

INTRODUCTION

Determinants of Health: Theory, Understanding, Portrayal, Policy

This book concerns the theory, understanding, and portrayal of determinants of health and the relevance of these to health-related public policies. In terms of "theory" I have sought to reflect upon the interpretation of the notion of "determinants of health" as well as the implications of how "health" itself is defined for that interpretation. As regards "understanding" I have been concerned to assess the ideas held by the Dutch public and policy actors in regards to what determines health (i.e. the "health etiologies" of these heterogeneous groups). In relation to "portrayal" I have intended to provide some insight into the way in which determinants of health are portrayed within the Dutch media and governmental documents.

By using the Dutch context as a case study, my ultimate goal in this book is a meditation on the general relevance of the public's (i.e. the layman's) understanding of health and health etiology to health professionalism¹. Public policy is the domain in which health professionalism (from the time and training a doctor can offer a patient to a nation's position on international labor standards) is given the overwhelming majority of its form. Therefore, since my hope is ultimately to reflect upon how the public's understandings of health and health etiology is relevant to the structuring of health professionalism, I am first – and even foremost – necessarily concerned with the relevance of those understandings for public policy.

Why Study the Theory, Understanding, and Portrayal of Determinants of Health?

Anthropological sources teach us that every human society holds a set of values similar – in greater or lesser measure – to those encompassed by the English word "health." Modern Dutch society is no exception to this rule. Since surveys began on the matter, "gezondheid," the Dutch equivalent of "health," has been perceived as the most important commodity in life by a substantial percentage of the population of The Netherlands (SCP, 1996). Since 1985, this percentage has averaged around 55% (SCP, 1996, 2000).

Though it constitutes a broadly accepted social value, however, health – like freedom or equality – remains an abstraction. We cannot see, hear, taste, smell, or feel the unifying

¹ For lack of a suitable alternative, I use the expression "health professionalism" in this book to mean all professional actions intended to have a positive impact on the frequency or intensity of the phenomena which a society calls "health." As such, health professionalism includes much more than medical and public health practice and research. As I employ it, the term also includes professional advocacy of health objectives within both explicitly and non-explicitly health-related national and international policies.

notion represented by the word "health" (or its many linguistic equivalents). We must settle for witnessing *phenomena* (i.e. things we can sense) which for one reason or another embody that notion for us. As is the case with any other abstract end, therefore, the pursuit of health is in the most fundamental terms a striving toward those phenomena which we label as health.

The "health sciences" are grounded in the belief that the phenomena which we label "health" display more or less predictable associations with other phenomena (which may or may not themselves be labeled "health"²). Kant asserted that when we observe such associations, we are led by *a priori* intuitions – mostly of time, but also of space – to establish cause and effect. Those phenomena bearing an observable relation to the phenomena which we label "health" are labeled, "determinants of health." The health sciences are dedicated to the detection, characterization, documentation, and – if possible – the influencing of such determinants.

Ancient sources of wisdom as well as insights from modern physics remind us that our understanding of cause and effect is largely illusory. Every "cause" is in some sense also an "effect," and every effect is in fact the outcome of an infinite and unpredictable set of causes. It is almost paradoxical, therefore, that our lived experience of the world is in many ways dependent upon the identification of associations among phenomena. For such associations, despite the fact that they mask an ever-present uncertainty in underlying dynamics, are often predictable enough at macro – sometimes statistical – levels to be of great practical use in applied terms.

When we *act* to improve determinants of health, our assumptions of cause and effect are translated into means and ends. "Determinants of health" are used directly as – or subjected to secondary – means of increasing the relative presence of phenomena labeled "health." Consider the detection of the statistical association between absence of tobacco smoke in the lungs and lower incidence of lung cancer. In this case "absence of tobacco smoke in the lungs" is translated directly into a behavioral means (i.e. "not smoking tobacco") for achieving a lower populational incidence (or individual likelihood) of lung cancer. Further, secondary means, such as policy-based or behavioral interventions, are employed to achieve the same ends.

In practice, scarce resources must be allocated to the achievement of health-related ends. This implies that not all possible health-related ends can be pursued and that not all possible means can be employed. Choices have to be made about which health-related ends are most worthy and which means are most suitable. The pursuit of ends which large percentages of the population do not value or which are infeasible would in most cases be an unethical waste of available resources. Ideally, therefore, the health ends selected by professional and public health institutions would be maximally democratically-support-

2 As I discuss in greater depth in Chapter 1, phenomena labeled "health" may sometimes be considered determinants of other phenomena labeled "health."

ed and responsible (i.e. both feasible and valued). Similarly, allocating resources to means which do not achieve valued ends or are incompatible with public values would mean those resources might have been put to use in better ways. Therefore, the means employed in the interest of desired health ends would preferably be both maximally democratically-supported and efficient.

Maximizing democratic support for health-related ends and means implies the need for ongoing dialogue and negotiation between professionals empowered to make decisions about those ends and means and the general public. Democratic support among the public for health ends depends on whether the public associates those ends with health, the extent it sees them as associated, and the relative intrinsic value it ascribes to those ends regardless of their association with the encompassing health value. Democratic support among the public for the means employed in the pursuit of health ends is rooted in the public's understanding of the scientific, normative, and aesthetic legitimacy of those means. Because it relies on creating consensus between professionals and the public, optimizing democratic support for the health ends pursued by professionals and the means employed in pursuit of them demands dialogue and negotiation with the public.

Guaranteeing that health ends are responsible and that the means chosen to pursue them are efficient also entails ongoing dialogue and negotiation between professionals and the general public. Part of the traditional social contract of the health professional is to promote longevity and minimize measurable disease. At times professionals empowered to make decisions about which health ends should be pursued do and must use their privileged position to assure that those ends are achievable, measurable, or ethical. Yet the public may in fact exert pressure on those professionals to redefine what is considered unachievable, immeasurable, or unethical. Ensuring that the means employed to achieve health-related ends are efficient is also a two-way street.

Professionals, at times, do and must influence the choice of health-related means to make certain that those means are effective and are employed with a minimum of investment of scarce resources. Yet the causal reasoning behind means selection must be shared with the public. On the one hand, the public must certify that the means chosen by professionals are both normatively and aesthetically acceptable. On the other hand, the public often must itself act in collaboration with or independent of professionals to promote health when the means in concern are those to which they have partial or exclusive access.

Dialogue and negotiation between professionals and the general public regarding health-related ends and means requires the mutual exchange of understandings and positions. The understandings and positions of professionals in regards to the most appropriate health-related ends and means are hardly homogeneous, yet the whole assortment is easy to find in scientific journals, government publications, medical texts, as well as in the media and public domain. However, far less is known about the understandings or positions which the public holds about what constitutes and determines health or what these understandings imply for the public's views of the appropriateness of various health-related ends and means.

Much good research has been done previously on "lay beliefs" about what constitutes and determines health (Herzlich, 1973; Pill and Stott, 1981, 1982; Cornwell, 1984; d'Houtaud and Field, 1984; Pill and Stott, 1985a, 1985b; Curren and Stacey, 1986; Calnan, 1987; Pill and Stott, 1987; Bunker, Gomby and Kehrer, 1989; Calnan, 1989; Curren, 1989; Joosten, 1989; Van der Heuvel, 1989; Blaxter, 1990; Calnan, 1990; Anderson, Blue and Lau, 1991; Skelton and Croyle, 1991; Spector, 1991; Stainton Rogers, 1991; Scheper-Hughes, 1992; Helman, 1994; Tsevat, Cook, Green, Matchar *et al.*, 1995; Blaxter, 1997; Dijkstra, Bakker and De Vries, 1997; Petrie and Weinman, 1997). Yet each of these existing studies has possessed at least one (and often more than one) of the following traits:

- a qualitative design implemented among a small sample of respondents;
- a focus on lay beliefs as they relate to specific – often pathogenic – themes within health etiology (e.g. documentation of lay beliefs of the benefits of smoking cessation);
- no focus on social variation in lay beliefs;
- no integration or coupling of the study results with corresponding policy contexts.

Though irreplaceable, qualitative designs alone cannot provide the generalizability requisite to action at the aggregate level of public policy. Focus on specific themes within health etiology leads to a loss of the wider, overall perspective of understandings which may be at work among the public. For instance, assessing the public's awareness of the harms of smoking tells us nothing about whether that same public would support steps to promote health through better housing standards or traffic safety regulations. A lack of insight into social variation in public understandings precludes the possibility of policies for health which connect with the values of the populations affected by them. Finally, the absence of integration of study results with corresponding policy contexts creates a simple but significant analytical gap in the application of such results in policy contexts. By missing one or more of these four elements, therefore, previous studies on lay beliefs are limited – to a greater or lesser extent – in their ability to establish the relevance of the lay beliefs they assess for the structuring of health professionalism through public policies.

The goal of this book, therefore, is to make a strategic contribution to existing research by examining the relevance of public understandings of what constitutes and determines health for the structuring of health professionalism through public policies. Hence its central research question is taken to be:

What are the Dutch public's understandings of what constitutes and determines health, what do those understandings mean for the structuring of health professionalism through public policy within the status quo, and what could they imply for the future structuring of health professionalism through public policy?

More specifically, this means addressing the following six specific research questions:

- 1 How can we conceptualize a role for the public in defining the ends pursued in the name of health and in evaluating or employing independently the means to achieve those ends?

- 2 What is the context of understandings of health and health etiology among the Dutch public?
- 3 Are understandings of health etiology a function of one's conceptualization of health itself?
- 4 How do the public's health etiological understandings compare with those portrayed by the media and public policy?
- 5 To what extent and how are, should, and could the public's understandings of health and health etiology (be) incorporated within health-related public policies?
- 6 Given the whole picture, what is the relevance of understandings of health and health etiology among the Dutch public for the structuring of health professionalism through public policy in The Netherlands?

In order to make it possible to answer the research questions, the research presented in this book attempts to surmount the barriers found in previous studies by possessing four corresponding characteristics:

- both qualitative and quantitative methods;
- a maximally-broad, salutogenic focus on lay beliefs (e.g. documentation of the full spectrum of lay beliefs of what determines health);
- focus on social variation in lay beliefs;
- integration or coupling of the study results with corresponding policy contexts.

Structure of the Book

The structure of the book follows the general lines of scientific inquiry in relation to the specific research questions and characteristics discussed above. First, with two theoretical arguments (Chapters 1 and 2), I hypothesize the relevance of public understandings of health and health etiology to the structuring of health professionalism. Second, I document and characterize the Dutch public's understandings of health and health etiology by means of both a qualitative (Chapters 3 and 4) and quantitative (Chapter 6) study. Third, I analyze what the Dutch press portrays as determining health (Chapter 5). Fourth, the results among the Dutch public are compared to policy content and their relevance to public policy development analyzed (Chapter 7). Finally, I end the book with a general reflection on the findings and their theoretical implications (Chapter 8).

Throughout the empirical chapters (Chapters 3-7), I employ the first person plural form "we." This is to acknowledge Geo Visser, M.A., for help with coding (Chapter 5), Math Candel, Ph.D., for statistical contributions (Chapter 6), and Evelyne de Leeuw, Ph.D., and Jurrit Bergsma, Ph.D., for the inspiration and guidance they brought to the empirical work as a whole. However, with the exception of parts of the Methods section in Chapter 6 (written in collaboration with Math Candel), all text is mine and, as such, my responsibility alone.



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