

CHAPTER 4

INDICATIONS OF SOCIAL VARIATION IN UNDERSTANDINGS OF THE PRECONDITIONS FOR AND DETERMINANTS OF HEALTH AMONG RESIDENTS OF MAASTRICHT, THE NETHERLANDS

INTRODUCTION

"Health" is considered by most Western populations to be a high personal and public priority. In the Netherlands, a majority of people identifies "gezondheid" (health) as the highest priority in life (NIPO, 1995; SCP, 1996), ranking it squarely above partner, family, or faith.

Yet, while "health" as a value may meet with widespread social consensus, the specific goals which various social groups associate with health appear to be quite diverse. Studies in Western Europe, for instance, have shown that conceptions of health differ by socio-economic status (Herzlich, 1973; Cornwell, 1984; D'Houtaud and Field, 1984; Calnan, 1987; Bunker, Gomby and Kehrner, 1989; Calnan, 1989; Blaxter, 1990; Calnan, 1990), as well as gender and age (Van der Heuvel, 1989; Blaxter, 1990; Williams, 1990).

René Dubos (1959) suggested some time ago that health is better understood as an elusive individual and social goal dependent on the presence of the resources requisite for its experience. In the same work, (1959: 110-24), Dubos categorized such health-requisite resources into those of the *milieu interne*, or capacities of an individual or group, and those of the *milieu externe*, or all other resources relevant to the meeting of challenges, including the political, economic, and physical environments in which individuals and populations live. It comes as little surprise to any social scientist concerned with health that the distribution of both internal health-related resources, such as a well-functioning heart or a smoking habit, as well as external resources, such as social capital or income level, varies greatly among social groups.

Much existing health-related literature rather imperialistically uses the phrase "determinants of health" when what is actually being referred to are the determinants of (measurable aspects of) morbidity or mortality. This is an expedient substitution for the health professional, to whom it provides an excuse to discuss "the determinants of health" as though these were scientifically validated facts. Though some determinants of morbidity and mortality may have a strong scientific basis, however, the determinants of health are not facts. In accordance with Dubos' vision, the determinants of health are those resources whose presence or absence impacts the capacity for achieving the health-relat-

ed goals which are valued by an individual or group. It is increasingly clear that both the health-related goals which social groups value and the resources which they possess to achieve them are quite diverse. Such diversity suggests that health professionals have a methodological and ethical duty to recognize that the determinants of health, as the product of two variable entities, may be correspondingly socially diverse.

The two-way nature of the dialectical process which takes place between health professionals and the public implies that, at times, it is necessary for professionals to *learn from a population's understandings* about its unique resources and goals. The idea of "positive health" has been compelling to health professionals for millennia (Dubos, 1959). However, it continues to suffer from an inability to be debated or pursued in operational or standardized terms (Seipp, 1987). Positive health may range from living without illness (Radley, 1994), to the presence of such experiences as existential integrity, life as a promise of good (Mordacci and Sobel, 1998), as well as reserve of strength or balance (Herzlich, 1973). As such, positive health may be more subject to social mediation than clinical health, which essentially implies the absence of disease and the postponement of death. Knowing more about what groups understand as the determinants of their clearly diverse positive notions of health can help make those concepts operational by identifying concrete resources (i.e. resources which can be standardized, measured, and provided) requisite to their attainment.

Health professionals have recognized for some time the need to *build upon a population's understandings* about its unique resources and goals. Participatory and empowerment initiatives which connect with pre-existing public knowledge in this regard have been shown to generate more effective and widespread participation (Eisen, 1994; Sellers, Crawford, Bullock and McKinlay, 1997). The literature on participation and empowerment has in some cases focused on how to better achieve the more traditional health-related goals of lower mortality and morbidity within a given population by identifying and building upon its unique social and environmental capital. Other times, the focus has been on working toward the specific health-related objectives of the population in concern, rather than those objectives which professionals might first recommend. In either case, however, knowledge of the population's resources and goals provides a critical link to the construction of initiatives which communities perceive as sensible and trustworthy. Finally, building on a population's unique health resources and goals stands to enhance the ability of professionals to strategically engender public participation in developing and carrying out healthy public policy (De Leeuw, 1989b; Labonté and Edwards, 1995).

At times and in situations where a clear ethical mandate exists, health professionals need to *influence a population's understandings* about its health-related resources and goals. This area of professional activity is also enhanced by accurate information in regards to the health etiological understandings held by target populations. Dijkstra (1998), in operationalizing the stages of change model created by Prochaska, DiClemente, and Norcross (1992), showed the importance of tailoring messages to the unique etiological beliefs of "precontemplating" smokers in the Netherlands. Green and Kreuter (1991), in their broadly cited text on health promotion planning, point to the need for profession-

als to gather information from a target population in regards to its unique human and material resources at the outset of initiatives which attempt to achieve behavioral or environmental change in the interest of health.

Research Objective

Despite a compelling history of sociological attention devoted to the definition of health itself (Herzlich, 1973; D'Houtaud and Field, 1984), very little is known about whether and how understandings of the *origins* of health differ among those social groups most commonly addressed by public health research and practice. By talking to people about their health-etiological understandings, we sought to provide a preliminary impression of whether and how such understandings may correlate with gender, age, smoking- and socio-economic status.

Due to the lack of previous research in this area, we employed a combined open- and structured interview method supported by content analysis to obtain an inventory of health etiological understandings. This method mandated a sample size which precludes the necessary statistical power to account for potential confounding among the four subject variables used in this study. With an internally balanced and representative sample, however, such indications would form both a valuable qualitative contribution on their own and a scientifically responsible basis for further research in this area among larger samples.

METHODS

Development of the interview questions, interview format, sample selection and contact, interview protocol, data recording and data analysis were discussed in Chapter 3.

Beyond the analyses conducted in Chapter 3, social variation at the macro-cluster level was also analyzed using t-tests for the subject variables with two categories (i.e. gender and smoking status) and one-way ANOVAs for the subject variables with more than two categories (i.e. age and average neighborhood income). Since response frequency at the cluster level was by necessity relatively low, social variation at the cluster level was not analyzed using tests of statistical significance. Rather, the percentage of respondents within each category mentioning a cluster at least once (e.g. what percentage of women mentioned the etiological theme smoking at least once?) was calculated. The differences in the categorical percentages between all categories of each subject variable were then calculated (and summed in the case of age and average neighborhood income, which had three and four categories, respectively, and thus three and six¹ comparisons, respectively) to determine which clusters displayed the most variation with respect to each subject variable.

¹ Among 4 categories there are 6 relevant differences, as among the four corners of a crossed box: ☒

Table 4.1 Sample distribution chi-square and corresponding [p] values

Category	Smoking Status	Age Group	Av. Neigh. Inc.
Gender	1.17 [0.425]	12.0 [0.008]	6.51 [0.164]
Smoking Status	--	9.70 [0.021]	17.3 [0.002]
Age Group	--	--	10.1 [0.073]

RESULTS

Additional Response Distribution Analyses

Response, reasons for non-response, and various aspects of response distribution are discussed in Chapter 3. However, Table 4.1 shows the internal distribution of the sample. Chi-square tests revealed two significant deviations from expected values based on municipal and national data. Smokers were overrepresented among respondents from the lowest average neighbourhood income quartile. Also, men were overrepresented among respondents 65 years and older.

Clusters and Macro-Clusters

Clusters and macro-cluster development were discussed in Chapter 3.

Differences in Inter-Categorical Response by Macro-Cluster

Figures 4.1-4.4 graphically represent the mean number of responses by category and corresponding p-values for the sociodemographic variables gender, age, smoking status, and average neighborhood income after response was adjusted to account for slight differences in categorical response frequency. Mean response calculations were based on all interview data except clusters which specifically denied the importance of a macro-cluster, such as "Behavior Not Influential."

Differences in Inter-Categorical Response by Cluster

Table 4.2 shows the clusters displaying an average inter-categorical variation within each subject variable of greater than 10% per categorical comparison. Therefore, the table displays all clusters displaying more than 10% intercategory variation for gender and smoking status, all clusters displaying more than 30% combined intercategory variation for age, and all clusters displaying more than 60% combined intercategory variation for average neighborhood income.

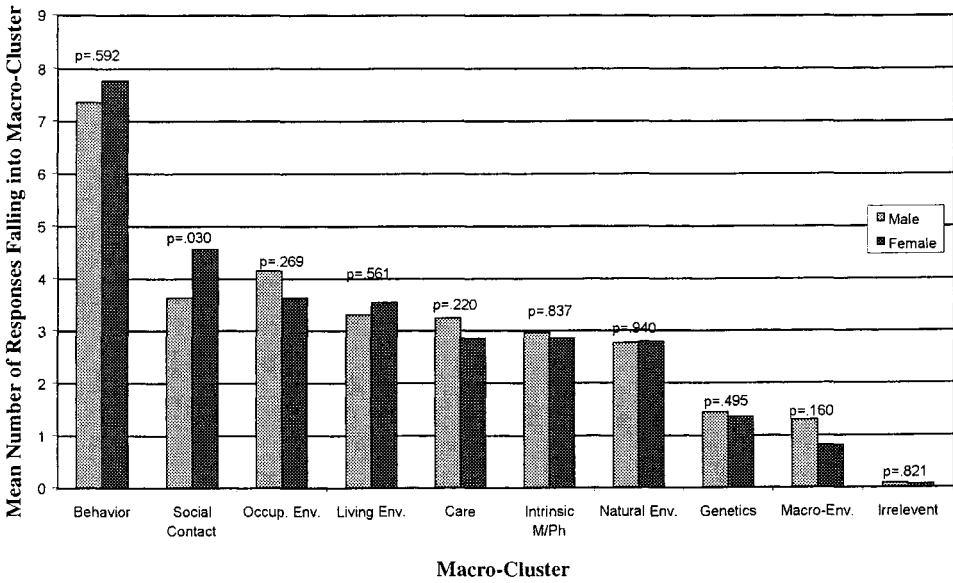


Figure 4.1 Mean Number of Mentions Per Macro-Cluster by Gender

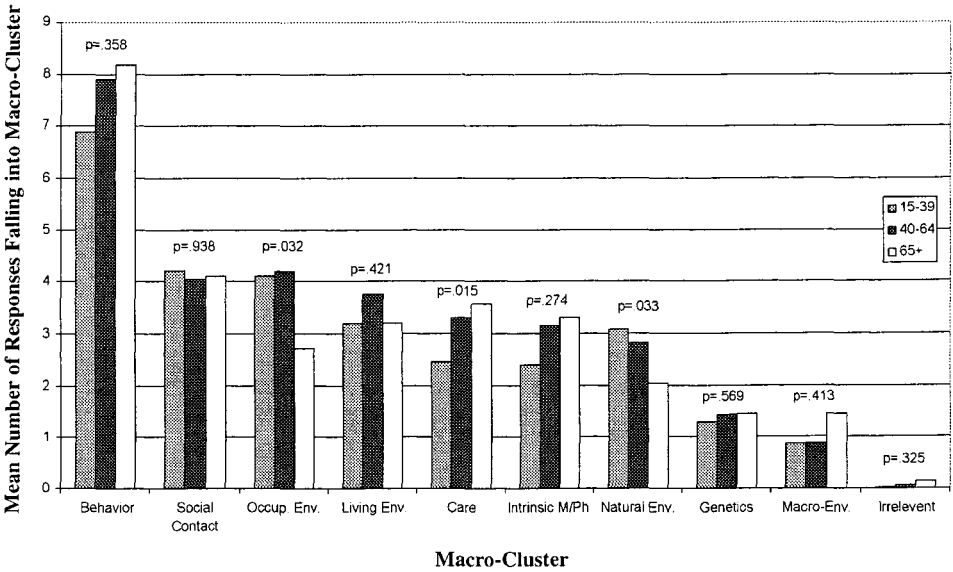


Figure 4.2 Mean Number of Mentions Per Macro-Cluster by Age Group



<http://www.springer.com/978-1-4020-0809-2>

Determinants of Health: Theory, Understanding,
Portrayal, Policy

Commers, M.J.

2002, XIII, 211 p., Hardcover

ISBN: 978-1-4020-0809-2