

CHAPTER 3

UNDERSTANDINGS OF THE PRECONDITIONS FOR AND DETERMINANTS OF HEALTH AMONG RESIDENTS OF MAASTRICHT, THE NETHERLANDS

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INTRODUCTION

Health Is a Diverse Ends

People's notions of health, including those of so-called "positive" health, are known to be quite diverse. Studies in Western Europe have shown that conceptions of health differ by socioeconomic status (Herzlich, 1973; Cornwell, 1984; d'Houtaud and Field, 1984; Calnan, 1987; Bunker, Gomby, and Kehrer, 1989; Calnan, 1989; Blaxter, 1990; Calnan, 1990), gender and age (Van der Heuvel, 1989; Blaxter, 1990), and ethnicity (Anderson, Blue, and Lau, 1991).

Other studies have shown that the meaning of health is also mediated by one's status as a patient (Tsevat, Cook, Green, Matchar *et al.*, 1995), status as a smoker (Dijkstra, Bakker, and De Vries, 1997) and (sub-)cultural membership (Dubos, 1959; Curren, 1989; Joosten, 1989; Scheper-Hughes, 1992; Helman, 1994). The work of Stainton Rogers (Stainton Rogers, 1991) describes at both detailed and more abstracted levels the myriad concepts which individuals identify as "health". At least among Western populations, "health" is a label ascribed to a variety of feelings, states, and measurements.

The Determinants of and Preconditions For Health Are a Diverse Means

Evidence of health's many meanings makes it reasonable to assume that a variety also exists in what people understand as the determinants of, or preconditions for, health. The Dutch, for example, display clear faith in both medical care and directed personal behav-

ior as distinct means to health. Roughly on par with the rest of Western Europe, The Netherlands will devote 9.6% of its national product in 1998 to medical care (Tweede Kamer der Staten-Generaal, 1997), revealing that the Dutch not only see medical care as a means to health, but as a quite valuable means at that. On the other hand, a large-scale study carried out by the Dutch Institute for Public Opinion Research [NIPO] in 1990 revealed that at least 70% of 1,172 Dutch residents sampled claimed to eat less fat, get regular exercise, and drink less alcohol in the interest of promoting personal health (NIPO, 1990). The same research revealed that at least 50% of those sampled did not smoke and ate more fiber also in the interest of promoting personal health.

Faith in medical care and directed behavior as distinct ingredients to health may hint at a much richer underlying diversity in people's understandings of what determines health. It is not hard to imagine, for instance, that a diabetic might be especially concerned with access to insulin and medical monitoring, a traveler with water quality or personal safety, an otherwise healthy person with the onset of Huntington's Disease latent in his or her genes, or an aging person with avoiding falls. Unfortunately, though common sense testifies to the enormous role which cultural and personal contexts play in defining the factors of greatest relevance to any given individual's health, there has been little research which documents what people understand as the determinants of their personal health.

Etiological Knowledge and Health

There are at least three ways in which empirical insight into public understandings of the determinants of health (i.e. "health etiological" knowledge) can be of value to health researchers and professionals in applied fields. All of these relate to the promise of better communication between professionals and the public in regards to initiatives to promote health and prevent disease and premature death.

First, empirical investigation of health etiological knowledge among the public can perhaps help to explain problems hitherto experienced with the generation of participation in the interest of health among the public. Professionals in the health sciences acknowledge in ever greater measure that public, or "lay" participation is critical for the maintenance and optimization of health among those individuals and populations whose health is in question. The two most widely employed models in health promotion, that of Green and Kreuter (Green and Kreuter, 1991) and the Ottawa Charter (WHO, 1986), both explicitly mention community participation as fundamental to health promotion. More specifically, where structural rather than behavior-based health promotion is concerned, it has been argued that the participation of communities and the multisectoral collaboration of important community stakeholders are requisite to the development and popular endorsement of public policy directed toward enhancing health (De Leeuw, 1989b; De Leeuw, 1993; Labonté and Edwards, 1995).

In the past five years, however, many reports on participatory initiatives have not only focused on the promising potential of participatory initiatives, but as well on the diffi-

culties of implementing such strategies effectively. A 1994 survey of community initiatives in the United States conducted by Eisen testifies to the importance of community participation in such efforts, but also documents many inherent and practical difficulties with achieving it (Eisen, 1994). Also at municipal and provincial levels, community participation in health promotion campaigns has proven difficult to generate and sustain (Goumans, 1997). Epidemiological public health initiatives have experienced problems with participation in large-scale "community-based" screening and prevention programs, such as the Minnesota Heart Health Program, which advocated behavior change in the interest of coronary heart disease reduction (Luepker, Murray, Jacobs Jr., Mittelmark *et al.*, 1994). The question is why the programs described by Eisen, Goumans, and Luepker *et al.* were unable to generate satisfactory levels of public participation. One hypothesis is that these campaigns did not connect sufficiently with the health etiological understandings of the respective publics they sought to involve.

Second, to the extent that health professionals are aware of the public's preexisting assumptions about what determines health, they are in a position to influence this knowledge more efficiently. This has implications at the level of health education, for example. In cases where the health etiological understandings of the public are inconsistent with prevailing epidemiological insights, the epidemiological validity of public knowledge can be more efficiently improved if the gaps in that knowledge are clear. For instance, if investigation of health etiological knowledge among the public revealed that people are unaware of the epidemiological significance of seat-belt use for health, this message may get higher priority in health education campaign funding. Alternatively, if people seem to be highly aware of the significance of diet and smoking for personal health, the general awareness messages in these domains can be left behind in favor of messages which are tailored more specifically to issues such as how to eat better or quit smoking. Similarly, empirical investigation into the health etiological knowledge of the public can improve the strategic position of professionals advocating that health be placed higher on public policy agendas. The amount of importance which the public ascribes to social rather than individual determinants of health, for instance, can logically be assumed to correlate at least in part with the public's concurrence with the idea that public policy is an appropriate means for promoting health. For instance, those who see air, ground, and water pollution as significant potential determinants of health would presumably be more likely to support policies to address such pollution in the name of health than those who ascribe little importance to these factors and more to individual factors, such as diet, exercise, and family contact. Thus, at both the levels of health education and health policy, empirical investigation into health etiological knowledge among the public holds the potential of making professional efforts more effective and efficient.

Finally, documenting what the public believes to determine its health offers the possibility of the discovery of determinants of health which are as yet unbeknownst to health professionals. Aaron Antonovsky (1979), one of the foremost theorists of health etiology, believed that most of the stressors which threaten the health of individuals and populations are well known to the individuals and populations they affect. It is quite possible

that some of these factors, due to the fact that they are difficult to operationalize in research or are only valid for subgroups within populations (i.e. gender, age, ethnic group), have not yet received serious or sufficient epidemiological attention. Such factors, to the extent that they seem theoretically plausible, would deserve further research if significant portions of the public identify them as having a significant influence on health. Nonetheless, this process can only occur on the basis of a broad inventory of the factors which the public identifies as influencing its health.

Research Objective

Knowing more about what people understand as leading to health may help explain documented problems with the generation of public participation in the implementation of interventions or of public support for health policies directed at socially-operative determinants of health. Such insight would also enable health professionals to influence the health etiological understandings of the public more effectively and efficiently. Finally, knowing more about what people understand as leading to health may generate discovery of determinants of health as yet unrecognized by health professionals.

The goal of the present study, therefore, was to provide a broad inventory of understandings among residents of Maastricht, The Netherlands, in regards to what allows or determines health. The objectives in generating such an inventory were threefold. First, we hoped to provide a first glimpse of the full scale of popular understandings of the determinants of health within which health professionals build programs and conduct interventions. Second, we sought to generate a small-sample inventory which would provide a basis for the generation and subsequent testing of social variation hypotheses in larger-scale survey research. Third and finally, in light of the relative dearth of standardized survey questionnaires within the domain of this research, we sought also to test methodologically the question of whether responses to an open, minimally-directed question in regards to health's determinants and conditions would differ from those to structured, semi-directed questions on the same subject.

METHODS

Development of the Interview Questions

Due to the lack of standardized and validated questionnaires in regards to the broad spectrum of perceived determinants of health, it was necessary to construct the interview questions independently. Manderbacka (1998) shows how diversity in the ways respondents understand questions relating to health or its origins can undermine the validity of studies which seek to shed light on these areas. In order to maximize the validity of interview data, question development was based on a pretest. The pretest was carried out among 34 health-sciences students of Maastricht University and 15 households in a low-income neighborhood of Maastricht. These groups were chosen because they were pre-

sumed to represent the most relevant extremes in the sociodemographic (i.e. in terms of age and socioeconomic status) and health-related knowledge distribution of our sample population.

Questions were developed in raw form based upon Blum's comprehensive model of factors impacting health, which distinguishes quite broadly among environmental, behavioral, genetic, and care-related determinants (Blum, 1983). These raw questions were refined to vary along three important dimensions in prevailing theories of health etiology. First, questions differed in whether or not they inquired about determinants of good health or ill health (Antonovsky, 1979). Second, since both the Dutch language and Dutch care professions distinguish between mental ("geestelijk") and physical ("lichamelijk") health, questions varied in their focus on determinants of "mental and physical health" or merely "health". Third and finally, since etiological discussion displays a deep-rooted split between focuses on specific "determinants" and general "pre-conditions" (Macdonald, 1998), questions were designed along the lines of both models.

The pretest was carried out among the students and low-income households using the raw questions which varied along the three dimensions described above. The criteria used to select the final set of interview questions from the raw questions were respondents' own estimation of the extent to which: 1) questions were immediately understandable and unambiguous, 2) their views on the etiology of health had been broadly surveyed; 3) their thinking on etiology had referred to notions of good and ill health as opposed to merely ill health; 4) their beliefs would not vary with changes of time or place.

Results of the pretesting showed that the most successful questions contained a positive health focus, explicitly specified "mental and physical health" when (but only when) a question was not further structured with aspects of etiological theory, and used a "pre-conditions" as opposed to "determinants" focus. The final set of interview questions, therefore, incorporated these three aspects. Also, phrases like "according to you" and "your health" were inserted to assure that respondents understood it was their own personal etiological opinions and individual health which were of interest (D'Houtaud and Field, 1984).

Interview Format

Because we were interested in exploring differences in response to open and structured questions, a two-part interview was constructed. Part One consisted of a single open and minimally-directed question which confined the interviewee only by explicitly asking for those things which could be of positive influence upon the interviewee's mental and physical health (see Table 3.1). Part Two comprised seven subsequent questions which asked interviewees to identify preconditions for and determinants of "good health" relating to their living, occupational, and natural environments, social contact, behavior, genetic inheritance, and medical care, respectively (see Table 3.2).



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