in lifestyle outcomes, thus it is generally the interaction between agency and structure that determine the outcome.

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French sociologist Bourdieu explains that the everyday practices of individuals are influenced by the structure of their social world and their everyday practices in turn create that structure. Individual practices are connected to culture and structure, and ultimately to power, through the conception of habits. He explains this using the concept 'habitus', which is 'the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them' (Wacquant 2005: 316, cited in Navarro 2006:16). In other words actions in the everyday life are habituated and, as they are embodied in a person they are then taken as granted. Thus individual activities cannot be understood solely in terms of socio-structural factors or behavioral factors. A good understanding requires an integrated causal system in which direct influence of socio-structural factors and its operation through psychological mechanism to produce behavioral effects are also included. However it does not mean that the behavior which has its base in human agency is not merely a conduit for external influences. Human agency operates generatively and proactively on social systems, not just reactively (Bandura, 1999).

When human agency is seen in a narrow sense and argues human behavior as reason for promoting unhealthy habits for bad health, it ends up with victim blaming.An understanding on forming of perceptions through interplay of experience, socialization and class circumstances can argue that structural factors predispose the individual towards particular behavior. Thus behavioral choices are typically in keeping with the norms of a group or social class, and the habitus imposes boundaries on the probable form of action (Blaxter, 2004). Thus to an extent human agency itself is largely influenced by the wider social structure through the interplay of social and class circumstances.In the same sense people in comfortable sick role neither see health and illness as internal, the outcome of their own attitudes and behaviors, and therefore in their own hands. Nor see health and illness as mere external, the consequences of outside influence or simply acquired by chance. But it could better put in to the interplay between the human agency and social structure.

Why comfortable sick role

The concept of sick role was a constantly used idea in the sub-discipline of medical sociology from 1951 onwards when it was put forward by Parsons. However by 1990 the concept had almost disappeared from the research literature (Burnham, 2014). Burnham (2014) finds beyond the generational and theoretical changes that made sick role idea less acceptable to sociologists there were two immediate reasons a) the negative politicization of the concept and b) the shifts of medical sociologists to a focus on applied health behavior. Twaddle (Twaddle,1979 cited in Burnham, 2014) points that a move from sick role concept first to illness behavior and then towards health behavior can be seen as a move of the sociologist, especially in the 1990's towards applied medical sociology. The sick role, medical sociologists found was difficult or impossible to use as an instrument to improve treatment, that is actively to intervene in what happened to individual 'patients' or statistical 'risk groups'. As a result the new goal becomes reform on the part of people who were part of the ill person's social environment as well as on the part of the patient.

This is happening at a time when transition to chronic illness necessitates medicine to deal with health problems well beyond singular cause of disease. As Porter (1999) pointed out, even though the twentieth century witnessed the most intense concentration of attention and resources ever on chronic disease it gain relatively little success. And one reason for relatively little success in eradicating many chronic and degenerative diseases is because the strategies which earlier worked so well for tackling acute infectious disease have proved inappropriate to deal with them, and it has been hard to discard the successful 'microbe hunters' formula". Crawford (1977) noted, people are told to be individually responsible for

their health conditions at a time when they are becoming less capable at individual level to control the determinants in their environment which shapes their health. Further he says if faith in medicine is eroded by the non- appearance of the 'magic bullet' and the fear of over-reliance on technology and, cost of medicine become difficult to sustain – then the attractive answers is prevention, and individual responsibility. This shows the present health promotion model based in lifestyle change and individual responsibility is ultimately blaming the victim. Such arguments thus on the onside mystifies the understanding of social production of disease. On the other hand weaken the demand for rights and entitlements for a comprehensive health care (Crawford, 1985). This shows instead of sidelining ideas like sick role by developing distinctive approaches to deal with health and illness, have to find possibilities to further develop approaches which deals beyond singular cause of diseases. Such ideas were needed to understand the functioning of human body in the context how people have constructed their life through their understanding of the relation of human being with the wider environment.

As health conditions has its routes beyond individual level factors to societal level factors, in addition to individual level motivation a community level cohesion always motivates individuals to follow comfortable sick role. For example the effect of income inequality on health could be translated through underinvestment in social goods, such as public education and health care; interruption of social cohesion and the erosion of social capital (Kawachi & Kennedy, 1999). In such case community will strives to impose cohesion among individual to remain in comfortable sick role to ensure the performance of social roles from each individual so that social goods in the society could be protected. Specific to health, through their social roles people establishes a condition in the society in which they could protect and promote their health. So that all people will be able to attain a level of health that enable them to participate actively in social and economic life of the society in which they live.

As seen, in comfortable sick role pain itself is not represented as sufficient reason for people's consideration of the health condition as illness. On the other hand strength of the body (especially as in health as able to do things or health as fitness) is well acknowledged. However when moving out to comfortable sick role to avail formal care, as expressed byBlaxter (2001)pain is an enough reason to be formed as disease and strength is poorly considered. In other words consideration of people in comfortable sick role is not always match with that of considerations in formal health care and they do not prefer to hold the patient status. At the same time they are not neglecting the health condition rather at the second stage they do self treatment by relying on their lay network. This could be partially explained through individual's desire to not fully loose their control in treatment as in the case of availing treatment from formal health care outside comfortable sick role. Stimson & Webb (2001) have observed such situations where the patients resisting the attempts which minimize their control in diagnosis and treatment. For example, patient's presentation of their self as a strategy (through conscious presentation of self invoking a desired reaction) to control and direct the consultation process along their desired ways. And their reluctance to agree with the doctors when the doctors do not states their interpretation of illness in a sufficiently convincing manner to the patient.

At the second stage of comfortable sick role people largely depend on the local health tradition which at most time lies out of the formal health care system. While viewing Local Health Tradition as one of the base to build upon for a continuation of care, from home and community, to health centres and dispensaries, to hospitals will serves the people best (Saxena & Priya, 2009). First of all it helps the people to deal with many of their health problems at their comfortable level, secondly it will help to maintain and further strengthen the local health tradition within the community and, thirdly it will become a first point of connection with the formal health service system for many of the underprivileged. Similarly

many more such reasons can be identified to understand why individuals prefer to be in comfortable sick role and why concepts like sick role are important in dealing with health conditions of people.
Various studies have been done in this area with significant findings (Kansra P. and Gill H.S. 2017, Singu H.B. and Kaur R. 2017, Sarkeret al. 2017, Kansra P. and Gill H.S. 2016, KansaraP. and Gupta V. 2016, Chouhan K. and Prasad S.B. 2016, Sourabh et al. 2016, Kumar et al. 2016, Sharma et al. 2016, Kumar et al. 2016).

REFERENCES

[1] Bandura, A. (1999). Social Cognitive Theory: An Agentic Perspective. *Asian Journal of Social Psychology*, *2*(1), 21–41. https://doi.org/10.1111/1467-839X.00024
[2] Banerji, D., & Andersen, S. (1963). A sociological study of awareness of symptoms among persons with pulmonary tuberculosis. *Bulletin of the World Health Organization*, *29*, 665–683.
[3] Becker, H. S. (1963). *Outsiders: Studies in the Sociology of Deviance* (First FREE PRESS PAPERBACK EDITION 1966). New York: The Free Press. Retrieved from https://monoskop.org/images/2/2b/Becker_Howard_Outsiders_Studies_In_The_Sociology_Of_Deviance_1963.pdf
[4] Bierlich, B. (2007). The problem of money: African agency and Western medicine in northern Ghana. New York: Berghahn Books.
[5] Blaxter, M. (2001). Lay concepts of health. In M. Purdy & D. Banks (Eds.), *The sociology and politics of health: a reader*. London ; New York: Routledge.
[6] Blaxter, M. (2004). *Health*. Cambridge, UK, Malden, MA: Polity.
[7] Blumer, H. (1986). *Symbolic interactionism: perspective and method* (Nachdr.). Berkeley, Calif.: Univ. of California Press. Retrieved from https://books.google.co.in/books?redir_esc=y&id=HVuognZFofoC&q=symbolic#v=snippet&q=symbolic&f=false
[8] Burnham, J. C. (2014). Why sociologists abandoned the sick role concept. *History of the Human Sciences*, *27*(1), 70–87. https://doi.org/10.1177/0952695113507572
[9] Clarke, A. E., Mamo, L., Fosket, J. R., Fishman, J. R., & Shim, J. K. (Eds.). (2010). *Biomedicalization: technoscience, health, and illness in the U.S*. Durham, NC: Duke University Press.
[10] Cockerham, W. C. (2008). *The social causes of health and disease* (Reprinted). Oxford: Polity.
[11] Cockerham, W. C. (2010). *The new Blackwell companion to medical sociology*. Chichester (Royaume Uni); Malden (Mass.); Oxford (Royaume Uni): Wiley-Blackwell. Retrieved from https://books.google.co.in/books?id=2oqwDQAAQBAJ&pg=PA12&dq=Weber+provides+a+theoretical+background+for+these+discussions,+he+identified+two+concepts:+life+conduct+and+life+chances.&hl=en&sa=X&ved=0ahUKEwicz76_n5XfAhUFuY8KHTGwB40Q6AEIKTAA#v=onepage&q=Weber%20provides%20a%20theoretical%20background%20for%20these%20discussions%2C%20he%20identified%20two%20concepts%3A%20life%20conduct%20and%20life%20chances.&f=false
[12] Conley, D., Strully, K. W., & Bennett, N. G. (2003). *The starting gate: birth weight and life chances*. Berkeley: University of California Press. Retrieved from https://books.google.co.in/books/about/The_Starting_Gate.html?id=j9XpREzMpysC&printsec=frontcover&source=kp_read_button&redir_esc=y#v=onepage&q&f=false

[13] Crawford, R. (1977). You are Dangerous to Your Health: The Ideology and Politics of Victim Blaming. *International Journal of Health Services*, *7*(4), 663–680. https://doi.org/10.2190/YU77-T7B1-EN9X-G0PN
[14] Crawford, R. (1985). A cultural account of "health": control, release and the social body. In J. B. McKinlay (Ed.), *Issues in the political economy of health care*. New York: Tavistock Publications.
[15] Emirbayer, M., & Mische, A. (1998). What Is Agency? *The American Journal of Sociology*, *103*(4), 962–1023.
[16] Foulkes, I. (2001). One in five Swiss children left unvaccinated. *Swissinfo*. Retrieved from https://www.swissinfo.ch/eng/one-in-five-swiss-children-left-unvaccinated/1890454
[17] Freidson, E. (1988). *Profession of medicine: a study of the sociology of applied knowledge* (University of Chicago Press ed). Chicago: University of Chicago Press.
[18] Good, M.-J. D. (Ed.). (1994). *Pain as human experience: an anthropological perspective* (1st paperback printing). Berkeley: Univ. of California Press.
[19] Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental Illness Stigma, Help Seeking, and Public Health Programs. *American Journal of Public Health*, *103*(5), 777–780. https://doi.org/10.2105/AJPH.2012.301056
[20] Kawachi, I., & Kennedy, B. P. (1999). Income inequality and health: pathways and mechanisms. *Health Services Research*, *34*(1 Pt 2), 215–227.
[21] Mechanic, D. (1978). *Medical sociology* (2d ed). New York: Free Press.
[22] Navarro, Z. (2006). In Search of Cultural Intepretation of Power. *Institute of Development Studies Bulletin*, *37*(6). Retrieved from https://core.ac.uk/download/pdf/43539433.pdf
[23] Parsons, T. (1951). *The Social System*. Glencoe: The Free Press.
[24] Porter, R. (1999). The greatest benefit to mankind: a medical history of humanity. New York: W.W. Norton.
[25] Read, M. (Ed.). (1966). Culture, health and disease: social and cultural influences on health. London: Routledge.
[26] Saxena, S. A., & Priya, R. (2009). Mainstreaming AYUSH & revitalizing local health traditions under NRHM: an appraisal of the annual state programme implementation plans 2007-10 and mapping of technical assistance needs. New Delhi: National Health System Resource Centre.
[27] Stimson, G., & Webb, B. (2001). Going to See the Doctor. In M. Purdy & D. Banks (Eds.), *The sociology and politics of health: a reader*. London ; New York: Routledge.
[28] Topley, M. (1970). Chinese Traditional Ideas and the Treatment of Disease: Two Examples from Hong Kong. *Man, New Series, Royal Anthropological Institute of Great Britain and Ireland*, *5*(3). Retrieved from https://www.jstor.org/stable/pdf/2798950.pdf?refreqid=excelsior%3A6867623be2233f31886a68359be8e7ec
[29] Twaddle, A. C. (1979). *Sickness behavior and the sick role*. Boston: G. K. Hall.
[30] Wadsworth, M. E. J. (1991). *The imprint of time: childhood, history, and adult life*. Oxford : New York: Clarendon Press ; Oxford University Press.
[31] Yeo, M., & Sawyer, S. (2005). Chronic illness and disability. *BMJ*, *330*(7493), 721–723. https://doi.org/10.1136/bmj.330.7493.721
[32] Kansra P., Gill H.S. Role of Perceptions in Health Insurance Buying Behaviour of Workers Employed in Informal Sector of India. Global Business Review, 18(1), 2017.
[33] Singu H.B., Kaur R. Determinants of health seeking behaviour among low income households of Punjab: Does health insurance coverage matter? International Journal of Public Sector Performance Management,3(4),2017.

[34] Sarker K.K., Sethi J., Mohanty U. Effect of spinal manipulation on specific changes in segmental instability, pain sensitivity and health-related quality of life among patients with chronic non-specific low back pain-A randomized clinical trial. Annual Research and Review in Biology, 18(2),2017.
[35] Kansra P., Gill H.S. Occupational Differences in the Awareness and Perception of Health Insurance of Workers Employed in Urban Informal Sector of Punjab. Journal of Health Management,18(3),2016.
[36] Kansara P., Gupta V. Service quality redefined: Public vs private hospitals from the patients' perspectives. Indian Journal of Public Health Research and Development, 7(3),2016.
[37] Chouhan K., Prasad S.B. Self-medication and their consequences: A challenge to health professional. Asian Journal of Pharmaceutical and Clinical Research, 9(2),2016.
[38] Sourabh A., Rai A.K., Chauhan A., Jeyaram K., Taweechotipatr M., Panesar P.S., Sharma R., Panesar R., Kanwar S.S., Walia S., Tanasupawat S., Sood S., Joshi V.K., Bali V., Chauhan V., Kumar V. Health-related issues and indigenous fermented products. Indigenous Fermented Foods of South Asia, 2016.
[39] Kumar P., Bala L., Sharma N. Effect of proprioceptive neuromuscular facilitation training on physical fitness and optimum health of school students. Man in India, 96(9),2016.
[40] Sharma P., Shivaram T.R., Sharma A. A methodical review of e-health systems developed for Indian healthcare sector. Indian Journal of Science and Technology, 9(44),2016.
[41] Kumar G., Kumar A., Kumar M., Walia V., Prasher S., Tuccu M.A. Indoor radon monitoring in the Mandi district of Himachal Pradesh, India, for health hazard assessment. Radioprotection,51(1),2016.