Overview

This chapter addresses the key question ‘what is health?’ There are no easy, straightforward answers to this. Trying to define health relies on developing understanding about a wide range of perspectives, subjectivities and experiences that are, in turn, socially, historically and culturally located. Nevertheless, this chapter will try to uncover some of the inherent complexities in attempting to understand what we mean by ‘health’. To do so, an array of different materials will be drawn upon in order to make sense of what it is we are trying to ‘capture’ (or, in the first instance, ‘define’).

Definitions of health

Health has been called ‘an abstract concept’ that people can find difficult to define (Earle, 2007a: 38). You may appreciate this more fully having completed learning task 1.1. Nonetheless different attempts have been made. One of the most frequently referenced definitions of health in the last few decades is the classic one offered by the World
Health Organization. Health is defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ (WHO, 1948 cited in WHO, 2006). One of the strengths of this definition is its all-encompassing breadth. It moves away from the notion that being healthy is simply about not being ill. In this sense it has a more positive, holistic view about what health is. However, the WHO definition, has also been criticized on many counts, for example, as being unattainable and idealistic (see Lucas and Lloyd, 2005). According to this definition, is it possible for anyone ever actually to be healthy? In addition there are other dimensions of health that are not considered in this definition such as sexual, emotional and spiritual health (Ewles and Simnett, 2003)

Question

Health is one of those things that most people assume they understand. But if we just stop and consider it for a moment and try to focus on it, it starts to float about in our minds. (Johnson, 2007: 45)

Reflect on your own understanding of what ‘health’ is. Think about the following:
(a) What does the word ‘health’ mean to you?
(b) What does it mean to you, to be ‘healthy’?
(c) Can you come up with a definition that captures what you mean by ‘health’? If you can, try not to focus on this in terms of health as being only the absence of disease (or there being something ‘wrong’).

Write your ideas down and you can refer back to them as you read this chapter.

Health Organization. Health is defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity’ (WHO, 1948 cited in WHO, 2006). One of the strengths of this definition is its all-encompassing breadth. It moves away from the notion that being healthy is simply about not being ill. In this sense it has a more positive, holistic view about what health is. However, the WHO definition, has also been criticized on many counts, for example, as being unattainable and idealistic (see Lucas and Lloyd, 2005). According to this definition, is it possible for anyone ever actually to be healthy? In addition there are other dimensions of health that are not considered in this definition such as sexual, emotional and spiritual health (Ewles and Simnett, 2003)
Health can be viewed positively or negatively. Tones and Green (2004) refer to this as dichotomous differences in approaches to defining health. On the one hand there are positive approaches to defining health (health as well-being or as an asset) and on the other hand there are more negative definitions of health — those that are illness or disease oriented. When health is viewed in a negative way, then definitions will tend to focus on health as absence of disease. When health is viewed in a more positive way definitions tend to be broader and take into account concepts such ‘well-being’. The World Health Organization definition outlined earlier is an example of a more positive definition and marks a shift in understanding away from a more narrow, medical and negative view of health.

‘Well-being’ is another rather slippery concept and is also difficult to define (Chronin de Chavez et al., 2005). There is a lack of consensus as to what well-being is, although generally theoretical understandings converge around the three major aspects of physical, social and psychological well-being. Like the notion of health, this makes it difficult to investigate, as it means different things to different people. However, drawing on the concept of well-being to understand health is important. Laverack (2004) offers a useful way of thinking further about the concept of well-being. He separates well-being into three different types — physical, social and mental. Physical well-being is concerned with healthy functioning, fitness and performance capacity, social well-being is concerned with issues such as involvement in community and inter-personal relationships as well as employability and mental well-being — which involves a range of factors including self-esteem and the ability to cope and adapt. The concept of well-being varies between disciplinary perspectives; however, it is receiving increasing attention and it is generally argued that it offers a broader understanding of health than those drawing on a more scientific, medically dominated position (Chronin de Chavez et al., 2005). A further concept that is arguably related to how health may be perceived is quality of life. For example, functional perspectives may assume that increased health automatically results in increased quality of life (Lee and McCormick, 2004).

Definitions of health can also focus on different aspects of health. Some are idealistic, as in the WHO definition offered earlier. Some definitions have a more functional view of health, where it is seen as the ability to be able to ‘do’ things and get on with life. Other definitions centre on the idea of health as a commodity. For example Aggleton (1990) argues that health is something that can be bought (by investment in private health care) or sold (through health food shops), given (by medical intervention) or lost (through disease or injury). The parallels with contemporary consumerism are evident in this type of definition.

Other types of definitions draw on the idea that health is about being able to cope and adapt to different circumstances and achieve
personal potential and may be more aligned with ideas from humanism. Drawing on humanist ideas, health might also be considered as self-actualization, which links with the idea of empowerment, a concept discussed in more detail later in this book. Health might enable the process of self-actualization or the attainment of health might constitute self-actualization. Either way, research appears to show that this is an important idea that has implications for health and, specifically, health-promoting behaviours (Acton & Malathum, 2008). Seedhouse (2001) describes health as the ‘foundations for achievement’. In keeping with the position of this chapter Seedhouse starts from the point of acknowledging that health is a complex and contested concept. Seedhouse views health as the means by which we achieve our potential, both as individuals and as groups. Seedhouse (1986: 61) therefore describes a person’s optimum state of health as being ‘equivalent to the set of conditions that enable a person to work to fulfil her realistic chosen and biological potentials’. This perspective also broadens understandings of health beyond the absence of disease or ‘abnormality’ as understood using a medical model (this will be discussed in more detail later in the chapter). Someone may be, for example, encountering disease or be disabled and still lay claim to health, thus challenging assumptions of a ‘normality’ of health. As Blaxter (1990: 35) argues ‘health is not, in the minds of most people, a unitary concept. It is multi-dimensional, and it is quite possible to have “good” health in one respect, but “bad” in another.’

Health can also be conceived of in a number of other ways. Health may be regarded as a value (Downie & Macnaughton, 2001) and, while most people would argue that ‘good’ health is of value too, the degree to which people will strive for, or prioritize, health will, of course, vary according to individual circumstances. Health is also viewed both as a right and as a responsibility. The Constitution of the World Health Organization of 1946 first held up health as a human right in the statement ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’ (cited in WHO, 2008a: 5). Article 25 of the Universal Declaration of Human Rights of 1948 references health in relation to the right to an adequate standard of living and many of the other articles are indirectly related to the ‘right to health’. ‘The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights’ (WHO, 2008a: 5). Viewing health as a ‘right’ can create tension, because with this comes a sense of responsibility for health that in turn generates debate as to who has responsibility for health – the individual or the state? These issues are discussed in more detail later in this book.

The variety and breadth of definitions of health presented here are not exhaustive but they serve to illustrate the many different ways in which health can be conceived and experienced and the problematic
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nature of trying to produce a definition that suits everyone. Downie and Macnaughton (2001: 11) argue that ‘health does not have a clear identity of its own’ and therefore we are faced with a real challenge when trying to define what it is. However, what we do know is that health is influenced by a wide range of factors. This will be discussed in more detail throughout this book.

To end this section, a useful framework about definitions of health is included. This is offered by Colin Johnson (2007). He classifies definitions into four main types – dictionary definitions, assumptive definitions, determinist definitions and spiritual definitions. These are further explained and sub-classified in table 1.1.

Essentially the concept of health is not static or stable over time or within different contexts. It is influenced by a plethora of things and means different things to everyone. The meaning of health is also contested and, as has been demonstrated, there is no universally agreed definition (Pridmore & Stephens, 2000: 30). Indeed, the concept of health remains elusive (Johnson, 2007). In his book Creating Health for Everyone: Principles, Practice and Philosophy, Colin Johnson (2007) offers a definition of health that extends to nearly four pages, which illustrates the nebulous nature of it and the somewhat impossible task of trying to produce a universally acceptable definition! However, he does state that ‘the concept of health is a cluster of sub-concepts, which together constitute a dynamic whole’ (p. 91) acknowledging the range of influences on understanding. While the framework Johnson uses provides a valuable contribution to our knowledge about definitions of health, and a useful framework, we are really not that much further forward in terms of concrete understanding (and, indeed, we may never be). The extent to which this actually matters is debatable.

Given the difficulties of trying to produce a satisfactory definition of health, the next section of this chapter will examine different theoretical perspectives on the nature of health and consider what these might have to offer to our understanding of ‘what health is’.

Activity

Compare and contrast two different definitions of health as discussed.
(a) What do the definitions have to offer in terms of furthering our understanding about health?
(b) What are the limitations of them? What are their strengths?
(c) How would you alter the definitions? What would you add or remove and why?
(d) How do the definitions compare or contrast with your own definition of health from learning task 1.1?

Learning task 1.2
This section of the chapter will consider a range of different perspectives on health, including theoretical perspectives, alternative models of health and also lay perspectives versus professional perspectives. Theoretical perspectives on health are distinguishable from lay perspectives on health (we return to these later) as those that are derived from academia. Theoretical perspectives on health inform professional perspectives, which are also distinguishable from lay perspectives.
To begin with, it is useful to consider two fundamental theoretical constructs of health – the medical model of health and the social model of health.

**The medical model**

The medical model of health is located within a scientific **paradigm** of understanding. It is sometimes also referred to as the ‘biomedical’ model (see Blaxter, 2004), the ‘biological’ model or even the ‘Western scientific medical model’. The medical model draws on scientific, mechanical, individualistic and **reductionist** understandings of what health is and views health in terms of **pathology**, disease, diagnosis and treatment. The physical body is viewed as being separate from social or psychological processes (Lyons & Chamberlain, 2006). Health is seen as being ‘located’ in the individual body and the causes of ill-health are viewed as being biological or physiological in origin, requiring expert intervention. Health, according to a medical view, is conceived of as the absence of disease or ‘abnormality’. If medically defined illness and disorder are absent then health is assumed to be present. The medical model is, and has been, very influential in terms of understandings of what health is. The dominance of ideas of health as ‘the absence of illness’ in **mainstream** discourse about health is testimony to this. The medical model does, however, have some distinct advantages and through technological advances in scientific knowledge it has been extremely influential in Western societies within the last two centuries. As a result the medical model of health forms the basis of much health care provision within these contexts.

However, the medical model of health has faced heavy criticism. One of the main criticisms is that the wider context is given little attention and therefore the numerous social, psychological and environmental factors that influence, or determine, health are not considered. It is difficult to account for the complexity of health if we consider it solely in biological terms, using the medical model. Another criticism of the medical model is that its view of health as the absence of disease or abnormality can be seen as being rather negative (Earle, 2007a). Surely health is about more than just this? Are we necessarily healthy simply because we are not ill? However, this is problematic because, as Duncan (2007: 8) argues, one of the main difficulties with arguing that health is about more than simply the absence of disease or abnormality is that this can lead to ‘muddle and confusion’, which may render meaningful description ‘impossible’. In addition, the widespread use of the medical model of health has increased perceptions that the responsibility for health, and indeed the control of it, lies with the individual (Jackson, 2007). This is a position that is reflected in more contemporary neo-liberalist stances in the Western world that emphasize personal responsibility for health (Murray et al., 2003).
This position is challenged by other concepts of health such as the social model, which will now be discussed in more detail. Before we move on to the next section take some time to carry out learning task 1.3.

**Learning task 1.3**

**Activity**

(a) Take a few minutes to reflect on all of the things that you think impact on, and influence, your health. Write them down.

(b) Can you spot any patterns or group the different influences in any way?

When you have completed this task, see part III of this book and particularly chapter 13 for Dahlgren and Whitehead’s (1991) rainbow model of health determinants. Are there influences that you had not thought of?

**The social model**

In contrast to the medical model of health the social model of health views health as being influenced by a range of different factors, including those that are political, economic, social, psychological, cultural and environmental (as well as biological) (Earle, 2007a). The causes of ill-health are attributed to factors outside the physical body – the wider structural causes, such as inequality and poverty, as well as factors such as social interaction and behaviour. The notion of health is seen as being socially constructed, which is central to the social model of health and this idea is discussed in more detail later in the chapter.

The social model operates from the view that a wide variety of factors need to be taken into account when conceptualizing health – factors such as the environment, influences on lifestyle choices, access to health care services, employment status and gendered identities, for example. The social model recognizes individual differences in health experience as being socially produced. In addition, it seeks to provide explanations for why differences exist. Crucially the social model of health also takes into account lay perspectives about health, which are discussed in more detail later in this chapter.

The social model of health is not without its critiques. It has been criticized for being so broad a model as to render it almost unusable. Kelly and Charlton (1995) argue that the social model cannot necessarily be viewed as superior to the medical model despite criticisms of it. For example, they point out that while health promotion is
premised on a social model of health in terms of the way that health is conceived (holistically), the discipline still relies heavily on expert knowledge that can be traced back to scientific origins. Therefore science (and the medical model of health per se) has its part to play in understanding about the nature of health. The social model has also been criticized on the basis that the breadth of understanding it takes into account may lead to practices in health promotion and public health that have different priorities and therefore can only be implemented on a small scale. Earle (2007a: 54) therefore suggests that, rather than being able to pin down the ways that the social model of health may be used to, for example, improve or promote health, the ‘rhetoric’ of the social model of health has been used in the following ways:

– as a set of underlying values (philosophical approach to health)
– as a set of guiding principles to orientate health work in a specific way
– as a set of practice objectives

In summary, the medical model views health as derived from biology, so ill-health is caused by biological factors that can be identified, diagnosed (as compared with a scientifically defined ‘norm’) and treated by expert medical knowledge. In contrast, the social model of health views it as socially constructed and influenced, so ill-health is caused by social factors, knowledge about ill-health is not confined to medical expertise and a more holistic, less reductionist view of health is subscribed to. Table 1.2 highlights the key differences between these two models.

The importance of social factors and the social model of health is demonstrated in Dahlgren and Whitehead’s (1991) rainbow of determinants (see part III, especially chapter 13).

| Table 1.2 The medical model of health compared with the social model of health. |
|----------------------------------------|----------------------------------------|
| **Medical model**                      | **Social model**                      |
| Narrow or simplistic understanding of health. Medically biased definitions focusing on the absence of disease or dis-ability. | Broad or complex understanding of health. More holistic definitions of health taking a wider range of factors into account such as mental and social dimensions of health. |
| Doesn’t take into account the wider influences on health (outside the physical body). | Takes into account wider influences on health such as the environment the impact of inequalities. |
| Influenced by scientific and expert knowledge. | Takes into account lay knowledge and understandings. |
| Emphasizes personal, individual responsibility for health. | Emphasizes collective, social responsibility for health. |
Salutogenesis  For the most part, in Western cultures at least, when we talk about health we are actually talking about negative health experience or ‘ill-health’ rather than more positive aspects of health. This has its roots in the medical model of health. Salutogenesis turns this idea around. Antonovsky was the instigator of this idea and he has challenged the ‘pathogenic’ nature of the medical model including its fixation on the elimination of disease constituting ‘health’. Antonovsky (1996) argues that the focus should be on ‘symptoms of wellness’ rather than cases of disease and at-risk groups and that, given that we are ‘organisms’ we should accept that we will, at time, have things ‘wrong’ with us. The suggestion is, therefore, that ‘none of us can be categorized as being either healthy or diseased, (instead) we are all located somewhere along a continuum’ (Sidell, 2010: 27).

The holistic model

The contrasting medical and social models are not the only way to conceptualize health. Another way of looking at health is by taking a ‘holistic’ view, which takes a more integrated approach (Chronin de Chavez et al., 2005). This takes into account the interaction of biological, psychological and social factors (Earle, 2007a) and also views the person as a ‘whole’ rather than a sum of their ‘parts’. Holistic notions of health may be seen as taking into account mind, body and spirit (see Patterson, 1997 – in Earle 2007a). The difference between the social model and a holistic approach to health is that the holistic approach tends to focus on the individual rather than social structures that influence the individual (Chronin de Chavez et al., 2005 and Earle, 2007a). A holistic approach underpins many complementary (or so called ‘alternative’) approaches to health. While a strength of an holistic approach is that it takes spiritual health into consideration one of the criticisms of holistic approaches to health is that, similarly to the medical model, it is more individualistic and does not take wider social factors into account.

The biopsychosocial model

The biopsychosocial model of health is very closely aligned to holistic views about health but is nevertheless distinguished from it in the wider literature. Engel (1977, cited in Marks et al., 2005: 75 and Sarafino, 2002: 16) developed the biopsychosocial model of health and illness – an expansion of the (bio)medical model that combines social, psychological and biological aspects of health and accounts for the interaction between these. Biological factors include factors like genetics and our physiological condition and systems. Psychological factors include taking into account how we behave, how and what we think and how we feel. Social factors include consideration of the fact that we are social beings who interact with others within groups, com-
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Communities and societies. This is a model of health that has influenced research, theory and practice in health psychology but arguably has not had as much impact in other disciplinary areas in relation to health.

Different perspectives

Different perspectives offer different contributions to our understanding of health. In the first instance let’s consider philosophical perspectives about health. Seedhouse (2001) argues that it is important to consider philosophy when trying to answer the question ‘what is health?’, since philosophy should be employed where competing and conflicting ideas about phenomena exist – health is a very good example of this. Another perspective is offered by psychology. Stephens (2008: 19) argues that psychology views health as ‘a matter for individual minds’. Mainstream approaches to health in psychology that focus on the individual in terms of cognitive processes and behaviour are closely aligned to the individualistic medical model of health, and the idea of the body as a machine (Stephens, 2008), which challenges more holistic ideas about health, reflected in more critical psychological perspectives. (See chapter 6, which explores the contribution of psychology in more detail.)

Social construction

One of the key issues when trying to define health that also impacts on perspectives about health is the idea that ‘health’ is socially constructed. This means that the way we think about health is determined by a range of factors that influence us at any given time, in any given place. As a consequence, the notion of health is seen to be organic and fluid, changing all the time. Social constructionism argues that ‘meaning’ is socially constructed. In terms of health then, we can see that the meaning we give to it, or the way that we understand it is not straightforward or uncomplex. From a social constructionist perspective the meaning of health is created (constructed) through the way that we, as social beings, interact and the language that we use. Through talking about health we draw on different discourses, creating social consensus about what health actually is. We then reproduce and reinforce ideas about health through our talk and use of different discourses. This means that ideas about health are both time-bound and culture-bound – they change and vary across time and place. In addition, many different ways of talking about health (discourses) may (and do), exist at any one time.

A moral phenomenon

It is also worth considering briefly a dominant theoretical idea about health that is concerned with its moral nature. Crossley
(2003) argues that, increasingly, health has become synonymous with ideas to do with being a good and responsible person. The pursuit of health is therefore seen as something virtuous and highly valued. Lupton and Peterson (1996) refer to this as the ‘imperative of health’. The extent to which this notion is prevalent is indicated by research findings that demonstrate that people prefer to claim that they are healthy (Blaxter, 2004) or at least are trying to be (Cross et al., 2010). This ties in with neo-liberalist notions about individual responsibility. The notion that individuals have a moral responsibility to look after their own health is echoed through many aspects of health promotion and health service provision. Lawton et al. (2005) highlights the promotion of self-management and self-care in people with type 2 diabetes, for example. The morality of health is strongly linked to ideas of ‘good citizenship’ and the drive to be a fully functioning member of society – one who protects and maintains their own health rather than being a strain on society’s finite resources. In contemporary Western societies this can be seen, for example, in the way that people who are overweight or obese are judged and blamed for their size.

So far we have focused on the way that health is theorized, which has largely drawn on professional discourse about health. The next section of this chapter will explore these ideas in more detail in relation to lay understandings about health.

**Lay perspectives**

This section of the chapter will consider lay perspectives on health and how these can contribute to understanding what health is. First we need to determine the meaning of the term ‘lay’ in this context. Lay perspectives (or ‘lay knowledge’, Earle, 2007a; or ‘lay expertise’ Martin, 2008) are distinguishable from theoretical or professional perspectives in that they are the perspectives of ‘ordinary’ (or non-professional) people. Essentially lay perspectives are about how non-expert people understand and experience their health and how they perceive it. Bury (2005) refers to lay understandings as ‘folk beliefs’ and argues that research into lay concepts of health has revealed complex and sophisticated understanding and ideas that go beyond the medical model outlined earlier.

Blaxter (2007) points out that it is not necessarily useful to use the term ‘lay’ because lay knowledge and understanding is informed, at least in part, by professional knowledge and understanding. So Blaxter (2007: 26) suggests that ‘lay understandings can better be defined as commonsense understandings and personal experience, imbued with professional rationalizations’. Nonetheless, since the term ‘lay perspectives’ is commonly used and understood and is, as such, reflected in much of the literature and research in this area, it will be used in this chapter. From this point on the term ‘lay perspectives’ will be used as
a generic term, which is also seen to encompass the terms ‘lay beliefs’, ‘lay understandings’ and ‘lay concepts’.

Lay perspectives are central to the social model of health as discussed previously. The importance of paying attention to people’s subjective experience of health has been highlighted by many, including Lawton (2003). This is based on the fundamental assumption that people themselves often have the greatest insight into their own experiences of health and that it is therefore important to understand what these are (Earle, 2007a). Most often lay accounts or concepts of health are ‘uncovered’ through empirical research, so it is important to bear in mind the limitations that features such as study design and theoretical assumptions will have on findings and the way in which they are interpreted (see chapter 3 on researching health for further explanation of research methods). When reading research in this area it is also important to make note of whether the research is focused on ‘health’ rather than illness (as is commonly the case due to the difficulties of defining ‘health’). Lawton (2003) and Hughner and Kleine (2004), among others, argue that relatively few studies have actually focused on concepts of health as opposed to illness and Blaxter (2007) argues that different studies use different measures, categories and means of investigation, which is also problematic. Nonetheless there is a body of knowledge that continues to evolve and grow around lay perspectives of health.

Lay perspectives are not homogenous nor are they uncomplex – they have been described as ‘multi-factorial’ (Popay et al., 2003). They differ across individuals, communities and cultures and evolve over time. They also differ with age, levels of education, social class and gender. It is important to consider lay perspectives on health for many reasons. Not least because they tend to challenge theoretical, reductionist notions about what health is and draw on a much wider range of understandings and experiences, which inevitably adds to the debate. Indeed, much of the contemporary health care provision agenda in Western societies is driven by public and user-involvement in which lay perspectives are inevitably key (Martin, 2008).

A study by Calnan (1987) carried out in the 1980s is often referred to in the literature on lay perceptions of health (although it actually focuses on lay understandings of health inequalities). Calnan’s summary of the findings revealed that ‘being healthy’ was viewed as such things as being able to get through the day (‘functioning’), not being ill, feeling strong, fit and energetic, getting exercise and not being overweight, being able to cope with the stress of life. Being healthy was also viewed as a state of mind. In contrast being unhealthy was viewed as things like being unable to work, being ill or having something wrong – a serious, long-term or incurable illness, not coping with life, being depressed or unhappy, lacking energy and a poor lifestyle.

More recently Blaxter (1990 in Blaxter, 2004) provided a framework of five categories (or ways) of describing health. This was based
on the findings of a major UK study in which, among other things, people were asked what it was like to be healthy. The five categories of responses were as follows:

1. Health as not-ill
2. Health as physical fitness, vitality
3. Health as social relationships
4. Health as function
5. Health as psychosocial well-being

Blaxter’s findings are referred to in more detail throughout the rest of this chapter in relation to different lay understandings. Stainton-Rogers (1991) also studied lay descriptions of health and illness and offers a framework of seven different lay accounts for health as follows:

1. Body as machine (links with medical model understandings)
2. Body under siege (external factors influence health, i.e. germs)
3. Inequality of access (i.e. to medical services)
4. Cultural critique (linked with ideas about exploitation and oppression)
5. Health promotion (linked with ideas about responsibility for health as being individual and collective)
6. Robust individualism (linked with rights to a satisfying life)
7. Willpower account (linked with ideas about individual control)

In trying to define health lay understandings (and indeed, professional ones) we are constrained by the use of language and for the most part, people tend to draw on mainstream discourse around health in order to articulate their understandings. Changes in knowledge and understanding over time also bring changes in understanding about health. In a study on Eastern Canadian ‘baby boomer’s’ perspectives on health (and illness), Murray et al. (2003) noted several different narratives about the changing nature of health and illness.

Things such as age, class and gender influence how we think about health. In a sense, these different aspects of an individual co-exist and it is not really possible to separate them out. I, for example, am a Caucasian woman, aged 21 years (plus a bit!) and would be described as being middle-class – as defined by my profession. All of these features may influence the way I think about health, in addition to my past experience, my beliefs, my culture and many other things. However, for the purposes of this discussion, lay understandings of health will be considered under some of these different aspects while the problematic nature of using this type of categorization, which is ‘very social in nature’ (Stephens, 2008: 6) are acknowledged.

**Understandings according to culture**

One of the major things that has been seen to influence understanding about the nature of health is culture. Cultural perspectives on health offer many different ways of looking at health and the way
that we think about health is influenced by our culture (see chapter 5 for more detailed discussion of the relationship between culture and health). Likewise different belief systems, for example, about the origin of life, the existence of a ‘higher’ being, and the meaning of life, all influence understandings about health. An example of the way that culture impacts on ideas about health is the promotion, in contemporary Western cultures, of the slender body as equated with health. This results in the promotion of the thin ideal through the discourse of ‘healthy weight’, which equates being slim with being healthy (Burns and Gavey, 2004). This type of discourse suggests that health is achieved by being within certain weight limits (as medically and socially defined). Critics of this position argue that this is more to do with looking healthy (as defined by Westernized body ideals) than being healthy (see Burns & Gavey, 2004 and Aphramor & Gingras, 2008 for example) and yet this is a very pervasive idea in contemporary culture, which is being seen to have wider influence globally (chapter 12 explores global influences upon health).

With regard to mental health research in Zambia, Aidoo and Harpham (2001) explored the ways in which urban women in low-income groups explained mental ill-health as compared with local health care practitioners and found that the women tended to speak of ‘problems of the mind’ while the practitioners used terms such as ‘stress’ and ‘depression’. This illustrates two points about the influence of culture on understanding of health. Firstly, that the practitioners were likely to have been influenced by more Westernized ideas about mental health through their training and secondly that the ‘culture’ of the practitioners contrasted with the culture of the non-practitioners in terms of understanding and experiencing mental ill-health. The practitioners used different definitions of ill-health, viewing depression as an indication that something was wrong, while the non-practitioners – the women – only defined physical symptoms as ill-health (note again that the focus here was on negative (or ill-) health rather than positive health). ‘Problems of the mind’ were not necessarily viewed as ill-health (Aidoo & Harpham, 2001).

Understandings vary according to social class and level of formal education. Several authors (see Bury, 2005; Blaxter, 2004; Duncan, 2007 and Marks et al., 2005 for example) reference a substantial, seminal piece of published work examining beliefs about health by Herzlich in 1973. Herzlich carried out one of the earliest studies that looked at lay concepts of health in middle-class French people and she found that ideas about health were closely linked with the ‘way of life’ in urban living. The way of life was seen to mitigate against good health (by causing stress and fatigue) and to generate illness. In contrast, positive health was viewed as being something inherent within the individual – health as existing in a vacuum (acknowledged only by its absence or being ill), as a ‘reserve of strength’ and as ‘equilibrium’ (Duncan,
Ill-health resulted from the impact of environmental factors when there were not enough ‘reserves’. Blaxter (2004: 49) states that these three representations are also sometimes discussed as health being to do with ‘having, doing and being’.

Blaxter is an influential writer and researcher in the area of concepts of heath (see Blaxter, 1990 and 2004). Her research has focused on exploring lay beliefs about health within the UK. An early study by Blaxter and Paterson (1982, cited in Blaxter, 2004) found that middle-aged women, and their daughters, in poor socio-economic situations defined health as ‘not being ill’ first and foremost. Blaxter’s (1990) Health and Lifestyles study found that the better educated and those with higher incomes used the ‘health as not-ill’ definition more frequently as well as the ‘health as psychosocial well-being’. This draws on a medical perspective viewing health as absence of illness.

Understandings across the lifespan

Children and young people’s perceptions of health Many studies have explored how children and young people talk about health.

When asking children about their health Brannen and Storey (1996) found that relatively few felt that their health was good (34% good, 48% fairly good, 9% not good and 9% unsure: Brannen & Storey, 1996: 25). The children in the study frequently linked their health status with eating habits. In a different study Brynin and Scott (1996) asked children if they thought that health was a ‘matter of luck’. They found while younger children are more likely to accept this, older children are more likely to believe that health is under their own control and less a matter of luck.

Ideas about health appear to change with age during childhood and adolescence. Chapman et al. (2000) examined how children and young people define health. The younger children (aged 5 –11 years) defined health in terms of diet, exercise and rest, hygiene and dental hygiene. They described health in more negative terms such as illness, smoking and the environment. The younger children also referred to emotions and mental health. The older children (over the age of 12 years) included things like smoking and drinking behaviours, having a healthy mind, feeling happy and confident and self-acceptance. Interestingly the older children also linked looking good, being happy and feeling confident with being healthy.

A more recent study, carried out in New Zealand, also explored children’s understandings of health and found that these were wide-ranging (Burrows and Wright, 2004). Being healthy was seen to be about being happy, thinking positively about yourself and being kind. In addition the children linked health with physical bodies, morality and character and also took into account mental, social, spiritual and environmental factors.
Older people’s perceptions of health  In terms of age, research shows that understandings about health become more complex and develop ‘multi-layers’ of understanding over a person’s lifespan (Hardey, 1998). Blaxter’s (1990) Health and Lifestyles study found that older people tended to define health more in terms of being able to function and do things or care for themselves. Much of the research claiming to focus on lay perspectives in older age actually examines illness experience rather than concepts of health or well-being (in common with other research into ‘health’ across the lifespan). What it tends to reveal is that the onset of chronic diseases is viewed as being inevitable in older age and part of normal transition through this specific life-stage, as such challenges to ‘health’ in older age are more or less anticipated (see Lawton, 2003 for an overview). In addition being ‘independent’ is strongly linked to ideas about being healthy (Lloyd, 2000).

Understandings of health vary according to gender  Among others, Emslie and Hunt (2008) contend that gender has a major part to play in lay perceptions of health. Again we can draw on Blaxter’s work here to illustrate the fact that ideas about health may vary according to gender. Blaxter (2004) claimed to find clear gender differences, particularly in the way that men and women responded to questions about health. Women seemed to be more interested in talking about health and generally gave more detailed answers. Specifically she found that young women’s ideas about health included the importance of social relationships and being able to look after the family (drawing on functionalist notions of health). Emslie and Hunt (2008) likewise found that, with regard to perspectives on differences in life expectancy between males and females (on average women live longer), women’s accounts were more likely to focus on reproductive and caring roles and men’s accounts more on the disadvantages of their ‘provider’ roles.
Gendered assumptions about health tend to portray that women are interested in health and men are not. However, Smith et al. (2008), in their research on Australian men, found that the men self-monitored their health status to determine whether to seek professional help and they argue that this shows a higher degree of interest in health than has previously been assumed of men as compared with women generally. Robertson (2006) carried out a study exploring men’s concepts of health, including sub-samples of gay and disabled men. He found that many of the men’s narratives about health involved notions of control and release that were associated with issues of risk and responsibility. While these themes are echoed in research focusing solely on women, ideas about the nature of risk and responsibility in health do differ with gender.

Perspectives and theoretical (professional) understandings about health can be very different from one another. While lay accounts undoubtedly draw on expert and professional understandings, to some extent they can, and do, offer alternative and increased understandings about the nature of health. A substantial amount of research has been done in this area and, as Robertson (2006) argues, this has shown the extent to which lay perspectives understand health as something that is integrated with daily life rather than being a separate entity. The importance of lay perspectives to how health is defined and theorized is therefore apparent.

Nevertheless, some criticisms have been levelled at taking lay perspectives into account in terms of the legitimacy of them and the value that they bring to general understandings of health (Entwistle et al., 1998). Entwistle et al. (1998: 465) argue that lay perspectives may be biased, unrepresentative and, it can be argued, they are ‘rarely typical’. In addition there are assumptions of mutual under-
standings, which may be problematic. Are ‘expert’ interpretations of ‘lay’ opinion accurate and reliable? Are we using the same language to mean different things or different language to mean the same things? With regard to ‘beliefs’ Shaw, in his 2002 paper ‘How lay are lay beliefs?’, problematizes the concept and examines the inherent difficulties with using this term. He argues that it is virtually impossible to study lay beliefs because they are intertwined with a number of things including medical rationality. Even ‘commonsense’ views, he argues, are ‘based upon understandings within expert paradigms’ (Shaw, 2002: 287). Given the problematic nature of lay concepts of health Shaw contends that what we should be focusing on are lay ‘accounts’ – specifically lay accounts of illness. Kangas (2002) contests this position however and warns against juxtaposing lay and expert perspectives on health arguing that this can ‘blur the analysis of their complex relationship’ (Kangas 2002: 302). So this is something that is worth bearing in mind – despite the distinctions the majority of the literature makes between ‘lay’ and ‘expert’ (or professional) perspectives, in reality the boundaries between the two are often less clear cut. With respect to terminology Prior (2003) notes a change over the last twenty or so years in the academic literature from a focus on lay health beliefs and understandings to a focus on lay knowledge and expertise, which is worth noting, since it may affect the way we attempt to ‘understand’, account for and incorporate non-professional definitions (and concepts) of health. Prior (2003: 45) criticizes those who use the term ‘lay expert’ as failing to be specific about ‘how exactly lay people might be expert’ but later in her paper argues that lay people do have information and knowledge to share.

In summary, health means different things to different people. Notions of health may differ between groups and between different contexts. Perceptions of health will vary across the lifespan and are influenced by a range of factors including individual experiences and socialization. Personal experience and subjectivities mould our understandings of what health is and the meanings that we attach to it. These are, in turn, influenced by a range of things such as our social and physical environment and culture.

Why is this important for understanding health?

There are several reasons why it is important to look at different perspectives about health – both theoretical perspectives and lay perspectives. Firstly, appreciating different understandings of health may help towards understanding why people behave in certain ways when it comes to their health (Hughner & Kleine, 2004). This, in turn, can influence the way in which interventions intended to improve health are designed, communicated and implemented. As Earle (2007a)
argues, anyone concerned with trying to change or influence health needs to understand what people mean when they talk about health. Secondly, in terms of health promotion we need to be clear about what it is we are actually trying to promote (health promotion is explained and analysed in chapter 7).

Thirdly, it is important because, as Entwistle et al. (1998) argues, lay perspectives can complement ‘expert’ perspectives and add to knowledge and understandings. As such they should be incorporated into, for example, health care provision and also research into health. Understanding what health is about is crucial to researching it (Earle, 2007a). If we don’t know what we mean by the term ‘health’ how can we investigate its existence and meaning? Parallels between lay and expert understandings do exist with regard to some things; for example, in terms of how stress is conceived and understood (Clark, 2003) but this is not always the case. Differences in understandings have been found in relation to a range of health-related phenomena such as, for example, the body (Netleton & Watson, 1998). Finally Schoenberg et al. (2005) points out the need to take people’s views into account in terms of influencing policy and programmes (in health) that are appropriately designed and sustainable.

As Duncan (2007: 93) argues, ‘we can assume nothing about the nature of health’ – it is contested, varied and changing. In addition, in order to understand health we need to take into consideration a variety of different perspectives to avoid having a narrow, constrained idea about what health is. Drawing on different disciplines and giving due consideration to lay perspectives can aid and enhance our understandings about health. In addition Tones and Green (2004) argue that trying to come up with a working definition of health can provide a basis for practice in promoting health – after all, as pointed out earlier, we need to have at least an idea of what it is we are trying to promote! Definitions of health therefore have implications for a range of things including theory, practice, policy and promoting public health (Marks et al., 2000). In a special issue of the Journal of Health Psychology published in 2003 on the topic of health concepts, the editor at the time, Flick, argued that there were still a lot of ‘open questions and unresolved problems’ when it came to addressing the main issues (Flick, 2003: 484). Flick summarized these as the variety of health concepts that are encountered in everyday life and through professional practice. Now, a few years later, it seems that the same challenges remain. Lawton (2003: 32) argues that more work needs to be done, the reason being that the ‘contexts within which health (is) defined and experienced are constantly shifting and changing’.
Summary

- Health is a complex concept and is difficult to define. Many different definitions and understandings exist.
- Understandings of health differ according to experience and expertise. Factors such as age, social class and gender impact on these. Theoretical perspectives about health can aid our understandings of subjective health experience.
- Lay and expert understandings of health may differ but both are central to developing understandings about what health is, how it may be explored and how it may be maintained.
Questions

1. Health means different things to different people. Consider what health might mean to other people in different contexts for example – a person who uses a wheelchair, a person in a country experiencing conflict, a person who is experiencing a mental health problem or some other person of your choice. How might their understanding of health differ from yours and why?

2. Drawing on the material in this chapter, compare and contrast theoretical (or professional) understandings/concepts of health with lay understandings/concepts. Take time to reflect on why it is important to take both types of perspectives into consideration.

3. What factors do you think impact on, and influence, your understandings about health and what health means to you? Which of these are most significant and why?

Further reading

This book is one of the most useful, readable texts around on lay perspectives and health. Readers should note that it focuses mainly on understandings of health within a ‘global north’ (or ‘Western’) context. However, it explores the meaning of health in some depth, drawing on a range of literature and research so it is a very good introduction to the key issues.

This book addresses the question ‘what is health?’ and critically examines a range of diverse perspectives. It is a useful follow-up to this chapter and explores a number of issues in greater analytical depth than can be achieved here. See Part III, Critical Perspectives on Health, for a more in-depth critical discussion about the nature of health.

This is another useful text in terms of exploring, in more detail, the nature of health and its complexities. David Seedhouse has a very specific, philosophic perspective about health that contributes to contemporary understanding and debate. This book focuses on two key issues – ‘what is health?’ and ‘how can health be achieved?’