

SAĞLIĞIN VE HASTALIĞIN ANLAMI: FARKLI SOSYO-EKONOMİK STATÜ GRUPLARININ ALGILARI

The Meaning of Health and Illness: Perceptions of Different Socio-Economic Status Groups

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Abstract

Conceptualisation and definition of health and illness have been major discussion topics in the social sciences. Drawing on the data of a field study conducted in 2009-2010 in Eskisehir, this study aims to examine how different socio-economic groups perceive and define health, illness, and disease. The sample of the study consists of 355 people from three different socio-economic status groups, and the study is an attempt to sociologically examine their health and illness perceptions. The findings indicate that different socio-economic groups' perceptions and definitions show determinable differences from each other and are not independent from the social structure and material conditions that surround people.

Keywords: Health, illness, sociology of health, socio-economic status groups, Eskişehir

Özet

Sağlık ve hastalığın tanımlanma ve kavramsallaştırılma biçimi sosyal bilimler literatüründe süregiden tartışmalardan birini oluşturmaktadır. Bu çalışma, 2009-10 yıllarında Eskişehir'de üç farklı sosyo-ekonomik statü grubundan toplam 355 kişilik bir örneklem üzerinde yürütülmüş olan bir alan araştırmasının bulgularına dayanmaktadır. Çalışmanın amacı farklı sosyo-ekonomik statü gruplarının sağlık ve hastalık kavramlarını algılama ve tanımlama biçimleri açısından gösterdikleri benzerlik ve farklılıkları sosyolojik olarak irdelemektir. Bulgular farklı sosyal ve ekonomik statülere sahip olan toplumsal grupların sağlık ve hastalık kavramlarını algılayışlarının ve tanımlayışlarının birbirinden belirlenebilir şekilde farklılık gösterdiğini, bireylerin

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algılarının kendilerini çevreleyen, sınırlandıran ve biçimlendiren maddi koşullardan ve toplumsal yapıdan bağımsız olmadığını ortaya koymuştur.

Anahtar Kelimeler: Sağlık, hastalık, sağlık sosyolojisi, sosyo-ekonomik statü grupları, Eskişehir

Introduction

There is an ongoing debate concerning the definition of health and illness in various areas of the social sciences (Law and Widdows, 2008; Blaxter, 2004; Dixit et al. 2008). On one hand, there are definitions grounded in the biomedical model, detaching individuals from their social context, reducing them to physical bodies and organs, illness to observable symptoms and defects, and health to the absence of illness. On the other hand, the definitions grounded in anthropological and social constructivist approaches make holistic health definitions that contain almost everything related to the social environment. Studies both indicate that the conceptualisations of health and illness shape health-related behaviours (Hwu, Coates and Boore, 2001; Helman, 1991) and that empirical research on the conceptualisation process of these concepts is inadequate (Hughner and Kleine, 2004). Although the quantity of the studies focusing on the meaning of health is relatively limited in Turkey, studies emphasize the social and structural factors in individual construction of health and healthiness (Cirhinlioğlu, 2003; Kasapoğlu, 2008) and point that illness has a separate socio-cultural and identity related aspect other than the biological condition that the physician identifies (Oskay, 1993; Özen Güçlü ve Adak, 2002; Nazlı, 2007, 2012). To increase the effectiveness of health improvements and health policies, it is important to develop a deeper understanding of how health and illness are perceived, conceptualized, and defined by lay people as well as by health professionals.

The World Health Organization (WHO, 1948) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. Yet, this definition is found to be analytically impracticable (Law and Widdows, 2008:10) and ‘unreasonably’ highly standardized (Lewens and MacMillan, 2004:664). Classifications of health definitions also differ. Hughner and Kleine (2004) classify lay peoples’ definitions of health into five categories, which can be summarized as: (a) health as the absence of illness; (b) health as being able to carry out daily functions; (c) health as equilibrium, happiness, and relaxation, (d) health as the freedom and capacity to choose how to live; and (e) health as constraint. Herzlich (1973) classifies the definitions of health as: (a) health as the absence of illness (the negative definition of health); (b) health as a reserve, which constitutes the capacity of resistance; and (c) equilibrium as positive health. Blaxter (2004) indicates that health can be conceptualized in four ways, as: (a)

the absence of illness, (b) a state of balance, (c) a function, and (d) a status. On the other hand, Bauman (1961) indicates that health is defined with three orientations, (a) feeling state, (b) symptom and (c) performance. In addition to these classifications, health has been understood as a positive value and status both morally (Cornwell, 1984, Wright, 1982; Szasz, 1974) and politically (Sontag, 1983).

The distribution of the categories of these classifications of health are based on social patterns. Arguing that the conceptualisation process is related to age, socio-economic status, education level, religion, and current physical condition, Bauman (1961) relates the dominance of performance-orientated definitions in his research to the business- and success-related norms in American society. On the other hand, the rather low proportions of both performance-orientated and negative definitions of health (as the absence of illness) in research conducted in Brazil (Schall et al, 1987) indicate the effects of culture in the process of conceptualisation of health. Studies on the conceptualisation of illness show that illness most frequently is defined related to physical condition, and like health definitions, illness definitions of people also vary according to social variables (Boruchovitch and Mednick, 2002; Chen, 2003) and moral evaluations (Cornwell, 1984).

Drawing on field research conducted in Eskisehir, Turkey, the aim of this paper is to determine how health and illness are perceived, conceptualized, and defined by different socio-economic status groups. It also aims to examine sociologically the similarities and differences among these groups on defining health and illness, and to analyse the patterns underlying these definitions.

Method

The research was conducted in Eskisehir, Turkey in 2009-2010¹. Turkey has a population of nearly 75.000.000, of which, 77% live in urban areas and 23% live in rural areas. Eskisehir is a city in Central Anatolia, next to the capital, Ankara. The population of the province is nearly 1.700.000, and of the city centre is 700.355. Of the population, 92% live in urban areas. Of the employed population in Eskisehir, 44% work in industry, 44% in services and 12% in agriculture (www.tuik.gov.tr). Industry is concentrated in urban areas; agriculture is the main source of income in rural areas. Therefore, Eskisehir both represents the positive qualities of urbanization and the disadvantages of rural areas.

¹ The data used in this paper is a part of a PhD research (Göncü-Şavran, T. 2010. Social Inequalities and Health: A Sociological Research in Eskisehir, Anadolu University Graduate School of Social Sciences).

The sample of the research is composed of three different socio-economic groups. The variables used to determine the socio-economic status group are income, education level, occupation, age, sex, birthplace, living place, marital status, and number of children. It is largely documented and well known that the factors of income, education, employment status, occupation, and the characteristics of living place are related to health in many ways. Therefore, the sample is composed of three clusters, which are relatively homogeneous in the aspect of the variables mentioned above and are assumed to represent three different socio-economic status groups. The measurement of the status is a controversial issue in social sciences. Yet, the three clusters selected show homogeneous distribution in the abovementioned variables of socio-economic status, broadly share a common lifestyle, and form social status groups in a Weberian sense. Thus, the findings on similarities and differences become concrete in the sample groups. The sample (n = 355) that was selected from these clusters by quota sampling, thus, consists of (i) peasants who live in the three villages of the two most underdeveloped counties of Eskisehir, which are assumed to represent the characteristics of the rural population with lower income and status (n = 103) (rural low status group); (ii) people who live in the two main labour settlements of the city centre, which are assumed to represent the characteristics of the urban population with lower income and status (n = 126) (urban low status group); (iii) associate professors and professors working in a state university (n = 126), which are assumed to represent the characteristics of an urban population with middle-high income and status (n = 103) (urban middle-high status group).

The data were gathered in 2009-2010. Face-to-face, semi-structured interviews were completed with the rural and urban low status groups (n = 229); in-depth interviews were completed with six people, and two focus group interviews were completed from each status group. The data from the urban middle-high status group were collected by questionnaire (n = 126) and three in-depth interviews were completed within this group. The data were quantified and analysed by SPSS. The questions that form the focus of this paper were open-ended questions (e.g., “what does healthy mean?”, “what is illness?”, “what is the cause of illness?”) yet, they are categorized and transferred to SPSS with special care to maintain the plurality of the answers given.

The Social and Demographic Characteristics of the Sample Groups

Rural Low Status Group

In the county development index of Turkey, the counties in which the rural low status group live have the ranks of 619 and 591 among 872 counties

(Dinçer and Özaslan, 2004:114). The main source of income in all three of the villages where rural low status groups live is agriculture; yet, they all lack irrigation systems and dams. They also lack a central sewer system and primary healthcare centre; all have problems about collection of garbage, and two have problems about access to clean drinking water. Most of the houses are in a physically poor situation. Of this group, 52% are males, 48% are females, 92% were born in villages, and the fathers of 91% are peasants. Of them, 85% have a primary school education at most (11% are not literate), 5% have a secondary education, 9% have a high school education and 1% have a university education. They are mainly peasants (35%) and homemakers (39%), 9% are blue-collar, 3% are white-collar workers or civil servants and 14% are either self-employed artisans, or irregular informal workers. The mean age is 54,31 (min = 17, max = 77, SD = 16), income is 202 euros (min = 0, max = 1060, SD = 412), household size is 3,17 (min = 1, max = 9, SD = 1,5), number of children is 4,35 (min = 1, max = 9, SD = 1,9), years of social security is 12,2 (min = 1, max = 41, SD = 10,2). More than two thirds of the houses do not have a toilet in the main building; more than one fifth do not have a domestic water system. Nearly two third do not have a separate room for children and 15% have at least one dependent patient at home.

Urban Low Status Group

People in the urban low status group live in two working quarters in the city centre, which generally is where blue-collar informal workers live. Of them, 52% are male, 48% are female, 50% were born in villages, and of the fathers, 60% are peasants. More than half of this group (58%) migrated to the city centre from villages and 18% from other city centres. Of this group, 73% have a primary school education at most (10% are not literate), 12% have a secondary education, 13% have a high school (lycee) education and 2% have university education. They are mainly blue-collar workers (30%) and homemakers (41%), 6% are peasants, 3% are white-collar workers or civil servants and 19% are either self-employed artisans, or irregular informal workers. The mean age is 49,46 (min = 21, max = 86, SD = 13), income is 316 euros (min = 0, max = 2135, SD = 602), household size is 3,25 (min = 1, max = 9, SD = 1,5), number of children is 2,53 (min = 0, max = 8, SD = 1,8), duration of social security is 17,47 (min = 1, max = 54, SD = 15). More than half (51%) have a separate room for children and 5% had at least one dependent patient at home.

Urban Middle-High Status Group

Of the urban middle-high status group, 59% are male, 41% are female, only 11% were born in villages; their fathers are mostly (40%) white-collar

workers or civil servants, and only 7% of their fathers are peasants. More than half (62%) were born in city centres, 27% in county centres and 11% in villages. All of the people in this group have a PhD level education and all of them are employed in a state university. The mean age is 47,52 (min = 34, max = 65, SD = 7,5), income is 2473 euros (min = 854, max = 6406, SD = 2439), household size is 2,89 (min = 1, max = 5, SD = 0,9), number of children is 1,38 (min = 0, max = 4, SD = 0,7), years of social security is 24,10 (min = 4, max = 53, SD = 8,7).

From the rural low status group to the urban low and urban middle-high status groups, the levels of education, income, birth in urban areas and intergenerational upwards social mobility increase, while number of children and household size decrease. Although the urban low status group is the poorest group, the income levels of both the rural and urban low status groups are under the poverty (1052 euros) and hunger (323 euros) thresholds in Turkey (www.turkis.org) for the period data were collected.

Findings

Perception, Definition and Conceptualisation of Health

Theme	Explanation	Sample
Maintaining the self	Protecting the body in the aspects of food, temperature, and hygiene	<i>"You know, keeping your body. You shouldn't let your body be miserable. To catch your body, your cleanness, your eating. To make everything, your bed, your food spanking clean." "You'll take care of yourself, of your eating and drinking, of your sleep, of your body rest, of your cleanness."</i>
Physical health	Feeling vigorous, fit, lively, energetic, and functional	<i>"To be fit, let's say while you're walking on the road, you shouldn't moan about your aching or pain."</i>
Emotional health	Feeling stress-free, peaceful, cheerful, and happy.	<i>"I feel healthy when my morale is high" "If you had a nice day, if you feel all right, happy, without any stress"</i>
Physical, emotional and spiritual health	Feeling good both physically and emotionally.	<i>"To have the wholeness of physicality and spirituality, to feel good about both." "To be active both physically and spiritually, to make all the activities perfectly."</i>
Absence of illness	Absence of any illness, disease, or symptom.	<i>"You are healthy if you don't have any diseases" "Healthy, by the square, I mean living without pain or ache."</i>
Coping with everyday life	Having the capacity to cope with everyday life activities without getting help.	<i>"...if you can walk to somewhere you desire and come back, you walk well, that is health." "You're healthy if you are able-bodied, if you don't depend on somebody while doing your work."</i>
Quality of life	Having a high quality of life.	<i>"If you have a high quality life, you're healthy"</i>

The answers given to the open-ended question of “what is being healthy?” are classified according to the contents and seven themes of definitions occurred. Before focusing on the definition tendency of status groups, it would be helpful to make a brief explanation of the themes.

The definitions, when categorized in the frame of these themes, significantly differ among sample groups ($n = 289$, $X^2 = 120,24$, $SD = 16$, $p \leq .01$). As seen in Table 2, the rural low status group conceptualize health in the frame of ‘good nutrition, protecting from cold, hygiene, and staving off stress and sadness’. Among the three groups, the rural low status group relates health to the absence of illness at a minimum. Especially according to the urban low status group, the rural low status group relates health to the market and financial issues to a lesser extent and pays more attention to the emotional aspect of health. The probable reason of this is that the majority of the rural low status sample are not wagedworkers, thus, not contacting the market via their bodies-health-wages as much as other sample groups. Although not reducing health to the absence of illness like the urban low status group does, and making relatively holistic definitions, the rural low status group sample provide mainly body-focused definitions of health.

Rural low status group n = 103	Urban low status group n = 126	Urban middle-high status group n = 126
37% Maintaining the self	32% Absence of illness	37% Physical, emotional and spiritual health
23% Emotional health	28% Maintaining the self	16% Absence of illness
21% Physical health	16% Physical health	15% Emotional health
9% Absence of illness	15% Emotional health	11% Physical health
8% Coping with everyday life	5% Coping with everyday life	11% Coping with everyday life
2% Physical, emotional and spiritual health	3% Quality of life	8% Quality of life
	1% Physical, emotional and spiritual health	2% Maintaining the self

The urban low status group define health mainly as ‘the absence of illness’. In addition, definitions provided by this group under various themes refer to economic potential more than the other two groups. People in this group are mainly informal sector workers and housewives; and they see health both as a prerequisite for entering the labour market and as a consequence of a relation with the market. This relation with the market is established by paying prices for food and reaching amenity by means of the earned wages. Contrary to the rural low status group, members of the urban low status group do not

have strong informal social networks, and have an intense relationship with monetary economy. Thus, the perception of health is mainly determined in terms of market. Some of the respondents in the urban low status group relate financial issues to health as:

"First comes money, then health. They all say health comes first, but money comes first by jingo."

"If your [economic] condition is not good, your health is unfortunately not good, too. If you live from hand to mouth, can't make both ends meet, can't buy what you want, how can you talk of health?"

After the themes of 'absence of illness' and 'maintaining the self', the urban low status group define health most frequently under the 'physical health' theme.

These definitions reflect an instrumental functionalist perception of the body in general. Although the rural low status group also make physical definitions, the urban low status group differ in using words such as 'dynamism', 'robustness', 'to be able-bodied', 'being able to work' and statements such as "to be dynamic at all times", "to be able to work", which express the requested characteristics of the labour force, much more frequently than the two other groups. This emphasis on both the absence of illness and the ability to work indicate that the urban low status group, compared to other status groups, conceptualize health much more in the frame of *physical activeness*. This shows that the urban low status group perceives health as a condition that makes it possible to have jobs, go to work and earn wages, thus, to continue their relationship with the market and the life. This finding is parallel to those of some studies (Calnan, 1987; Blaxter, 1983) concluding that workers mainly define health by linking it to keeping jobs and being able to work.

Capitalism connects health, illness, and labour in two dimensions. The first dimension is the emphasis the labour force has to stay healthy in order to be productive. In the second dimension, the body is seen as a fixable mechanical spare part as in the biomedical model, this leads to the emphasis that: (a) workers are indeed bodies that are substitutable in a Taylorist manner; and (b) ill health is a condition that requires treatment/repair, which means purchasing goods and services from the health market. In the perception that these two emphasises develop, health fertilizes both the workforce and the market by inventing new diseases when necessary (Moynihan & Cassels, 2006). The fact that the urban low status group defines health most frequently as the absence of illness indicates that they accept the pragmatist connection between health and labour, which capitalism builds, and this connection shapes

their health perception. This acceptance is a consequence of internalising the power discourse (Foucault, 1976); thus, the 'rightful' definitions of concepts that power introduces are accepted and the norm is shaped by these definitions.

While lower status groups tend to emphasise physical components of health, the urban middle-high status group has a relatively holistic health perception. The majority of the urban middle-high status group define health by referring to physical, emotional, and spiritual components. When including the definitions that mention coping with everyday life and quality of life, it can be said that more than half of the urban middle-high status group has a holistic health perception. Yet, the 'everyday life' notion of this group is built around the concepts of duty and responsibility. This group's definitions like "*adequate body resistance, performance in work, and enjoying the private life*", "*high level of life quality, being physically trouble-free and spiritual peace*", although in a different way from the urban low status group, still contain market-related concepts like duty, responsibility, and performance.

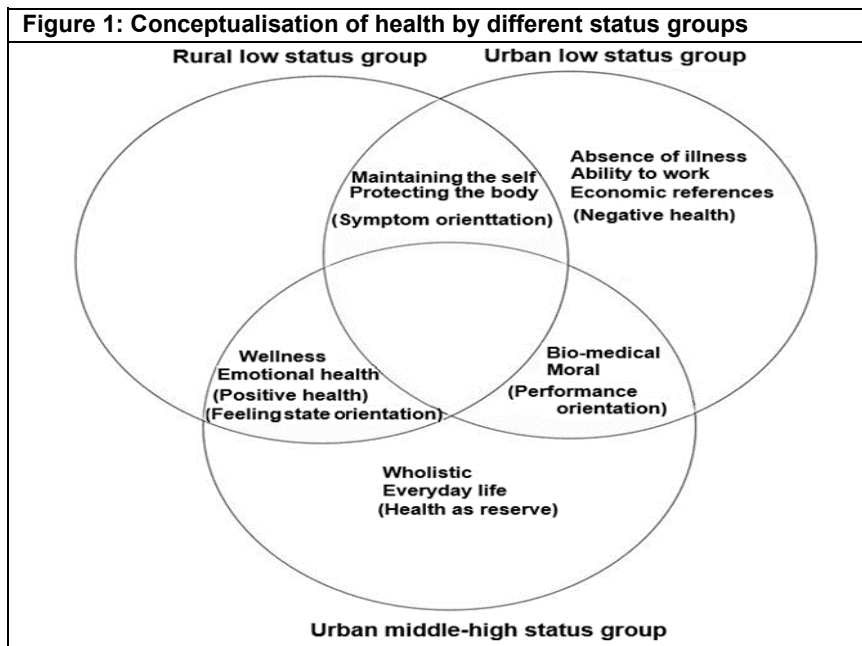
For the urban middle-high status group, the physical, emotional, and spiritual aspects of health unite in the aim of "*coping with everyday life without help*" or "*standing on your own feet*", as they frequently state. This group has higher education and status, lower household size, and a higher migration rate according to the other groups. Lacking the primary relationships, the *gemeinschaft* type of lifestyle and the social solidarity that the rural sample group has, the urban middle-high status group is relatively isolated and seems to be aware of this situation. This isolation can be said to result in this groups' relationship with the market to be more and denser according to the other groups, and become almost inherent to everyday life. Lacking the informal networks of lower status groups and getting lonelier in everyday life, the urban middle-high status group tries to schedule each specific part of everyday life and to use its time 'effectively, productively, and of high quality' in order to maintain its status position by performing the proper roles. Therefore, this group perceives health as a precondition, not only for working in a paid job, but for properly performing all of the internalized duties and responsibilities related to the social status position. Some of the health definitions of the urban middle-high status group implying this situation are as follows.

"To be able to manage your everyday life and all your activities with full performance".

"The condition that lets you effectively participate in social life and efficiently perform your duties and responsibilities".

The risk perception of the urban middle-high status group, which has

higher levels of education, market relations, and awareness, is higher than the other status groups. In the risk society (Beck, 1992), the risks that are embedded in the technological and political system become economic factors in the market and are transformed to profit. In the security paradigm of neoliberalism, people who cannot protect themselves from risks would be sacrificed for the sake of the security of the whole society; and people are said to be individually responsible for taking necessary precautions so as not to be sacrificed (Gambetti, 2008). Healthism discourse (Wright and Burrows, 2004) also places individuals at the centre of production of health, sees individuals always under risk of potential dangers, links risk to choice, responsibility and guilt, and holds individuals responsible for protecting themselves from risks by 'having a healthy lifestyle' (Petersen, 1996). In a neoliberal context, health is rapidly being commoditized and becomes a part of market relations. Thus, people in the urban middle-high status group perceive everyday life as a shift in which they are expected effectively and efficiently to perform a number of duties and responsibilities towards the institution in which they are employed, towards family, towards society and towards the state. For this group, this shift must be regulated and maintained, and health is the precondition for both this regulation and the complement of duties.



The general frame of the perceptions of the three status groups is seen in Figure 1. Although not as holistic as the urban middle-high status group, by emphasizing emotional health, the rural low status group intersects with the

urban middle-high status group and dissociates from the urban low status group. The urban low status group associates with the rural low status group on body-focused and symptom-oriented definitions of health, with the urban middle-high status group on biomedical and performance-oriented definitions of health; yet, the negative health definitions, such as the absence of illness and linking health to poverty, dissociate it from both of the other groups. The urban middle-high status group associates with the urban low status group by performance-oriented definitions and with the rural low status group by feeling-state-orientated definitions. Distinguished from the low status groups, the urban middle-high status group perceives health as a multi-dimensional precondition set, which allows performing everyday life in certain quality standards as required.

Conceptualisation of illness

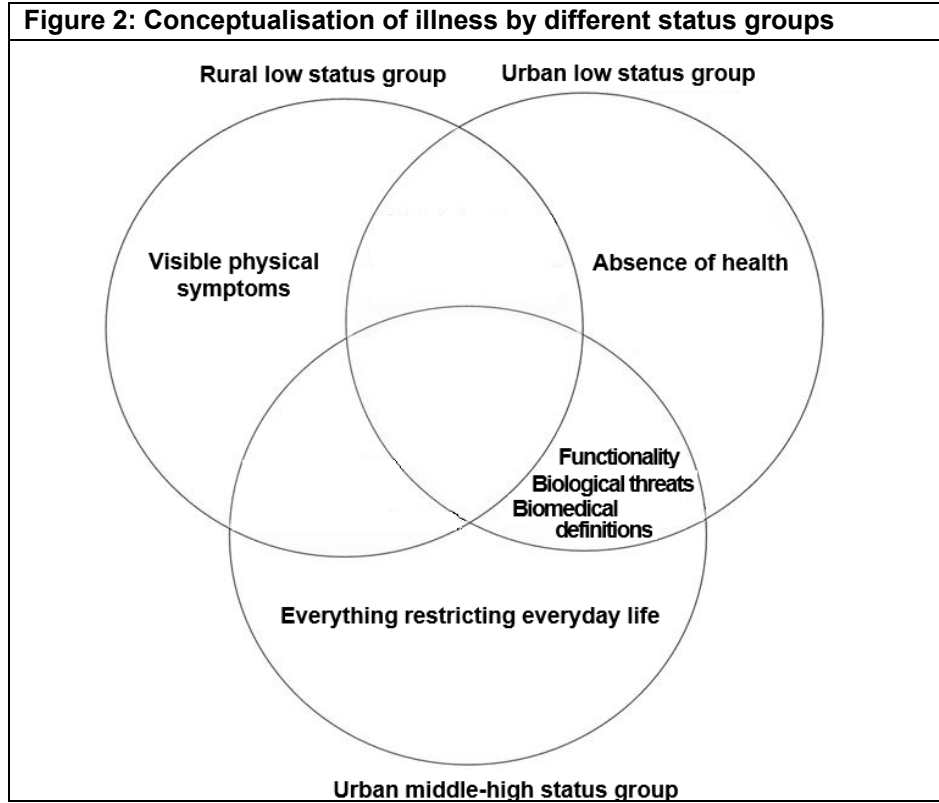
The definitions of illness of the sample can be gathered under four themes as shown in Table 3. The definitions of illness, as in the definitions of health, generally vary according to the three sample groups. The lower education and income is, the more illness is defined by visible physical symptoms such as 'coughing, being pale, and tired'. Of those who define illness by *visible physical symptoms*, 56% are in the rural low status group. The urban low status group also makes this kind of definition; yet, the majority of this group define illness as either the absence of health or a condition occurring due to *outer biological threats* such as germs, viruses, or parasites. The urban middle-high status group also tends to define illness with biological concepts. Yet, these definitions do not contain outer threats; instead, they contain issues of inner functioning of the body. In addition, the urban middle-high status group makes holistic illness definitions like '*everything spoils everyday life*' or '*everything impairing the quality of life*' much more frequently than the other two groups do.

Table 3: Themes and categories of illness definitions*						
Theme	Categories	Sample	Rural low	Urban low	Urban middle-high	%
Visible symptoms and signs of illness n = 134	Lack of energy, being tired, exhausted or painful	"When you are sick in bed. If a man can't get up, he's ill."	43,9	39,5	16,6	100
	Being not able to get out of bed	"Feeling strengthless, coughing, sneezing. Illness is something you can see."	69,2	30,8	-	100
	Heart attack, sudden increase of blood pressure		57,1	42,9	-	100
Absence of health / biological references n = 50	Absence of health	"The disturbance of our body by parasites and bacteria"	11,8	64,7	23,5	100
	Disturbance of the body by parasites	"Succumb of the body towards germs"	21,4	57,1	21,4	100
	Failure in proper functioning of the body	"Deterioration of a part of the body, bankrupt [failure] of any organ"	10	26,3	63,2	100
Emotional references n = 52	Unrest, sadness, unhappiness	"Restlessness of people. Home is restless and disturbed when there is a patient in."	23,6	38,2	38,2	100
	Suffering		21,4	28,6	50	100
	Death, trouble	"To suffer. You don't go to work, don't do anything, and lie down on the job. Can't decide on your own."	45,5	36,4	18,2	100
Holistic definitions n = 21	Conditions that restrain everyday life	"An obstacle in front of living. You can't eat what you want, it is an obstacle in front of everything." "Source of weakness, dependence, a problem you immediately have to solve"	4,8	14,3	81	100
*Because the question was open-ended, some answers contain more than one theme; thus, the percentages are valid for the number of answers, not of respondents.						

While defining illness, the urban low status group when compared to the rural low status group, and the urban middle-high status group when compared to the urban low status group more frequently uses economy- and market-related concepts like 'order', 'damage', 'duty', 'assignment', 'bankrupt', and statements implying that the body is a machine that has to function regularly but breaks down sometimes. In the urban middle-high status group, the frequency of defining illness as non-function or malfunction of the body is more than twice that of the urban low status group. In addition, the urban middle-high status group uses statements implying deficiency or defect like 'stirring up trouble', 'failure' or 'delinquency' more frequently. The definitions of the urban middle-

high status group like “the defeat of the contaminated body that lacks resistance”, “the indication of the inability, incompetence of human body”, “physiological fault in any structure that constitutes the organism”, “decrease in performance and efficiency”, can be seen as statements that individually ‘blame’ the victim’s body and self by linking poor health to lifestyle factors (Crawford, 1977).

Figure 2: Conceptualisation of illness by different status groups



As seen in Figure 2, the urban middle-high status group intersects with the urban low status group with respect to defining illness with an emphasis on instrumental functionalism; it draws apart from the other groups by strongly relating illness to everyday life. Perceiving everyday life as a holistic field of duties and responsibilities, the urban middle-high status group has a “quality of life” notion associated to sustaining the roles that norms demand. Quality of life should be maintained and illness is a factor damaging this quality. This perspective of the urban middle-high status group can be seen from their definitions of illness as “a condition which reduces the efficiency of life, hardens the life”, “bodily symptoms which have negative effects on the quality of everyday life”, “...all situations affecting / obstructing everyday life activates”.

Seeing illness as both a defect or fault and an obstacle for fulfilling duties of everyday life is a clue that the urban middle-high status group perceives illness as morally problematic. Cornwell (1984) indicates that in opposition to health, which is seen as a morally positive situation, disease is seen as something to be condemned and this causes many people with poor health to perceive and define themselves as healthy. When people with at least two chronic diseases in the sample are examined separately, it is seen that 70% of the urban high status group evaluate their health as good or very good. This rate is 37% in urban and 19% in the rural low status groups. In other words, most of the people in the middle-high status group and part of those of the urban low status group perceive illness and disease as a morally wrong status (Cornwell, 1984:124) and avoid being stigmatized as ill. In other words, the higher the status, the more people with poor health tend to avoid being stigmatized as ill.

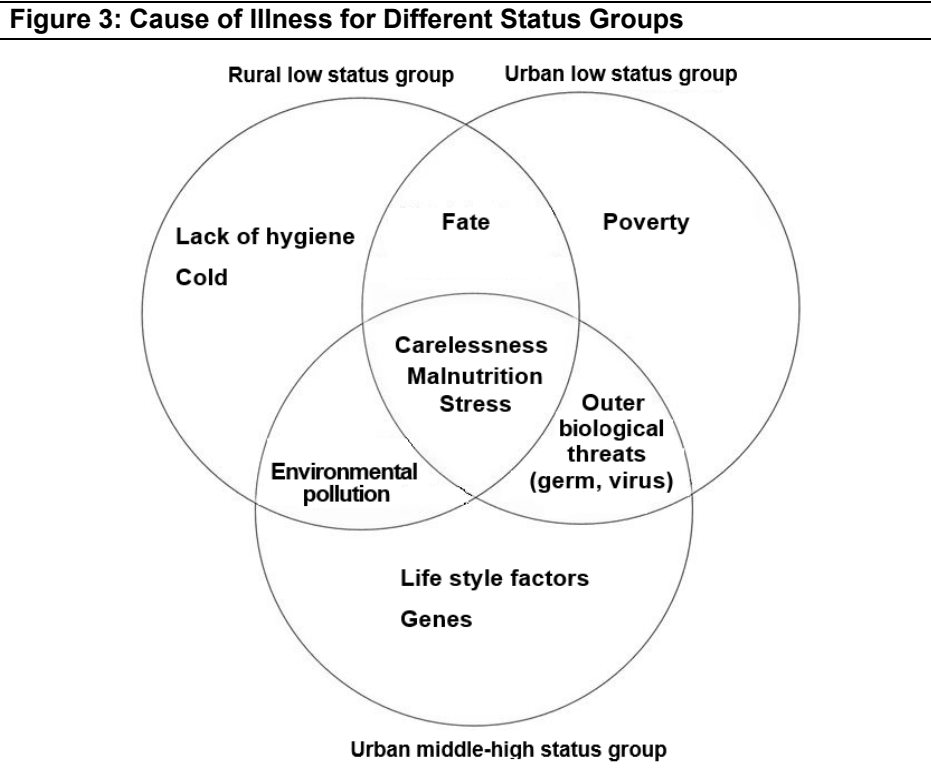
The rural low status group defines health and illness over problems from their own lives and define them by using the language of life world (Habermas, 1971). Williams and Popay (2001: 32-34) note that while making health-related definitions, lay people emphasize structural problems concerning their own lives, unlike experts who emphasize risk factors like nutrition habits or tobacco consumption. The rural low status group, who give concrete examples while defining illness /disease and of whom the tendency to blame the individual is low, seems to use the language of the life world. On the other hand, the urban middle-high status group, and the urban low status group to some degree, as a result of internalizing the discourse of regime of total health (Armstrong, 1993), are more prone to use the language of the system world (Habermas, 1971), which reflects the scientific knowledge thought by the "experts" of positivism and capitalism. This indicates that these groups are more influenced from the health discourse of the market and the state. The lives of urban status groups are being shaped by the market relations in urban areas, and the domination of the system world over the life world is more severe in these lives. The urban middle-high status group is related to the market over duties, responsibilities, and status roles that help in maintaining the status. The urban low status group is related to the market over economic relations as seen in the statement "*a person gets ill when he doesn't care for himself, when he gets tired, stressed, when he works hard, or from family environment. But indeed everything depends on money, if you have money, you have good health, you have peace*". Yet, in rural areas, everyday life flows partially from outside the market relations, as a participant from the rural low status group indicates, "*...thanks god not everything is money in the village*".

The Cause of Illness

Theme	Category	n	Rural low	Urban low	Urban middle-high
Living conditions	Carelessness, malnutrition	125	34	36,5	34,9
	Poor working and living conditions	47	8,7	5,6	24,6
	Poverty	24	5,8	10,3	4
	Environmental pollution	13	5,8	1,6	6,3
	Lack of hygiene	34	14,6	7,9	7,1
	Cold	39	23,3	11,1	0,8
Emotional conditions	Stress	125	35,9	34,1	35,7
	Exhaustion, wear	14	5,8	3,2	3,2
Biological threats	Germ, virus, bacteria	37	6,8	10,3	13,5
	Ageing, old age	9	4,9	0,8	2,4
	Pooling of resistance	9	1,9	-	5,6
	Genes	32	1	2,4	22,2
Individual life style factors	Life style factors	23	-	4	14,2
Fate	Fate	10	3,9	4,8	-

The sample was asked what causes illness as an open-ended question. Although “stress” and “carelessness/malnutrition” is the prominent cause of illness for the entire sample, the answers of the three groups differ from each other.

As seen in Figure 3, except from the common categories of the cause of illness as carelessness /malnutrition and stress, the rural low status group emphasizes lack of hygiene and weather conditions (cold), and intersect with the urban low status group by referring to fate. The urban low and middle-high status groups emphasize outer biological threats like germs or viruses more than the rural low status group. The urban middle-high status group differs from the other groups by emphasizing genetic factors and individual lifestyle factors (e.g., physical inactivity, malnutrition, tobacco, and alcohol consumption) and the urban low status group differ from other groups by referring to poverty.



The rural low status group emphasizes hygiene more than the other two groups, because according to urban areas, in rural areas, it is more difficult to keep food, places, and clothes clean. In addition, villages in the sample have additional hygiene problems when the water resources dry in summer. For this group, environmental pollution also seems to be important as a cause of disease, because water pollution and problems in collection of garbage are parts of daily life.

The urban middle-high status group seems to mention working and living conditions more than the other groups do, yet the content of the concept is imprecise in their statements. While mentioning living conditions, people in this group use unspecific and abstract phrases like “*life conditions*” or “*living in unhealthy environments*”. Similarly, they refer to poor working conditions with examples like “*dissatisfaction from working life*”, “*unhappy work and home environments*”, “*friends or supervisors at work*”, in a more emotional aspect, without mentioning structural problems like unemployment, low wages, and absence of job security or social security. These data indicate that the social and political factors influencing health or disease do not have an important role in the perceptions of the urban middle-high status group. A perspective focusing

on the psychological aspects and neglecting the structural aspects of inequality causes the endorsement of explanations that blame the individual for poor health (Lynch et al., 2000). The urban middle-high status group, who focus on individual duties and responsibilities while defining health, is also prone to blame the individual while explaining the cause of diseases as 'lifestyle factors' for present time and 'genetic factors' for past time.

According to the other groups, the urban low status group mentions environmental pollution, old age, poor working and living conditions less and tends to see poverty and fate as the cause of illness and disease more. Although rural residents in the sample live in agriculturally unproductive villages, three fourth of them own their houses; also, they have the chance to feed themselves with their small dairy cattle, to sell them in emergency, and to be assisted by neighbours and sometimes by village headman. Unlike them, only slightly more than half (55,6%) of the urban low status group own their houses and they lack social solidarity networks, informal surviving strategies and cashable commodities. It is not surprising that the urban low status group that is more bound by the money economy refer to poverty as a cause of diseases more than the other groups do, because the relation between money and health is more visible in nutrition and healthcare access of the urban low status group.

The rate of perceiving fate as the cause of disease is low in the sample in general; yet, it increases in the rural and urban low status groups. When the question "is the cause of disease living conditions or fate?" is separately asked to the sample, 20% answered fate, 72% living conditions and 7% both. The correlation between this attitude and monthly income (.230**) and years of formal education (.305**) indicate that as income and education increases, the ratio of perceiving fate as the cause of disease decreases.

In addition, while 11% of the people without any chronic illnesses and 19% of the people with only one chronic illness state that fate is the cause of illness, the rate increases to 30% for people with at least two chronic illnesses. Arguing that good health is being seen as morally valuable and illness/disease as degrading and discreditable, Cornwell (1984:131) claims that the moral problems resulting from being ill can be removed if disease is legitimized. With the help of medicalization and rationalization, to build the 'otherness' of the illness gives individuals the chance of legitimizing being ill, proving that the disease is a separate entity that 'happens' to the person, not something for which the individual is personally responsible (Cornwell, 1984: 129-30). The correlation between the number of chronic illnesses and the rate of perceiving fate as the cause of illness (-,111*) seems to indicate the effort to escape from the morally problematic situation that Cornwell (1984) mentions. As their health

worsens, individuals show more effort to prove that they are not personally responsible for the situation and become more prone to attach the illness to fate, which provides an impersonal reason for illness.

Discussion

The concepts of health, illness, and disease are built by individuals who are influenced by surrounding social and economic conditions. While perceiving and defining health and illness, people are influenced by the relationship they establish with the market and the society. Thus, different social groups may make dissimilar definitions of these concepts by depending on their specific norms and values. In these different definitions, the structures that limit and form people are reproduced by their reflexive practices and conceptualisation of health and illness is reflecting the duality of structure (Giddens, 1984). Because the reflexive practices are shaped by the social and economic conditions, conceptualisation of different socio-economic groups vary. In this frame, the data of this research show that the higher income, education, and urbanization level and the lesser number of children and household size is, the more people define health by mentioning all of the physical, emotional, and mental aspects, as a reserve (Herzlich, 1973) or a capital (Grossman, 1972) and conceptualize it with performance orientation (Bauman, 1961). Living in urban areas, the middle-high status group tries to abide by the norms of both work and consumption cultures, which have become a part of their own habitus and perceive health as a variable of social success (Schilling, 2002:627-8). Urban residents with lower education and income levels bring the physical aspect of health to the foreground, make negative health definitions (Herzlich, 1973), and conceptualise with a symptom orientation (Bauman, 1961). On the other hand, the rural status group health is defined primarily by protecting the body, being reduced to physical health, and conceptualised with a performance orientation (Bauman, 1961).

The health perception of the rural sample group is constructed with natural concepts, related to concrete indicators, and communicated with the language of the life world (Habermas, 1971). The health perception of urban sample groups, though differentiating depending on income and education, is constructed with market terms with the motive to adjust to the market conditions, communicated with the language of the system world (Habermas, 1971), and related to an anxiety of being stigmatized as ill. The urban status groups perceive health as a necessary part of their social roles. This is especially important for the urban low status group members who relate health to the working role. This explains the urban low status groups' high rates of

referring to impersonal factors like germs or viruses, while defining health and the struggle to emphasize that the responsibility of being ill is not theirs to carry.

Illness and disease are the products of medical discourses and medical discourses reflect the dominant mentality of society (Turner, 2011:105). The way people perceive, understand, and interpret their health conditions depend on the general cultural values about appropriate behaviours (Turner, 2011:241). Especially urban status groups try to adjust to neoliberal norms of behaviour and comprehensions of health. Aiming to administrate society with minimum costs, the liberal market reduces health to the needs of the labour market, to physical fitness, productivity, and efficiency because capitalism maintains itself by transforming bodies to an obedient, dutiful, compliant, useful labour force (Foucault, 2007:103). This becomes possible with discipline of the bodies (anatomopolitics) and administration of biological processes of the population (biopolitics), which both need the normalising/generalizing discourses to be internalised (Foucault, 2007:102-3). Urban status groups tend to internalise the normalising health norms of the market more than the rural status group. The urban low status group is prone to perceive health as bodily fitness, which is the precondition of being able to sell their labour in the labour market and define it within the reductionist biomedical paradigm. On the other hand, with physical, emotional, and mental aspects, for the urban middle-high status group, health is the precondition of maintaining their status in both work and leisure time.

Although there are differences, both of the two urban status groups seem to internalize the neoliberal health explanations that blame the victim for poor health. Especially, the urban middle-high status group ignores the social factors influencing health and blames the victim for genetic characteristics and lifestyle factors. They seem to accept that the instrumentally effective body is 'an important variable of social success' (Schilling, 2002:627) and internalize the functionalist claim that health and disease are "expressions of the success and failure experienced by the organism in its effort to respond adaptively to environmental change" (Dubos, 1965:xvii). From this perspective, the ill individual, who is held responsible to be healthy by protecting him/herself from surrounding risks, loses productivity, efficiency, and the functional capacity that allows him/her to perform social duties.

The Regime of Total Health (Armstrong, 1983), including the healthism discourse (Wright and Burrows, 2004), urge individuals to assume the responsibility of their health, to maintain, monitor, and to express their health status. In general, the neoliberal health paradigm forces the notion that people are individually responsible for their own health and they personally have to take necessary precautions against health risks. These personal precautions

appear as focusing on lifestyle factors and purchasing individual or complementary health insurance in addition to state insurance coverage.

The two urban sample groups' health definitions, which emphasize productivity and performance, indicate that their health perceptions mainly are shaped by the biopolitics of the neoliberal market. The urban status groups seem to internalise the norms of the healthism discourse so much that they perceive the illness situation as something hindering them from providing dutiful and useful labour, something "morally wrong" (Cornwell, 1984), and in order to avoid being labelled ill, they tend to underrate their illnesses when compared to the rural sample with the same health status.

Conclusion

The findings show that health and illness perceptions are not stable concepts that are independent from the social context in which people live. The normalising powers of both the market and the medicine as a social institution have strong effects on peoples' perceptions of health. There are also perceptible similarities and differences among different socio-economic groups' perceptions of health and illness. Following the sociological pattern of these perceptions may provide a better and deeper comprehension of peoples' health-related behaviours.

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