Sociocultural determinants of health and illness: A theoretical inquiry

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Abstract

This article articulates the hypothesis that people do not perceive health as a single dimensional phenomenon of a physical absence of disease. In contrast, health can be determined by multi-dimensional factors that include people's lifestyle, their perception of health and illness, and their health-seeking behaviour. By exploring available literature it highlights some of the studies which have generated mixed results and describes various social and cultural factors learnt across the research processes including the evidence that effective communication between doctors and patients can improve health outcomes such as patient satisfaction, patient adherence to treatment, and disease outcomes. Social support generally shows a favourable impact on the maintenance of health and coping with stress and illness. Patients who obtained social support from family members and friends were found to be more cooperative with their attending doctors and nurses in learning about their future and in understanding the meaning of life.

Keywords: health, illness, sociocultural determinants, socioeconomic position, social support, stress

Introduction

In 1948, the World Health Organization's (WHO) constitution defines "health" as a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. At that point of time, the WHO definition does not access health solely based on diseases alone. This is because an individual's health status is determined by many other factors that would affect the functioning of an individual. WHO's notion of health is such that the wellbeing of an individual is not only limited to their physical fitness, it also includes their mental fitness and social life as well. This means that an individual may be free from any disease or infirmity, but the social factors surrounding that individual could affect the wellbeing, which then even leads to a serious illness.

In relation to WHO's health definition, one may interpret that the health of an individual can be contributed not only by medical factor, but also by sociocultural factors as well. For example, in his experience on caregiving, psychiatrist and medical anthropologist Arthur Kleinman (2009: 292-293) relates how caregiving to loved ones who suffer from the infirmities of advanced age, serious disabilities, terminal illnesses, and the devastating consequences of such health catastrophes as stroke or dementia, can be tiring and emotionally draining. So much so that, caregivers providing effective caregiving are required to receive practical and emotional support. As the caregivers offer cognitive, behavioural, and emotional support to the care-receivers, caregivers themselves are left with a great burden of stressful life that adversely affects their wellbeings. This, if not treated well by other professionals, may at the end bring about serious illnesses. This means that although the caregivers may be physically and mentally fit, the social effect of caregiving duties and responsibilities can be a great factor contributing to the health status of the caregivers.

Hence, in the Alma-Ata Declaration of 1978, WHO reaffirms that health is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other sectors specifically the social

dimension of health. In the declaration, emphasis was given to the importance of community participation in healthcare and thus the incorporation of community cultural values into healthcare. In focusing on the integration of culture in healthcare, the new dimension of health definition allows people to manage their ways of living, which are then influenced by their surroundings, their beliefs, their culture, and their socioeconomic positions.

Consequently, people do not perceive health in one physical dimensional as an absence of disease. In contrast, health can be determined by multi-dimensional factors that include people's lifestyle, and people's perception of healthcare services. In a society, there are many different ethnic communities. Each individual community practices their particular way of lives and perceives healthcare services differently from others; of which these social dimensions of their lives ultimately exert impact on their wellbeings. A deeper analysis indicates that the different lifestyles and perceptions adopted by different community people are generally influenced by the particular community's sociocultural factors such as their socioeconomic positions and cultural beliefs. Thus, different ethnic community members experience different pattern of health status.

As such, this theoretical discussion seeks to explore the literature, of the importance of sociocultural factors in people's lifestyle, their perception of health and illness, and health-seeking behaviour.

Social determinants of health and illness

Several studies have stated that the social determinants of health include socioeconomic position (Note 2) and social support (House, 1981; Berkman & Glass, 2000; Lynch & Kaplan, 2000; Muntaner et al., 2006; Galobardes et al., 2007). Each of these elements will be discussed at length in turn below.

Lynch and Kaplan (2000: 24-28) in understanding socioeconomic position have associated the role of socioeconomic position and one's health. In their context, one's income level is closely related to healthcare accessibility. According to the researchers, individuals with better socioeconomic position enjoy better quality of lifestyles, healthcare services, as well as have better health status. In contrast, individuals with lower socioeconomic position have lower quality of life, less access to healthcare, and thus have lower levels of overall health.

Next, the influence of income inequalities on an individual's health status was also observed by Pei and Rodriguez (2006) in their study in China. In the study, the effects of provincial income inequality on individual's health status in 1991, 1993, and 1997 of nine provinces in China were analysed from the China Health and Nutrition Survey. The study showed that people living in provinces with greater income inequalities have poorer health as compared to provinces with modest income inequalities found in most modern cities like Guangzhou. This is because, in provinces with greater income inequalities, there are traditional healthcare problems such as accessibility problem to healthcare and also lack of proper healthcare facilities. As Quah (1977: 338) noted, there are some fundamental differences between traditional and modern healthcare systems in terms of their accessibility, such as the degree of medical technology, the level of bureaucratization, and their differential dependence on traditional values and beliefs. As such, less accessibility to health care system in provinces with greater income inequalities of Pei and Rodriguez's (2006) study is due to the people's traditional health beliefs, which have marginalized Western medicines, as well as non-cultural factors in their society that include poor medical facilities and government's policy in health care subsidies.

The relationship between one's socioeconomic position and health status is not confined merely to one's level of income, but also one's level of education. There is a large body of empirical evidence to support the claim that there is a positive relationship between education and health. The Black Report (Black et al., 1980) has shown that unskilled people were more likely to have poorer health than professionals. The argument lies in the fact that the professionals are more resourceful in getting better access to healthcare such as buying better drugs, getting better services, and even undergoing better surgeries. These are because professionals achieved higher levels of education and have, in general, secured better jobs and hence higher potential income levels, which then enable them to enjoy better healthcare services. This explanation coincides with a review study by Lynch and

Kaplan (2000: 22) that one's higher levels of education are positive predictions of better jobs and higher incomes, and is thus able to purchase more health-enhancing goods and services, such as hospital services and healthier foods.

In another study by Agarwal et al., (2007) on breast cancer patients in India, Malaysia and Hong Kong, findings suggest that women with higher levels of education, which had brought them higher levels of income, are more likely to have their disease diagnosed in its earliest stages. MacLean (2004) argues that women with more education have better access to healthcare. This means that their tumours are more likely to be detected and reported earlier when they get breast cancer. Comparatively, women with less education, due to lack of awareness, lack of funding, and lack of infrastructure, may be more likely to die of another cause before the tumour is detected.

Another social determinant of health that is measured closely with one's income and education is one's occupation. In the measurement and understanding of socioeconomic positions in regard to health, Lynch and Kaplan (2000: 23) argue that understanding about the relationship between health consequences and occupation or employment is crucial because it is the most obvious, intimate, and stable connection between humans and the productive processes that dominate much of the adult life. One cannot understand an individual's health consequences without understanding how work or lack of work structures the individual's life. Here, work includes not only paid work, but for care giving work by women who are not only formally employed but also hold other structural social roles such as housewife and motherhood.

Besides paying focus to an individual's work and paid work, studies of occupation and health explored the multiple pathways through which work affects health. For example, studies have found that one's working condition contributes significantly to one's several ill-health symptoms such as respiratory complaints of persistent cough and wheezing (Lynch & Kaplan, 2000: 20-28; Berney et al., 2000). Berney et al.,'s (2000) study on UK men and women between 63 and 78 years old, for instance, describes that respiratory disease symptoms of the UK individuals were due to their hazardous working environment such as exposure to disadvantaged material and environmental hazards, namely, air pollution, occupational fumes and dusts, and physically tough labour work.

In addition to the physical environment of individuals' employment, another aspect of studies on occupation and health concerns the high levels of workplace demands. The study of Ji et al., (2008) on occupation and breast cancer risk among Shanghai women showed that some of the occupations like medical and healthcare workers and teachers are linked to the established risk factors of breast cancer, such as work stress and late night or night shift work. Studies have shown that stress commonly follows extensive and long-term late night shift works that require interruptions to sleep patterns, resulting in fatigue and digestive disorders. Some of these health problems then lead to chronic diseases such as cancer (Kobayashi et al., 1999; Leka & Jain, 2010). For example, Kobayashi et al. (1999) studied the effects of night shift duty on physiological and psychological functions in 12 healthy unmarried Japanese nurses working in the same ward of a university hospital. They found that night shift work is highly stressful and is harmful to one's immune system later resulting in a range of deleterious health effects.

Another study by Lau et al., (1997) explores the work and family stress of Chinese adults in a contemporary Chinese society in Hong Kong with respect to the impact on their psychological wellbeing. The findings suggest that coping with high work demands and also being responsible for household affairs and rearing the children were reported as the highest stress responses. As highlighted in Lai's (1995) study on the relationship between work and family stress and psychological distress in urban Shanghai, women tend to experience more family demands than men. Thus, women's mental health status is tied closely to stress arising from high work and family demands, whereas men are more vulnerable to work stress than family stress. However, both Chinese men and women experience negative physical and psychological wellbeing such as feeling lethargic and depressed at some stage of their lives. These poor states of physical and mental health of the adults act as the onset of chronic illnesses such as heart diseases and cancer for some.

Other than the influence of socioeconomic positions, measured in terms of income, education, and occupation, in health and healthcare differences; social support plays a crucial role in the stress coping process for one's wellbeing. Individuals that are under stress, for instance, may be affected with illnesses like heart attacks. Thus, social relationships among friends and family members may provide emotional support or reassurance that the terminally ill individuals are loved and cared for by

others. In addition, social relationships of friends and family members may provide instrumental support by offering material resources such as food or money to assist the ill individuals. The social support received by the ill individuals thus helps to reduce the level of psychological distress and then assist in the recovery of the illness. Also, the ill individuals can receive informational support from others, such as provisions of guidance and feedback regarding his or her type of illness (Heitzmann & Kaplan, 1988; Weber, 1998).

It is evident that social support generally shows a favourable impact on the maintenance of health and coping with stress and illness (Cohen & Wills, 1985; Schwarzer & Leppin, 1991: Ding et al., 2008). For example, Ding et al., (2008) in their study that investigated social support of Chinese women with ovarian cancer during chemotherapy, found that social support from patients' family members was considered as a major social support resource for the Chinese women during their therapeutic process. In relation to Ding et al.,'s (2008) finding, Zhang et al., (2010) in their study to explore the level of hope in Chinese women with breast cancer during chemotherapy and its relationship with social support received by the women, point out that social support obtained by these breast cancer patients in China is considered the most important factor to increase the patients' hope level. Patients who obtained higher amount of love from family members and friends were found more cooperative with their attending doctors and nurses, and then gradually obtained information about their future to understand the meaning of life. This considerably increased their strength to fight the disease.

Another study on the role of social support in relation to health maintaining examines the forms of social support obtained by Canadian women participants with mental illness (Chernomas & Clarke, 2001). According to Chernomas and Clarke (2001), majority of the women participants in their study have a stable livelihood, and perceived the emotional and informational forms of social support as more apparent in their support systems. In addition, contacts between the women participants and their family members were through regular phone calls, as many of the women lived away from their supportive families. To them, family members provided emotional and appraisal support, and frequently, when they were able, financial support. In this study, social support not only acts as a form of a coping mechanism, it also serves as a source of information and provides a sense of wellbeing to the Canadian women with mental illness.

From the above studies on social determinant of health and illness, one may conclude that a social support network as a determinant of health provides a positive impact on health outcomes. On the other hand, several selected socioeconomic positions such as one's income, education, and occupation serve as defining characteristics of one's levels of health and illness (Lynch & Kaplan, 2000). Individuals with lower socioeconomic position suggesting lower levels of education achievement and a lower paid employment are said to have poorer access to healthcare. Occupation as a marker of one's socioeconomic position also influences one's health in terms of job stress as well as the employment's working environment.

Cultural perspectives of health and illness

Developing a culturally sensitive understanding of health and illness is paramount to a community, as its focus concerns not only the social determinants on health and illness of the people, but also the cultural environment found in the people's communities. The following discussion details the importance of different cultural perspectives in understanding diseases, beliefs about health and illness, as well as communication about healthcare.

Theoretically, Tylor (1994: 1) proposed a modern technical definition of culture that viewed the concept as patterns of thought and behaviour within a human society. With that, the British anthropologist discusses culture in an ethnographic sense and defines culture as a complex whole which includes knowledge, beliefs, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. Tylor (1994) defines culture as a socially-learned human behaviour and thought, of which can be seen in two aspects of culture: (i) the abstract aspect includes ideas and emotions such as knowledge, art, customs, belief and law or system of meanings or society's norms and values, and (ii) the total habitual way of life of a group of people, acquired through learning and shared by the members of that group. For example, while babies are born with a

physiological desire for food, they are not born knowing that certain foods are more nutritious, more wholesome, than others. They learn that from future interactions with their parents and other members of their society.

In 1952, Kroeber and Kluckhohn (1952: 357) suggested a number of meanings of the word 'culture' and argued that the concept refers to the study of behaviour and behavioural products. Part of culture consists of norms of behaviour, and another part consists of ideologies justifying or rationalizing certain ways of behaviour. According to Kroeber and Kluckholn (1952), culture is more than just social habits or patterns of behaviour that are learned and passed on from generation to generation. To the researchers, the learning factor is culture's essential and culture, as a body of learned behaviours common to a given human society; it has predictable form and content that shape behaviour and consciousness within a human society from generation to generation. For example, children acquire language in the same way as they acquire the basic cultural norms of the society they grow up in through interaction with older members of their cultural group.

Next, the definitions of culture by Geertz (1957, 1973) and Helman (2000) are also deemed as culturally appropriate in the discussion of health and illness. For instance, in Geertz's study, culture refers to the framework of beliefs, expressive symbols, and values with which individuals define their feelings and make their judgements (Geertz, 1957: 32-54). In addition, culture is a historically transmitted pattern of meaning embodied in symbols, a system of inherited conceptions expressed in symbolic forms with which men communicate (Geertz 1973: 89). Here, Geertz's definition of culture simply means that people's expressions in terms of emotions and ideas such as goodness and truth must be socially inherited and customary embodied and enacted meanings, and they must actually be constitutive of a way of life.

On the other hand, Helman (2000: 2-3) defines culture as a set of guidelines, both explicit and implicit, which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relations to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation, by the use of symbols, language, art and ritual. In other words, culture, to Helman (2000) is the underlying beliefs, perceptions, norms and values that are held in common by a group, and that serves as a foundation for social, economic and environmental interactions.

In sum, the bottom line is that, culture, as a whole is seen within the people's lives. Culture not only forms the framework within which people understand and make sense of the world, culture also provides meaning to the experience of health and illness. Every culture conceptualizes disease and illness differently. People in different cultures and social groups explain the causes of illness differently. In addition, the treatment people seek is often influenced by their beliefs and perceptions of what is causing their illness (Helman, 2000: 1).

From the above conceptual discussions of culture, Penn et al., (1995) view culture as playing a significant role in several health and illness areas such as patients' beliefs about causes of diseases, accessibility and acceptability of healthcare services, preferred treatments, and doctor-patient interaction. Each of these is described in more detail below.

Studies have shown that different cultures often attribute different cultural beliefs in tracing disease etiology, of which a disease may be caused by metaphysical agents such as possession, witchcraft, fate, luck, and *karma*; supernatural agents such as deity and spirit, and cultural habits such as dietary pattern and lifestyle. For example, Lui et al.,'s (2009) study on the cancer experience of Chinese patients in Brisbane, Australia indicates that the belief in fate and luck was commonly subscribed by the cancer patients as the etiology of their illness.

Other fatalistic views about perceived causes of cancer, particularly among Asian communities, relate to God's punishment or offending the family deity. In a cancer beliefs study by Wong-Kim et al., (2003: 26) on Chinese living in San Francisco, some of the participants considered the cause of their illness as a punishment to them as a result of an ancestor's misconduct. These Chinese participants strongly believed that if the ancestor had misbehaved, the descendants would suffer from their ancestors' immoral acts by having bad luck or suffering from incurable diseases such as cancer.

In another study, Zain and Ghazali (2001) of University of Malaya review epidemiological studies of oral cancer of various ethnic groups in Malaysia and suggest that the disease is closely related to the patients' cultural habits. The study's findings provide evidence that the Indian ethnic

group in the country and the indigenous people of the two states in East Malaysia, Sabah and Sarawak, were identified as high-risk groups for oral cancer. The close association of the disease and the two ethnic groups is mainly due to their betel quid chewing habits. For many Indians, betel quid chewing is perceived as breath freshening and also serves as relaxant properties.

Other cultural habits related to cancer patients' perceived causes of illness include cultural food habits and particular culture's lifestyle habits. For example, Kamarudin et al., (2006: 53) in their case-control study on females with breast cancer in Kuala Lumpur suggested that, most breast cancer females adopted certain lifestyles such as not exercise regularly. According to the authors, physical activity and exercise may affect hormonal concentration and energy balance in a person's body, further affecting the occurrence of diseases especially chronic diseases such as cancer.

Besides lifestyle habits, cultural eating habits is also associated with the causes of cancer. Armstrong et al., (1998: 233) in their study on nasopharyngeal cancer among Malaysian Chinese claim that the cultural habit of the Malaysian Chinese in eating salted preserved food such as salted fish, salted duck eggs, and salted leafy vegetables as well as salted meats like sausages, bacon, and ham, is linked to the risk of developing nasopharyngeal cancer. Culturally, as the ancestors of the Chinese in Malaysia were from the Southern part of China, they tend to have adopted a Southern Chinese diet. As reported in Yu et al.,'s (1986: 956-960) study on salted fish as a cause of nasopharyngeal cancer among Hong Kong Chinese, the southern Chinese diet contains a variety of salt-preserved foods, one of them being salted fish. In addition, salted fish is traditionally one of the cheapest foods available to supplement rice, particularly among the lower social class in southern China. Thus, regular consumption of salted fish has caused the Chinese population to be significantly associated with nasopharyngeal cancer.

The cultural influence in determining patients' causes of illness then continues to exert its impact on patients' accessibility and acceptability of healthcare services. In terms of accessibility and acceptability of healthcare, the common cultural barriers include ignorance of illness symptoms (Carlin & Solokoff, 1985), culturally insensitive services (Quah, 1977: 338), and language differences between healthcare providers and patients (Lam & Heathcote, 2010: 175). Each of these barriers is discussed in turn below.

Studies have shown that the Asian population, particularly the Southeast Asians, do not response to mild physical pain and mild discomfort in their body such as mild headaches, muscle pain, sore throat, fever, and cough; and thus do not see the need to seek healthcare professionals. For instance, in Carlin and Solokoff's (1985) study on Southeast Asian refugees, the findings reveal that many of the refugees treat some sufferings of physical pain and certain minor illness such as mild discomfort of body, as an unavoidable part of life. In this respect, the refugees continued to delay the action of seeking medical care, as majority of them considered Western treatment to be an inappropriate solution in response to physical body pain. In the study, the different perceptions, evaluations, and ignorance of illness symptoms had later affected the attainment of appropriate care and treatment for the refugees.

Next, it has been shown that despite the availability of healthcare services, certain cultural beliefs on illnesses may influence the utilisation of healthcare services of certain cultural groups. Health services like screening facilities maybe underutilized when people's cultural beliefs conflict with the healthcare knowledge passed to them. In a study on modesty by Andrew (2006), findings imply that Asian, Hispanic, Muslim, and Jewish females value modesty as a way of protecting them from the wider world. These cultures that have strict rules of modesty underutilise healthcare services. For example, the relatively few Israeli women participated in breast screening programs was most likely due to the reason that the procedure is thought to violate orthodox rules of modesty by requiring a woman to disrobe and have physical contact with a health technician. It is also reported that in the Israel's Haredi community, the media even avoid using the term 'breast cancer' for reasons of modesty (Andrew, 2006).

In Malaysia, the norms of modesty have become a frequent barrier in discouraging Malaysian women from breast cancer screening (Caffarella & Kamis, 2006; Parsa et al., 2008) as well as acceptance of HPV vaccines in preventing cervical cancer (Wong, 2008). For example, in studies by Caffarella and Kamis (2006) and Parsa et al., (2008), modesty has been described as a set of culturally determined values that relate to the presentation of oneself to others. In terms of breast cancer screening, most women feel too embarrassed to be examined by a male physician. Whereas, in

Wong's (2008) study to investigate the acceptability of the HPV vaccine among a multiethnic sample of young women in Malaysia, the findings show that in the cases where young Malaysian women who are in favour of HPV vaccines, modesty serves as a personal inhibitor for obtaining the vaccines. In most cases, the young Malaysian women would still be very much concerned about themselves whether the general public in the community would perceive them as sexually active.

A similar observation was found in Mo's (1992) study, which described modesty as a cultural value that prevents Chinese women living in the United States from obtaining breast examinations and screening mammography. Mo (1992: 262-263) in the study quoted that in a 1981 National Cancer Institute study in San Francisco (of which Mo is one of the researchers), discussions of Chinese women and their minimum participation in breast cancer screening indicated that the women were reluctant to be examined by male physicians. Mo's (1992) findings concerning breast screening and sociocultural values of modesty support the findings of Pillsbury's (1978) study which stated that Chinese women in China felt vulnerable being examined by a male healthcare provider. The researcher in her study of Chinese cultural beliefs and practices in relation to Chinese women's confinement and convalescence after childbirth indicated that 90 percent of obstetricians and gynecologists in China are women. This is because of the traditional Chinese women's reluctance to have reproductive problems dealt with by men due to modesty reasons.

Another issue in the discussion of accessibility and acceptability of health services relates to the language needs of the patients of some cultures. Due to the lack of proficiency in English, many patients, particularly Asians, are unable to describe their illness symptoms to the healthcare providers as well as unable to understand the providers' technical explanation of the illness diagnosis. For example, Lam and Heathcote (2010: 175) in their study of health issues faced by Chinese patients at the Toronto Western Hospital to determine whether this patient sub-group was satisfied with the health services provided to them found that language was one of the cultural barriers to health services in the hospital. It was shown that Chinese patients were not proficient in English have greater difficulty understanding instructions on how to take their medications. For example, whether to take medication after or before meals as well as to how much is considered the right dose of drugs prescribed. The study findings also indicate that limited communication between providers and patients due to language differences caused minimum disclosure from patients on their use of Chinese medical therapies instead of Western treatment, which may negatively affect patients' healthcare.

As shown in the above study on the impact of English language proficiency on healthcare, a further review of literature indicates that due to lack of knowledge in Western medical course of therapy as a result of poor communication between providers and patients, many patients deterred from utilising Western treatment. In view of that, it is commonly held that the use of alternative medicines such as traditional Chinese medicines is very common among Chinese and other Asian patients in countries such as Taiwan, Singapore, and Hong Kong (Ho et al., 1984; Wong et al., 1995; Chi et al., 1997). Wong et al., (1995) in their study in Hong Kong attempt to assess the role of traditional Chinese medicine in the people's healthcare and found that the Hong Kong people relied on Chinese herbal medicine as an alternative when Western medicine failed to provide the required necessary relief. Due to poor communication between doctors and patients, the latter often do not explore further with the Western doctors when they needed further consultation for the same illness. Instead, most of them consulted Chinese herbalists as they have more faith in the practitioners of Chinese traditional medicine and also, the use of herbal therapies by Chinese is more prevalent in general; of which it is recognised as one of the oldest treatments in Chinese culture.

With regards to the above discussion on the preference of traditional Chinese medicines by the Chinese cultural group due to poor doctor-patient interaction, an ethnographic study by Ho (2004: 758) with regards to the perception and management of tuberculosis by Chinese in the New York City further elucidates how traditional Chinese medicine is being utilised among the Chinese patients there. In the study, Ho (2004) highlights that traditional Chinese medicine is being used as a complementary to the biomedical treatment of tuberculosis because it helps to reduce the side effects of Western medicines such as fever and vomiting, and subsequently to restore bodily balance and the general health of patients.

In another study in the field of social epidemiology, the findings of Lee et al.,'s (2000: 45) study in the United States of America on the prevalence and patterns of use of conventional and alternative therapies chosen by Blacks, Chinese, Latino, and White women with breast cancer in San Francisco,

again provides evidence that Chinese patients are more likely to use Chinese herbal medicines than whites or blacks. However, Lee et al., (2000) in their findings also confirm the fact that majority of the women with breast cancer do not disclose their use of herbal treatments as an alternative therapy to their medical practitioners. In most cases, this phenomenon is related to the outcomes of patients' satisfaction with doctor-patient interaction. In Lee et al.,'s (2000) study, a difference in language use among doctors and patients causes minimum interaction between these two communities, whereby communication between them during consultations is often limited to explanations on the diagnosis of the patient's illness by the doctors. Patients speaking a different language tend to be reluctant to share information with the physicians such as informing them their use of an alternative therapy in Chinese herbal medicine.

As such, empirically, research on doctor-patient interaction has generated considerable evidence that effective communication between doctors and patients can improve health outcomes such as patient satisfaction, patient adherence to treatment, and disease outcomes (Kaplan et al., 1989; Stewart, 1995). Kaplan et al., (1989) in a study to assess the effects of doctor-patient interactions in relation to health outcomes of chronic diseases such as cancer note that a strong doctor-patient relationship often results in patients' participation in their consultation, of which doctors respect patients' norms and values and listen to their cultural views and perceptions of their illness. This in turn encourages information exchange where patient may also ask questions about the illness and express their own cultural perceptions. Friendly discussions between doctors and patients subsequently establish patient's trust in the doctor's diagnosis and prescriptions. This indirectly leads to patient's better adherence to treatment, health habits, and self-care, and ultimately betters health outcomes (Heszen-Klemens & Lapinska, 1984).

In a Malaysian study by Noor Azlan (2005: 83) of various health issues among urban Malays in Malaysia further support the findings of Kaplan et al.,'s (1989) study in health outcomes of chronic diseases. According to the researcher, frequent contacts between medical doctors and the urban Malay patients influence the latter in making their decision to choose the treatment from medical doctors in comparison to other non-medical treatments. Here, the situation is due to the reason that during the medical consultations, the doctors on duty not only prescribed the medication, but also provided the patients with extra biomedical information and knowledge pertaining to the illnesses suffered. The patients thus sense the doctors' compassion and in return, the patients will more likely to trust the doctors and act in the doctors' best interest in adherence to Western treatment, consequently contributing to the healing process of the patients.

Conclusion

This theoretical discussion on sociocultural determinants of health and illness has highlighted the importance of various social and cultural factors on individuals' health status. From the social perspective, both social determinants of socioeconomic positions and social support network have indicated positive impacts on individuals' health status. From the cultural perspective, the role of culture in relation to individuals' health status include individuals' beliefs about causes of illness, accessibility and acceptability of healthcare services, preferred treatments, as well as doctor-patient interaction. As individuals' health outcomes are determined by a convergence of social and cultural factors, one must address all factors in order to improve health problems. In addition, exploring the meaning of health and illness between doctor and patient can further enrich the doctor-patient interactions.

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Notes

Note 1. The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of WHO as the key to achieving the goal of "Health for All." Further details, see <http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf>
(accessed 20 August, 2008).

Note 2. According to Karl Marx, socioeconomic position is solely determined by one's source of income or by one's "relationship to the means of production." In contrast to Marx, Weber suggested that class is part of the multidimensional schema of stratification that creates groups whose members share a common position with similar life possibilities or life chances. According to Weber, the 'life chances' are actively created by individuals, through their ability to beneficially trade their education, skills and attributes for social advantage in the marketplace. To Weber, it is not just a person's ownership or non-ownership of property that determines class position; instead it was a person's possession of goods, opportunities for income, level of education and degree of technical skill. For an extensive discussion of the theory of class between Marxian's and Weberian's views in understanding the association between socioeconomic position and health, see K. Marx & F. Engels, eds, "Manifesto of the Communist Party" in *Karl Marx and Frederick Engels - Selected Works (Vol. 1)* (Moscow: Progress Publishers, 1969), 98-137; J.W. Lynch & G.A. Kaplan, "Socioeconomic position" in *Social epidemiology,* edited by L.F. Berkman and I. Kawachi (New York: Oxford University Press, 2000), 14-20; Bruna Galobardes, John Lynch & G. Davey Smith, "Measuring socioeconomic position in health research," *British Medical Bulletin,* vol. 81-82, no. 1 (2007): 21-37; Robert J. Brym & John Lie, *Sociology: Your compass for a new world, 3rd edn,* (Belmont: Thompson Wadsworth, 2007), 228-229.