Collective Lifestyles as the Target for Health Promotion

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ABSTRACT

The last five years have witnessed intense debate among health researchers in Canada regarding the overlap of the health promotion and population health discourses. Meanwhile, strong currents within health promotion have attempted to move the field beyond a focus on individual behaviour towards the influence of social environments on health, although the tendency is often to fall back on individual behaviour modification as the primary lever for change. The Population Health research agenda bypasses behavioural determinants of health and explores instead social determinants. This body of knowledge provides useful insight for addressing some of the tensions in the health promotion discourse. This paper explores two of these tensions: whether individuals at risk or general populations should be targeted for change; and whether lifestyle is an individual or a collective attribute. We propose the notion of collective lifestyles as a heuristic for understanding the interaction between social conditions and behaviour in shaping health.

ABRÉGÉ

Parallèlement au vif débat en cours sur les différences et similitudes entre les discours de la promotion de la santé et de la santé des populations, certaines tensions sont apparues en promotion de la santé. En dépit des efforts pour orienter davantage le champ vers les déterminants socio-environnementaux de la santé, les comportements individuels constituent encore souvent la cible ultime du changement. Délaissant les facteurs individuels et résolument tourné vers les déterminants sociaux de la santé, le domaine de la santé des populations peut contribuer à dénouer ces tensions. Dans cet article nous examinons deux tensions à la lumière de résultats d'études sur les déterminants sociaux de la santé. La première tension concerne la cible des interventions et la seconde le caractère collectif ou individuel de la notion de "lifestyle". Nous proposons le concept de "lifestyle collectif" comme outil heuristique pour comprendre comment les interactions entre les comportements individuels et les conditions sociales façonnent la santé.

The last five years have witnessed intense debate among health researchers in Canada regarding the overlap of the health promotion and population health discourses and the implications of such overlap for health policy making and health research in Canada.[1-3] These discussions were fuelled by a reform movement among Federal and Provincial health agencies and programs that led in some instances to a change in labelling from health promotion to population health. There were also attempts to integrate the two discourses into tentative models,[4] the usefulness of which still remains questionable. There may, however, be another way for health promotion to make use of the ideas developed by population health researchers. We propose that population health research may provide insights to foster the theoretical development of health promotion. This paper argues that health promotion is hostage to inconsistencies arising from an unresolved tension as to whether its focus should be on the individual or on populations. We then go on to examine this tension in light of certain insights provided by the population health literature. Finally we revisit the notion of lifestyle. Collective lifestyles, we will argue, should be conceptualized as a group attribute resulting from the interaction between social conditions and behaviour.

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BACKGROUND

The population health perspective in Canada is associated with the Population Health Research Group of the Canadian Institute for Advanced Research (CIAR) that has published an incisive critique of the health care system based on a synthesis of a vast amount of research.[5] Briefly, this group argues that once a certain threshold is reached, increased expenditure in the health care system (including public health) leads to diminishing returns in population health outcomes. They give emphasis to the social determinants of health, in interaction with the biological, and provide a framework with which to understand the occurrence of disease in populations.

It is interesting to note that the CIAR publications correspond roughly in time to a surge in activities among health promotion thinkers attempting to improve the definitions and theoretical underpinnings of their field.[6] This search for theory is in part the result of a shift in both practice and research from health education to health promotion. Beginning as a critique of traditional health education with its individual-behaviour-based approach, discussions in health promotion began to acknowledge the role not only of individual behaviour, but also of the physical, social and economic environments that shape both behaviour and health.[7] Despite several attempts to integrate the social environment into health promotion interventions,[8] a tension is created in the discourse and practice of health promotion as there is a tendency to fall back onto indi-

vidual behaviour modification as the primary lever for promoting health.[9] This tension is to be found in the health promotion literature regarding its definition, the target for change, and the notion of lifestyle. The broad population health research agenda, as developed by researchers in Canada but also in the United States[10-12] and the United Kingdom,[13,14] will be instructive in analyzing this tension given that it bypasses behavioural determinants of health and explores instead the social determinants of health.

Focussing health promotion on individuals or on populations

Defining Health Promotion and its Outcomes

Health promotion has been defined in numerous ways since the publication of the Lalonde Report.[15] Although some definitions lead one to interpret health promotion as a field that targets individuals,[16] most attempt to focus on populations by identifying organization-[17] or community-level processes[18] as the target for change. Despite definitions emphasizing the importance of population change for promoting health, individual behavioural risk factor outcomes are still often the ultimate criteria for judging the value of community health promotion interventions. This issue is exemplified by the debate surrounding the publication of evaluation results from certain heart health programs conducted in the 1980s.[19,20] Because these programs failed to demonstrate changes in individual behavioural risk factors, the efficacy of community-level interventions was put into question.

The Target of Interventions

A second discord in health promotion rests with questioning whether interventions should target risk factors and individuals, groups of individuals at risk, or whole populations and the circumstances that shape their health experience. While this may be a theoretical point of contention, in practice interventions generally tend to target individuals "at risk" for some particular health problem. The recent COMMIT trial is an example of an intervention focussing primarily on a group at risk – smokers.[21] Conversely, rather than being the real focus of interventions, the circumstances that shape health experience, or what we can term socio-structural conditions, are all too often represented either as "barriers" to successful attempts to modifying behaviours[22] or simply as instrumental to this same end. A subtle example of this paradox is the Cœur en santé St-Henri project.[23] Although this program focusses on the community as a whole, interventions are directed toward specific individual-level risk factors such as physical activity, smoking, and a healthy diet. Interventions targeting change at a collective level, such as the reinforcement of non-smoking policies, are mainly seen as supportive of individual-level behaviour modification.

Rose[13] has developed a convincing argument for the importance of population change rather than the targeting of high-risk groups. When a risk factor is normally distributed in a population, Rose argues that shifting the risk levels of the entire distribution will bring about more significant changes in health outcomes than if one focusses solely on the high-risk group. The advantages of this population approach come about in three ways. First, the risk is lowered for those situated in the high-risk group. Second, when many people lower their risk, even a little, the total benefit for the population is larger than if people at high risk experience large risk reduction. In many instances, people at average risk for a particular disease succumb to it. Because these "average" risk individuals form the majority of the population, the absolute number of disease events prevented may be greater if the risk is shifted for the entire distribution rather than for just those on the tail end of the distribution. This argument is consistent with the idea that groups of individuals function collectively and are affected by the average functioning of individuals around them. Duncan et al.[24] inform us that smoking cultures may develop in local neighbourhoods whereby the co-presence of similarly behaving people influences not only the number of times people practice the behaviour but also the quantity smoked.

Third, Syme[25] highlights that large preventive programs targeting high-risk individuals failed to modify the distribution of the targeted disease in a population because they did not address the circumstances and societal forces that induce people to engage in high-risk behaviours. Given this, he surmises that there will always be individuals moving from a lower-risk group to a high-risk category, thus replacing those for whom the intervention might have been successful.

To overcome problems not dissimilar to those highlighted by Syme, Corin[26] suggests that the concept of "at-risk groups" be complemented by that of "target conditions." When writing of target conditions, Corin explores the impact that collective influences have on the lives of groups. She maintains that by understanding the web of social and cultural determinants in a given context, and their effects on health problems, we may be able to improve on health interventions. The target of intervention is no longer the individual in isolation from her context, but rather the conditions that make people unhealthy.

Lifestyle as an Individual or Collective Attribute

In health promotion research, the term 'lifestyle' is usually defined in terms of behavioural risk factors and pathologized as a source of illness. In Healthy People 2000, for example, a number of lifestyle areas such as smoking or exercise are identified, characterized as behavioural risk factors and targeted for strategic planning.[27] Lifestyle is thus conceptualized as a number of discrete behaviours found to be associated with diseases in epidemiologic studies. Public health interventions based on this vision of lifestyle are increasingly associated with disease prevention instead of health promotion.[15,28]

Some population health studies provide evidence that the risk factor notion of lifestyle may be deficient in improving health. The work of Blaxter[29] demonstrated that the impact of traditional notions of lifestyle on health is modified by contextual factors. She found, for example, that the health gains associated with refraining from smoking were greater for people living in wealthier areas when compared to people living in less affluent neighbourhoods.

Studies of Roseto, Pennsylvania also suggest that contextual factors such as social cohesion may affect the disease experienced by members of a community over and above the prevalence of behaviour-related risk factors. Until the 1960s, despite similar fat consumption and prevalence of smoking, citizens of Italian origin living in Roseto experienced lower rates of coronary heart disease when compared to members of three less homogenous neighbouring communities.[30] The originator of the study hypothesized that Rosetans would soon lose their relative advantage given that the town was becoming more typically "American" in its behaviour and social functioning.[31] A 50-year comparison of mortality rates showed that the relative advantage of Rosetans over the neighbouring community of Bangor had completely vanished by the late 1970s[32] while the population of Roseto became less homogenous, endogamous and locally active.[33] Lasker deduced that a change in local practices may have led to this reduction in health advantage.

Population health therefore provides sound evidence for health promotion to focus interventions on populations, rather than on individuals, and to bypass individual-behaviour-related risk factors as the principal targets for change. Social and contextual conditions are not just instrumental to behaviour changes, but rather are in constant interaction with behaviour. A useful heuristic concept for describing this interaction is that of collective lifestyles.

Collective lifestyles and health promotion

History of the Term 'Lifestyle' and its Usage Today

The current conceptualization of lifestyle has swayed far from its origins, some of which lie in the writings of Max Weber.[34] Lifestyle for Weber comes about, and is enhanced, by one's status in society. Groups with different statuses have distinct lifestyles and the distinction between these groups lies in what they consume. He makes a further useful distinction between choice and chance in the discussion of lifestyle. In operationalizing lifestyle, Weber surmised that choice is the major factor, with the actualization of choices being influenced by life chances. As such, life chances are not a matter of pure chance, but rather they are the opportunities people have because of their social situation.[35] Lifestyles, therefore, are not random behaviours unrelated to structure and context, but are choices influenced by life chances.

Usages of the term 'lifestyle' in health promotion have digressed from their Weberian roots in two important ways. First, the interplay between life chances and life choices is absent; lifestyle focusses primarily on life choices. The concept of lifestyle has thus come to refer to a few habits of daily living measured as discrete unrelated behaviours.[36,37] This reductionist approach not only focusses attention on a limited number of practices, but also separates individual behaviours from the social and situational context, stripping individual action of any contextual meaning.

Second, lifestyle has digressed from its collective origins with the individualistic connotation that it has taken on. Weber's notion of lifestyle was one that was shared by groups of people having similar status. Lifestyle as it is currently understood views behaviour as an individual activity governed by individual decision making, not necessarily a practice that is shared by others. This conceptualization definitively isolates the individual from those around her.

CONCLUSION

The concept of collective lifestyles is an attempt to bring context back into behaviour. A collective lifestyle is not just the behaviours that people engage in, but rather the relationship between people's social conditions and their behaviours. Social conditions are here defined as factors that involve an individual's relationship to other people. This includes positions occupied within the social and economic structures of society, such as one's race, socio-economic status, gender, etc.[38] Furthermore, the idea of collective lifestyles proposes that this relationship between social conditions and behaviour is a collective experience, and therefore, may have similar influences on those who partake in this experience.* Collective lifestyles, then, provide a framework in which to understand the social generation of disease by extending it across levels and describing how individual- and group-level attributes jointly shape disease. It also reintroduces the notion of chance, operationalized as social conditions and their attendant resources. We argue that life choices are affected by life chances – an interaction that brings about risk rates and eventually disease rates among populations. It is the interaction between social conditions and the behaviour of individuals within populations that expresses itself through exposure to risk factors. Essentially the notion of a collective lifestyle is a tool with which we can try to understand what aspects of people's lives put them at "risk of risks."[38]

For future studies it will be critical to operationalize the notion of collective lifestyle. We suggest that this notion will be rendered useful if examined within a setting in which people live and share fundamental characteristics. Some examples might include workplaces or neighbourhoods. It will also be important to retain the fact that chance does not always impede certain behaviour but can also encourage it. Understanding the interaction between social conditions and behaviour in shaping health may be key to moving away from a health promotion still attempting to define its goals.

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* A large body of literature within sociology has approached this issue by examining the interplay between social practices, social structure and individual agency. Interested readers are referred to the work of Anthony Giddens and Pierre Bourdieu, two social theorists who have influential and contrasting views on the genesis of social practices in relation to social structure.

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