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Review Article

Social and cultural roots of health and disease from the perspective of medical sociology

Nasser Khodayari Shouti*

Department of Basic Sciences, Tabriz University of Medical Sciences, Tabriz, Iran

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ABSTRACT

Objective: This article provides a model for research and practice to address the socio-cultural concerns of patients in the field of health care. Society is a kind of bedrock of disease and health; hence the view of disease and health varies from one society to another.

Design and method: Sociological literature review was used.

Findings: The health profession should meet the needs of patients before they are taken to the hospital and after discharge from the hospital; That is, measures to prevent the disease or make people less ill and the latter to reduce the recurrence of the disease. In fact, individuals can be considered social and cultural beings, and disease, in addition to the existence of disorders in biological relationships, disorders in social, cultural, economic, managerial and political relations that affect other aspects of a person's relationship. Therefore, health care is truly holistic and must address the whole of a patient's relationship-physical, mental, social and spiritual. The sociological literature shows that many patients want health professionals to pay attention to their social needs, but health professionals cannot be very effective in this regard. This is not an alien expectation from the definition of health from the perspective of the World Health Organization; complete physical, spiritual and social well-being was not just the absence of disease.

Consequences: Concerns and concerns are important to many patients, especially regarding social inequalities. Much remains to be done in understanding research on the social and cultural aspects of patient care and how to address social and spiritual well-being as well as physical well-being.

Keywords: Health, Disease, Social roots, Cultural roots, Medical sociology

INTRODUCTION

The historical focus of sociology is on the social problems of human societies. Social problems include health problems, crime, deviance, violence, poverty, inequality, demographic problems, delinquency and institutional instability. Social forces such as modernization and industrialization have been the beginning of social change since the beginning of the eighteenth century. This social transformation as a result of changes in production relations led to several problems. The Industrial Revolution led to new forms of production systems, social relations, migration, urbanization, and especially new forms of employer-employee relations. Industrialization marked the overthrow of the family as an economic unit. This was a huge change in the social system with its consequences, and hence social problems such as unemployment, poverty, child labor, gender discrimination, crime and health problems emerged. This does not mean that all these problems arose only during the Industrial Revolution, but increased rapidly during that period. Any issue that threatens the well-being or survival of society is a social problem. Defines social problems as a social phenomenon that is harmful to society or its members and can be changed socially [1-5].

Without examining the pervasive roots of health and disease, including their social, economic, and cultural roots, productivity cannot be directly discussed, because the level of health and disease of societies is tied to the level of social and economic

***Corresponding author.** Nasser Khodayari Shoti, E-mail: nasser.khodayar@gmail.com.

benefits and security of these societies. But a discussion of the social and cultural roots of health is necessary in this regard.

As soon as we talk about health and disease, the first thing that comes to mind is medicine and its concepts. Health and disease, hospital, surgery, physician, nurse, medicine, testing, and other medical-related applications are reminiscent of applications. From this perspective, the issue of health is considered as a purely biological problem and no other solution should be sought beyond it; while health and disease are as much a medical issue as a social and cultural issue. Although the social and cultural dimensions of health have long been neglected, today the social dimension of health is considered sociologically necessary [6-10]. Health primarily involves social relationships and behaviors. Every successful science discipline sooner or later creates a historical narrative of how it began. For medical sociologists, the emergence of the medical social study stems from Talcott Parsons' theoretical account of the physician-patient relationship. Parsons envisioned the disease as a form of deviant behavior with the physician as a social gatekeeper to return patients to normal social functioning. According to Parsons, both the patient and the physician have a special role to play in overcoming the disease. The true origin of medical sociology, according to Weber, occurred when Parsons justified medical study for social scientists. Parsons first argued that health is functional for individuals and society: a little immediate reflection shows that the problem of health is deeply involved in the functional prerequisites of the social system [11-15]. Certainly, by almost any definition, health is included in the functional needs of each individual in society, so that in terms of social system performance, the general level of health is very low, the incidence of disease is very high and inefficiency in the social system of course, health and disease from the perspective of physicians have a different definition from the two from the perspective of sociologists. In other words, sociologists consider the origin and point of departure of health and disease to be society and not the hospital.

LITERATURE REVIEW

Social roots of health and disease

Today, in describing the phenomenon of health and disease, it is displayed in continuous collections, without separating physical, psychological and social structures. This approach is the same bio-psycho-social approach that includes the traditional biomedical approach. George Engel believed that physicians must simultaneously pay attention to the biological, psychological and social dimensions of the disease in order to properly understand and respond to patient's suffering. He proposed a holistic alternative to the common biomedical model that had dominated industrial societies since the mid-twentieth century [16-20]. The new parasite model became known as the social psychosocial model. He formulated his model at a time when science itself was evolving from a purely analytical, reductionist, and specialized attempt to become a more transcendental field. Engel did not deny that the mainstream of biomedical research had made significant progress in medicine, but criticized its overly limited (biomedical) focus on advancing physicians 'perception of patients as an object and ignoring patient's mental experience. Not only as a scientific proposition, but also as a fundamental ideology, the parasite sought to reverse the dehumanization of medicine and the incapacity of patients (Figure 1).

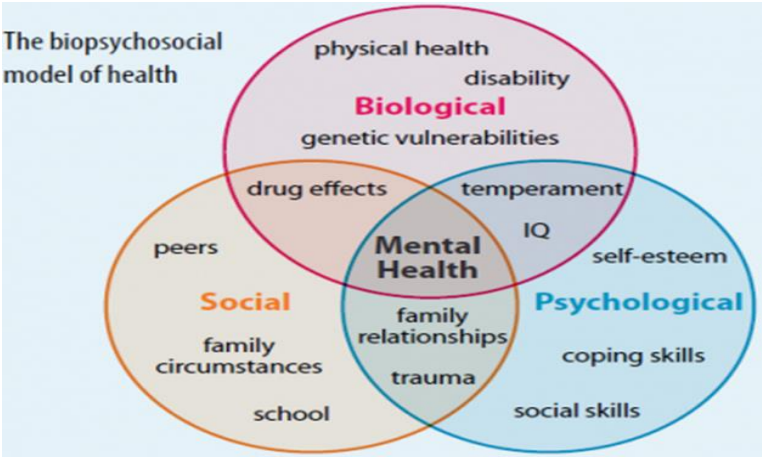

Figure 1. Bio psychosocial-model-of-health.

In this case, health has social and cultural dimensions, Keys points to five components: social integration, social participation, social acceptance and social cohesion, social actualization. In modern Western medicine, all health systems have emerged as a product of Western cultural history in one context. For this reason, the concepts of health and disease, which are mainly the product of social and environmental factors, are not considered separately from the human living environment [21-25].

In recent years, many books and articles have been published on the impact of social structures in the field of medicine. The authors' emphasis on the subject, despite their different approaches, contains this message; the relationship between health and social structures is no less than the relationship between the medical profession and health. In fact, social relationships contribute to and shape health [26-30].

All ideas, including private and public health, relate diseases to the conditions of health care institutions, medical sciences, and the social and cultural contexts that reflect human problems. Modern medicine has a limited view and a kind of narrow-mindedness, because from a purely technical point of view, it looks at the human body like a machine. If man has as much

psychological and social existence as biological existence, then there is a need for a broad view of health; because the phenomenon of health and disease is as social and cultural as it is biological. Health is an issue that has multidimensional physical, psychological and social aspects [31,32].

Today, reducing treatment to surgery, medication, etc. is not acceptable. Because health and disease as a medical concept is a psychological, social and even cultural anthropological concept. One of the major dimensions of health identified by Blackster is the general concept of health. It shows how different people define health, which explains the relativity of this concept. Blackster observed that "the most common way to measure self-perceived disease, regardless of the presence or absence of disease, is through a list of symptoms." For an abnormal population, the absence of symptoms means health. From this perspective, Blackster identified three "states" of health: freedom from disease, ability to function, and fitness. In this regard, health is also understood as energy and vitality in terms of fitness for functions: physical, social and normative activities.

But as to why health is an integral part of a society, one might say:

First, the health institution is one of the basic institutions that make up the social structure. Thus, just as it cannot be delegated to one person, it also affects other members of society. Second, in terms of rights and duties, it provides the ground for social intervention; because it is responsible for the living environment suitable for people in the community. From this perspective, this institution is closely related to people's health. Health has always been a cultural and social issue. The fact that the health institution is one of the basic social institutions that constitutes the social structure and the government is responsible for the health of its nation, has emerged at the same time as the formation of the national government. Two great developments that took place at the same time as the French Revolution. The idea of replacing the clergy with a doctor and the idea of achieving personal health were accompanied by political changes. In the light of this idea, the disease became a social issue and emerged from the patient's personal problem.

The relationship between health and development or health and poverty reduction is also explained in some ways:

First, health is inherently valuable. Health is often cited as one of the social dimensions of poverty using the "capabilities" approach to development, most famously expressed by Amartya Sen: Good health enables each individual to achieve the true ultimate goal of development, namely, "type "Lead life." He has a reason for valuing, a similar concept can be found in the human rights instruments that formulate health law and health care (Committee on Social and Cultural Economic Rights, 2000). The basic premise is that good health and the conditions that make it possible are part of the essence of a dignified life.

Second, health is a valuable tool. Economists have convincingly argued that good population health is a prerequisite for economic growth (World Bank, 1993; Macroeconomic and Health Commission, 2001). At the individual level, poor health can lead to a deeper spiral into poverty, as illness prevents a person from working to earn the money they need to survive and earn a living.

The importance of health from the perspective of the social system stems from the main functions of the health institution, which are: informing people about issues and issues related to health and disease, freeing people from disease and discomfort, providing healthy living and basic health services to them. Systems alignment is a key component of a health culture. The health institution is one of the fixed institutions in all social structures and is a member of the same social structure that is within it. If we define the system as a formed set of functional relationships of members, the idea of a proper connection between the institution of health and the social structure becomes a reality.

The sociology of health includes social epidemiology, disease, mental health, disability, and medicine. The basic premise of sociology is that health and disease cannot be considered as mere biological or medical phenomena. They are perceived, organized, and operated in a political, economic, cultural, and institutional context. The social construction of health is a major research topic in medical sociology.

In the second half of the 1980's, more confidence emerged in linking medical sociology to general sociological issues and concerns. The tendency to the sociology of health and disease has been expressed beyond medical sociology for some time, especially in the name given to the journal. Medical sociology should be more concerned with identifying itself with the central theoretical issues of sociology in this way. It is more formulated only by a shift to theoretical issues that ultimately transcends the old dichotomy of sociology in medicine and medical sociology.

A number of studies have attempted to assess the impact of social factors on health. A study by McGuiness, et al. estimated that medical care was responsible for only 10 to 15 percent of preventable deaths in the United States. While McConbach's studies suggest that this percentage may be underestimated, they acknowledge the tremendous importance of social factors. McGuinness and Fogh concluded that half of all deaths in the United States are due to behavioral causes; 18 other evidence suggests that health-related behaviors are strongly influenced by social factors such as income, education, and occupation. Gallia, et al. conducted a meta-analysis and found that the number of deaths in the United States in 2000, attributed to low education, racial discrimination, and low social support, was associated with the number of deaths associated with myocardial infarction. Cerebrovascular and lung cancer are comparable.

In general we can say; The most important factors that affect the social structure of health are: population, mortality rate, migration rate, family, social class, religion, language, culture and economy, position, occupation, gender, ethnicity, social status; Singleness, marriage, unemployment, age, social class, cultural structure. These factors are in fact variables that are related to the phenomenon of health and disease. Approaches that examine the relationship between health and lifestyle based on economic status have found malnutrition among poor, high-income, and needy families to be fatal and pathogenic.

The unequal distribution of disease and health among the

population is unmistakable. Research shows that some groups are healthier than others. This situation is related to the socio-economic status of societies. The root of many diseases, poor living conditions, misconceptions, inadequate education, economic deficiencies and in this regard malnutrition, issues such as lack of health services and such factors are due to the negative and negative conditions of the health system of that country. Health is a subset of the social system, which in turn has subsystems.

For the social dimension of the disease, changes in the concepts of the disease in the historical process and related issues can be given as an example; Especially in the 19th and 20th centuries, with great changes, the patterns of diseases also changed in modern industrial societies, while the diseases of the nineteenth century were called poverty, the diseases of the twentieth century became known as the diseases of civilization and wealth. These include overeating, sedentary lifestyles and diseases that result from harmful habits to alcohol and smoking, cardiovascular disease, diabetes, lung cancer, insomnia, anxiety, stress, depression, fatigue, chronic pain and illness. Accidents caused by traffic accidents and the like are on the rise, especially in industrialized countries. These conditions and diseases have existed for a long time. The pressure and damage caused by these diseases on human health is much greater than before.

Different social classes have different conditions for living a healthy life. In other words, there is a direct relationship between health and social class and the health of individuals. The right to use the health system of individuals is closely related to the status of their classes, but a healthy relationship that can be established with social classes determines the overall trend and is always a reciprocal relationship. This is because sometimes the relationship between health and social class can change. In Britain, for example, while chronic heart disease was an upper-class disease in the 1930's, it was a lower-class disease in the 1950's.

Access to financial resources, whether income or wealth, affects health by protecting individuals from the financial threat of macro-bills, as well as facilitating access to health-promoting resources such as access to healthy neighborhoods, homes, land uses and parks. Income can predict a number of health outcomes and indicators such as life expectancy, infant mortality, asthma, heart disease, obesity and many more.

Official statistics show that in any case, every illness and ailment is related to social class. For example, poverty is one of the main causes of the disease and the poor get sick more than the rich and their illness lasts longer. Those who live on welfare state subsidies and earn less are more likely to die younger. People in these social conditions work in unhealthy conditions, live in inadequate shelters, and consume cheap and unhealthy food.

Social class and health

In recognizing the social roots of health and disease, social class is at the forefront of factors. Research on differences in mortality rates in different societies shows that individuals in different societies are exposed to different risk factors.

A fair report entitled The Society for Justice, Healthy Living in 2010 found that 5% of the poorest and richest people in Britain are at risk of serious illness or disability, compared to 5% of the poorest and richest people. The life expectancy of the poor has been 17 years lower than that of the rich. Those who are very poor die at a young age and spend the rest of their lives arguing and overcoming many obstacles. Stomach and lung cancer are twice as common in men who work hard and do manual labor as in men who work professionally. Among the poorer social classes, women, the risk of respiratory disease is six times higher, the risk of death from cardiovascular disease five times higher, and the risk of death from lung cancer and fall three times higher. According to job and occupational analyzes, the incidence of long-term illness is 50 percent higher among unskilled or semi-skilled workers than among those with technical office jobs. There is a significant relationship between social factors and mental illness. Mental illness is a social phenomenon. Because it arises in social situations and its root is in the structure of society. Mental illness should be considered a disease of society, not a disease of the people from whom society is made. Socio-economic status as an independent variable can cause psychological distress in individuals (Table 1).

Table 1. Infant mortality rates in different social classes in England and Wales in 1980.

Social class	Mortality rate before birth
I	9/7
II	11/1
IIIN	11/8
IIIM	13%
IV	15%
V	17%

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on welfare state subsidies and earn less are more likely to die younger. In these social conditions, human beings work in unhealthy conditions, live in unsuitable shelters, and consume cheap and unhealthy food.

Research on socioeconomic inequalities in health has a long history in the UK. For more than 150 years, inequality in health outcomes has been a concern since the initial report of the welcome trust. Health outcomes generally worsened with socioeconomic harm. In the early twentieth century, the British government raised questions about employment in a ten-year census. This allowed researchers to measure health outcomes by social class. The RGSC was created in 1911 and was still in use until 2001. Socio-Economic Classification of National Statistics (NS-SEC) has now replaced the RGSC. To explain the current plan, see: At the same time, class inequality makes access to health facilities difficult. Because family physicians, hospitals, and health facilities are much less common in disadvantaged areas, the open and poor members of the working class ultimately use the crowded, high-traffic equipment and limited medical techniques provided by international health organizations. Have been accepted. Lower social classes use public transportation and have to spend a lot of time accessing family physicians to use hospitals.

Wilkinson, et al. has shown that in addition to considering the relationship between socioeconomic status and health, it is also important to consider this relationship at the societal level. Higher levels of income inequality at the national level are associated with poorer health in society as a whole. With a few exceptions, studies in CCEE-CIS countries have focused on the relationship between inequality and health at the individual level. Given the changes that have taken place in the region over the past two decades, it may come as a surprise that more work has not been focused on addressing this relationship at the societal level. Only part of a person's health depends on his behavior and choices. Problems at the community level such as poverty, unemployment, poor education, inadequate housing, poor public transport, interpersonal violence, and decaying neighborhoods also contribute to health inequalities as well as the historical and ongoing interaction of structures, policies, and norms that make life Shape, helps. When these factors are not optimal in a society, it does not mean that they are solvable: such inequalities can be reduced by social policies that can shape health in powerful ways.

The difference of social classes in the field of health is seen in every country and is considered as a natural inequality. In this case, especially the case that is annoying, the accumulation of inequalities and differences. Failure to receive health care during childhood or adolescence or poor access to health care means that you are more likely to develop the disease in adulthood. Low income, as long as there are obstacles to receiving the desired health services, the disease becomes more chronic and the possibility of treatment becomes much more difficult.

Socioeconomic Status (SES) has been identified as a fundamental cause of disease. People who are poor and powerless have worse health and longevity than those with money, power, and prestige. This situation was true during the times when infectious diseases were major killers and there was poor sanitation and overcrowding. It is equally true today when infectious diseases and crowding are no longer a threat in the US, but instead cancers and heart disease are the major causes of morbidity and mortality. People with lower SES continue to be the group that experiences the highest rates of morbidity and age-adjusted mortality from these more modern diseases, stimulated by risk factors such as poor nutrition, lack of exercise, and smoking that are more common in lower SES groups. In order to explain this persistence across time, Link and Phelan proposed the theory that social conditions were the fundamental cause of the health disparities that exist between people without socioeconomic resources and those with these resources. Child poverty is not just an economic or political problem. It is also a moral issue and a social justice issue and is increasingly recognized as an important public health concern. Early experience of poverty in children affects their health not only in youth but also in adulthood. The health consequences of poverty and how it affects childhood, as well as the long-term impact of childhood poverty on adult health have been considered in many studies.

In fact, among the health and disease factors, the main factor affecting health more than the biological factor, structure and social conditions, the model of the cultural and social organization, which in the emergence of this negative image.

Gender and health

Health and disease symptoms are slightly different in terms of gender variables. Because the patterns and trends of men's socialization and cultural presuppositions determine the role, orientation, behavior, preference, orientations of men and women on a large scale. In the current situation, all the roles of men and women are in the control and monopoly of culture or social system. This condition affects both the mental and physical condition of men and women, as well as the feeling of health and illness and the dimensions that expose them to the disease.

In research conducted in Western societies, the health status and disease of men and women, the symptoms of life and death, the types of diseases that affect them, etc. are expressed in the form of various answers and reactions, for example, Brown. Has stated that the mortality rate of women is much lower than men of all ages. The average mortality rate for men is 40 percent higher than for women, and a woman lives an average of five years longer than a man. In any case, two-thirds of deaths before the age of 65 are related to men. People between the ages of 85 and 65 have a female-to-male ratio of two to one. If we talk about mortality and average life expectancy, we come to the conclusion that women are healthier than men. Only statistics generally show that men who died very early did not experience the disease as much as women who lived longer. Women are the main consumers of health services and their period of disability and illness is longer than men.

The above characteristics, which reflect the negative issues regarding the characteristics of women, experts in explaining these characteristics, as much as they look at women's biological issues, they also understand the process of

socialization of women in society and the assumptions of social gender discrimination. According to the mortality rate of male children is higher and also women are genetically more resistant to heart disease than men, the socialization process of the male sex makes this sex more prone to disease. Men smoke more than women and use drugs. These substances can pose significant health risks. In addition, men do not care much about their nutrition, do not express their feelings like women, and are more stressed than women. From this perspective, women are more prone to illness of family members.

Gender has an impact on health in a variety of ways. Powerlessness and lack of control underlie much of the exposure to HIV/AIDS amongst women in Africa. Disproportionate barriers (that is, relative to men) in access to resources such as food, education, and medical care, disadvantage women throughout the developing world. Risk taking behavior is the norm amongst males throughout the world. Socially defined traits often stereotype men and women as having fixed and opposite characteristics such as active (male)/ passive (female), rational (male)/ emotional (female). The language of medicine and its underlying philosophy have, and may still equate male with normal, leaving female to be considered as "other" or, perhaps, abnormal. Both women's and men's occupational and behavioural roles, constrained by social norms, can result in hazardous, though different exposures to dangers and illness. Any of these aspects of gender may intercede in the pathway from an individual to his or her health.

Gender is conceptualized as one of the main determinants of population health and health inequalities within the framework of the World Health Organization (WHO) Social Determinants of Health (SDH). In this context, gender should be understood as the social characteristics, roles, responsibilities and expectations of an individual in a given society based on gender expression and how others perceive it. The dimensions of gender socialization of women and men naturally determine both the dimensions of social epidemics and the conditions of health and disease.

The concept of gender could include differences in socio-economic and cultural determinants of health between men and women. If the groups being studied or compared are men and women, the between group variations would then be summed up by gender. There remain, however, within group variations because not all women are the same. Data examining the percentage of births attended by trained personnel and aggregated by the level of the mother's education consistently favor the more educated and demonstrate variation in access to care. Within the grouping 'women' social determinants such as education or income often account for differences in power or access to care, and, ultimately, to health. Gender is conceptualized as one of the main social determinants of population health and health inequalities within the framework of the World Health Organization (WHO) Social Determinants of Health (SDH). In this context, gender should be understood as the social characteristics, roles, responsibilities and expectations of an individual in a given society based on gender expression and how others perceive it. The dimensions of gender socialization of women and men naturally determine both the dimensions of social epidemics and the conditions of health and disease.

The dimensions of gender socialization of men and women naturally determine both the dimensions of social epidemics and the conditions of health and disease. In research that has been done, the difference between male and female diseases, the role of gender culture in health and disease.

Differences in ethnicity, race and health

Ethnicity is another variable commonly used in studies of health inequalities. The Office of Management and Budget (OMB) has set minimum standards for the storage, collection and presentation of race and ethnicity data. The standards include 2 ethnic groups, "Hispanic or Latino" and "non-Hispanic or Latino" and 5 racial categories: Native American or Alaskan Native. Asian; Black or African American; Native to Hawaii or other Pacific islanders; and white. The concept of ethnicity is an attempt to further differentiate racial groups. However, like race, it carries its own historical, political and social burden. The current definition of ethnicity is arbitrary and poorly defined. For example, the term "Spanish" includes more than 400 million people from different ethnic groups and subgroups in more than 20 different countries. Therefore, trying to interpret the true meaning of ethnic differences is always a challenge. Despite these limitations, ethnicity provides more information when combined with race until researchers define its structure and justify its validity, reliability, and compatibility.

The determinants of health and disease are not only social class or gender, but also racial and ethnic factors are important factors in this regard. The cause of poor health status of ethnic and racial minorities is more than cultural and biological, social and economic factors. Brown explains this especially in Britain (Figure 2).

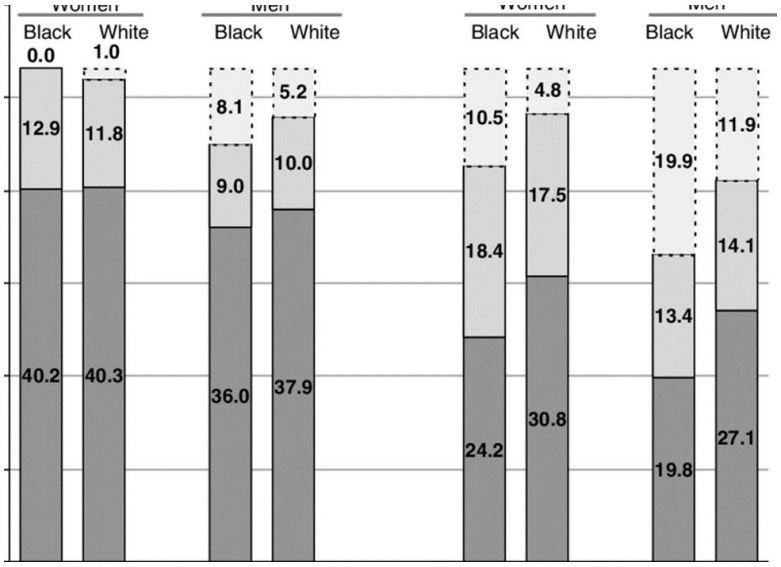

Figure 2. Average years of study based on race/ethnicity with a quarter range of selected health surveys.

Potentially lost years of life and years of unhealthy and healthy life at age 30: Sexually active groups with +13 and 0-8 years of education. Source: Crimmins and Saito.

The study of racial changes in health is done by a genetic model that assumes that race is a valid biological category, that the genes that determine race are related to the genes that determine health, and that the health of a population is largely determined by biology factors. Beyond concerns about the validity and reliability of race and ethnicity measurements, there is also the issue of distinguishing between race/ethnicity and poverty. It is important to test systematically for the interaction between race/ethnicity and socioeconomic status. Socio-economic classification analysis of racial/ethnic groups may provide more meaningful information than comparing racial and ethnic differences alone. Future studies on the relationship between race, ethnicity, culture, or acculturation, and health outcomes should go beyond showing the relationship between these variables and health outcomes and providing a causal pathway for such association. It is especially important for researchers to make better efforts to separate the effects of poverty from the effects of race/ethnicity or culture, and to determine how these variables are defined and measured.

Recent studies, however, have shown that genetic diversity in races is greater than between races, and that race is more of a social structure than a biological one. Thus, the concept of race, although socially significant, has limited biological significance. In addition to the limitations of race as a construct, there are problems with race validity and reliability that have been measured in most research studies.

Ethnic groups of blacks are much more likely than whites, who make up the majority, to develop their disease and express their health in much worse conditions than the rest of the population. The variety of diseases varies between different races. For example, African-Caribbean people are biologically prone to anemia and are more prone to high blood pressure and stroke. The diagnosis of schizophrenia is also high, so investing in hospitals for the disease and the like is likely. Among ethnic minorities of British nationality, they are more likely to be mentally retarded, and among the mentally ill, one in five are black and one in other ethnicities. Asians (Indians, Pakistanis and Bangladeshis) are more prone to heart disease and have a 50% chance of having a heart attack and dying from the disease. At the same time, the incidence of diabetes is common among these groups. Their mortality rate is high in the month or year after delivery. 30 to 50 percent of African-Caribbean, Pakistani and Bangladeshi are at risk. If we look at it from the perspective of real diseases, the similar situation of racial-ethnic groups can be clearly seen in terms of health. For example, over the past 20 years, blacks who have had a heart attack are 20 times more likely to die than whites. In the United States, 43% of people living with HIV are African American. Among the causes of death of African-Americans between the ages of 25 and 44, heart disease and cancer are at the forefront of accidents and crimes.

African Americans are the largest minority group in need of organ transplants. In 2019, blacks made up 12.8 percent of the country's population. The number of organ transplants performed on blacks in 2020 was 27.7% of the number of blacks currently awaiting a transplant. The number of transplants performed on whites was 47.6% of the number of transplants currently pending. While 28.5 percent of all volunteers currently awaiting transplantation are black, 12.9 percent will be organ donors by 2020. In 2020, 83.6% of black donor members were deceased donors. In 2020, 16.4 percent of black donors were alive, compared to 33.4 percent of whites. Although the total number of whites on the waiting list for organ transplants is about 1.4 times higher than for blacks, the number of volunteers waiting for a kidney transplant is about the same between blacks and whites. Blacks are more likely than white people to have diabetes and high blood pressure. These conditions are known to put patients at risk for organ failure.

The high mortality rate among ethnic and racial groups is mainly due to health inequalities. These inequalities include

race, poverty, malnutrition, language, and cultural barriers. Some discriminatory social policies and unfavorable conditions imposed on racial and ethnic groups expose them to disease and death more than white groups, increasing the risk factors in such cases. Again, members of ethnic and racial minority groups are at high risk for heart disease due to their high-fat diet among Asians.

Despite the results of this study, which shows that blacks have a high level of access to health care and first aid, the high level of poverty and high unemployment of blacks compared to whites is the cause. It negatively affects their daily preferences and explains the high rate of child mortality among blacks, the severity of the condition and violence among adults, or drug dependence and other health conditions.

Conflicts between different groups are evident if one focuses on several methods that reduce some of the major sources of morbidity and mortality, practices that are supported by strong scientific evidence and physicians' consensus. Jenks, et al. identified 24 such actions, which they named as care quality criteria for Medicare stakeholders, 21 of which were compared across racial and ethnic groups, from including inpatient procedures such as warfarin for patients with atrial fibrillation and outpatient procedures such as mammography at least every 2 years. Receiving appropriate treatment by each racial or ethnic group is compared with the percentage of receiving appropriate treatment in general. Racial and ethnic minorities appear to be in dire straits, especially for outpatient rather than inpatient procedures. Hispanics and Native Americans and Alaskan Indians in general may receive care that is inadequate for blacks, although they should be treated with caution due to their small numbers and problems with racial and ethnic identities. Individuals enrolled in both Medicare and Medicaid groups (of either racial or ethnic group) also receive less than average care, reflecting the socioeconomic dimension of poor care. However, their disadvantages are sometimes less than those of specific racial and ethnic groups.

Although the economic and educational situation of ethnic and racial minorities in the United States has improved in recent decades, discrimination in health care persists. For example, members of ethnic and racial groups are less common in regular research on medical and psychiatric drugs. Ethnic and racial minorities have limited access to health insurance compared to whites. While the number of whites who do not have health insurance for any reason is 12 percent, Latinos (Mexicans, immigrants from Central America to North America) 31 percent and Africans 21 percent according to state health officials. In the United States, uninsured people with a disease continue to live and die at a very young age.

Howard Wetzkin argues that ethnic tensions are causing medical problems among blacks. According to Howard, the pressure of hypotheses and differences based on ethnicity and race has increased blood pressure among African Americans compared to whites, blood pressure among blacks. It has doubled compared to whites and has become a factor in heart disease, kidney disease and high rates of sudden death.

Racial differences in hypertension and the consequences of hypertensive disease compared to their white counterparts are associated with mortality risks. These excessive risks of high blood pressure have a significant impact on the life expectancy of African-American men and women, which is significantly lower than that of Caucasian Americans. The risk of death from stroke is twice as high for African Americans.

RESULTS AND DISCUSSION

But what can be deduced from the discussion of the social and cultural roots of health and disease are points;

Although health and disease are associated with medical processes and concepts, they are a social and cultural phenomenon as well as medicine. In this sense, it needs a sociological perspective, because it is a phenomenon that is formed socially and culturally and is shaped by social structure. Thus, health and disease are the result of social and environmental products. It is society and how society perceives it that gives meaning to health and disease. Therefore, the presence or absence of some symptoms varies from community to community in the historical process. For example, obesity, once considered a symbol of wealth and prestige, is now accepted as a disease. In addition, new diseases are defined every day according to today's living conditions, and the issue of becoming medical or medical has led to the definition of new diseases. Beliefs, attitudes, attitudes and values are also effective in perceiving health-disease. Attitudes and behaviors towards this disease are a reflection of culture. A person's reaction and attitude are formed by culture in case of symptoms of the disease. From this point of view, whether the symptoms are considered a symptom of the disease or not, the criteria for health and treatment of diseases differ in different cultures. As a result, the individual's perception of illness in the process of socialization is regulated by the community in which he or she lives.

Health is also one of the institutions that make up the social structure. The starting point of health organizations in providing and maintaining health is the existence of healthy people. In this sense, its purpose is to ensure that its members are in a state of complete mental, physical and social well-being. In this regard, the social structure should be in communication and cooperation with other institutions. In this regard, the health institution is directly related to the political and economic structure.

CONCLUSION

It can be concluded that health and disease are not separate categories from society as a whole. Society is the basis and bedrock of both health and disease. If diseases are different from one society to another, and even the perception of diseases is different from one society to another, this goes back to the difference of societies. It is the origin of diseases and health of society and is nourished from there, and health and disease from this perspective is the result of social causes and factors, and society as a container, has its own contents that we call economics, politics and management and we learn from them. Illness and health are the domain and along the social realities and we must first look at the types of inequalities and

enjoyments in society and consider it as the starting point of health and disease.

Accordingly, health centers are the only monitors of social realities that depict and display what is happening in society. Obviously, in a society dominated by poverty, the share of health will be equal. Poverty is pathogenic and disease leads to double poverty, and this cycle will continue or dependence on a particular class, ethnicity, race, gender, etc. are among the factors that less allow the disease to reach its end line and the poor passenger train to get their poor passengers out of the disease wagons.

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