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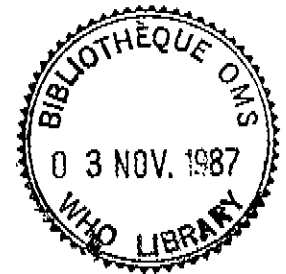


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LIFESTYLES AND LIVING CONDITIONS AND  
THEIR IMPACT ON HEALTH

Report on a WHO meeting

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# **I Lifestyles and Living Conditions and their Impact on Health — a Report of the Meeting**

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## 1. Introduction

The WHO's Regional Office for Europe's Regional Strategy: "Health for all by the year 2000" (Document EUR/RC 30/8) defines as one of the three areas of special concern for future efforts in health policy and education the furthering of lifestyles which are conducive to health. The document makes the recommendation that measures aimed both at individuals and at communities should be developed and implemented with this end in mind. It specifically points out that socio-economic living conditions have a significant influence on the creation of lifestyles conducive to health. The tendency to move towards a social concept of health, which the Regional Strategy implies, has given rise to a "Regional Programme for Health Education and Lifestyles" (Document EUR/RC 31/10). This establishes three areas of activity:

- health promotion.
- preventive health education.
- supportive health education.

The socio-economic and socio-cultural living-conditions are seen in this programme as structural factors in the development of lifestyles conducive to health. Individual decisions concerning health behaviour are seen as being dependent on working and living conditions, the influence of which has been largely ignored by a concept of health-promotion which is exclusively oriented towards the individual. It is therefore suggested that the social networks within which we live should be taken as the framework for the development of health programmes; thus health behaviour will regain its social dimension — which would be in line with the WHO definition of health, which covers social as well as physical and psychological well-being.

The two WHO-EURO-Documents mentioned formulate a series of problems for health education, for the solving of which a series of differentiated steps are necessary. The concept of "lifestyles" requires sociological, socio-psychological and socio-epidemiological investigation if it is to prove useful for specific health-promotion programmes. For this reason an intensive conceptualisation phase was carried out and the results of this work were discussed at various conferences of experts arranged by the Regional Office. The results of these conferences had a lasting influence on the further refining of the lifestyle concept.

In view of the decision to deal with the concept of lifestyles and its significance for health measures during the technical discussion at the 33rd Regional Committee meeting in Madrid in 1983, the Federal Republic of Germany stated its willingness, together with the WHO Regional Office for Europe, to lend its financial and organisational support to an international exchange of ideas on the effects of living conditions and lifestyles on health. This meeting was intended, on the one hand, to

document and discuss the state of development of the lifestyle-concept and, on the other hand, to investigate how far this concept could be implemented in health education and health policy-making. In line with these aims, experts in the areas of sociology, health-education and health policy were invited in order to allow for as wide-ranging as possible a discussion and evaluation of the working-papers.

## **2. Content and aims of the meeting**

In the search for reasons why health education concepts have hitherto been lacking in effectiveness and efficiency one particular factor is seen to be their primary concern with individually discernible indicators of medical "wrong behaviour". The socio-medical expression for this concern is the "risk-factor model". According to this model, health and illness behaviour are seen as a complex of biochemically and physiologically establishable factors in the individual — a complex which can be changed by appropriate causally demonstrable activities or intervention in the daily process of living. Eating habits, consumption of alcohol, tobacco etc., lack of physical activity, are, among others, seen as areas of individual behaviour which can be specifically influenced in a framework of prevention and intervention studies. A scientific survey of such studies has recently proved, however, that their strategic and methodological conception is inadequate and ineffectual; positive effects have not been forthcoming, and their suitability has to be put in doubt. It is not surprising, therefore, that a greater sociological orientation is taking over in the theory and practice of health-education, health policy-making, and epidemiology.

The point of departure for a change of approach is the view that human behaviour is a complex of (behavioural) structures and sequences which develop and manifest themselves in specific economic, ecological, social and cultural conditions and circumstances. Health behaviour is thus to be seen as a part of these structures; it is formed by them and also itself influences them. The link between cause and effects of these modes of behaviour is not entirely unambiguous. In intervening in this network of relationships one has to remember that certain modes of behaviour and the life in which they are manifested display several levels; in addition, one has to reckon with the fact that the effects of individual interventionist measures cannot be completely controlled.

In this connection human behaviour is seen as an excerpt, taken at one particular moment, from a lifelong process of socialisation; its meaning and function emerge above all against a background of the life-history of the individual. Because human behaviour is regarded as an ongoing process, alterations to this process can be attempted, provided the social and individual conditions of its development and the societal conditions and

lifestyles are taken into account. Behaviour involving a health risk is thus seen not just as a result of an individual decision, but, above all, should be analysed also in terms of its social, cultural and economic dependence and functionality, before apparently promising preventive and interventive strategies are tried out. In this way the classic epidemiological concept has to have its social dimension added, i.e. for health education and health measures a socio-epidemiological concept has to be developed which encompasses social as well as individual indicators.

The aims of the meeting were:

- (a) an overview of sociological and psychological concepts and research results concerning personality development and lifestyles;
- (b) an overview of sociological concepts and research results concerning living conditions and lifestyles;
- (c) an overview of socio-epidemiological concepts and research results concerning preventive and interventive studies of behaviour involving a health risk;
- (d) an evaluation of the relevance of the lifestyle concept for health policy and health education;
- (e) the development of recommendations for political decision-makers nationally and internationally, concerning future activities and measures in the area of health, health education and health research.

Background papers on the first four aims were produced which aimed to provide an overview of the problem area. The participants were requested to express their views from their own national point of view on these papers. The ensuing discussion was meant to lead on to the task of pinpointing and recommending possible ways of incorporating the lifestyle concept in concrete programmes.

### **3. Opening of meeting and welcoming of participants**

Dr. Kickbusch (WHO-EURO Regional Officer for health education), in her words of welcome, pointed out that the WHO Regional Office for Europe, in organising this meeting expected significant progress to be made in the concretisation of the lifestyle concept. The concept had an important position and function for the realisation of the Regional Strategy "Health for all by the year 2000" because of the fact that Europe was the only region of WHO in which work was being undertaken on the health problems of industrialised states. The move towards a social concept of health had therefore to be seen as a reaction to the specific social, political and cultural conditions in these states. However, the multiplicity of social and political systems within Europe should also not be forgotten; the question of transferability of the lifestyle-concept to *all* member states of WHO-EURO had to be carefully examined in every case.

Dr. Voigtlander (Federal Ministry for Youth, Family and Health) stressed the significance of the lifestyle-concept in connection with increased social responsibility for the health of each individual in society. Health should not be seen merely as a private but also as a public good, the preservation and furthering of which was one of the most important collective tasks of any society.

The conference chairman, Prof. Levin (Yale University), in his introductory remarks stressed that the lifestyle-concept could provide a source of inspiration to public health programmes if it could be made more precise at three levels:

1. *Health policy*: The implications of the concept for the public health system had to be established for three areas: programmatic and legislative developments and health promotion.
2. *Preventive and intervention measures*: The innovative character and the strategic implications for the furthering of health and for health education must be presented and communicated in a practical manner.
3. *Research*: Gaps in both basic and applied research and ways of bridging these must be listed individually.

#### **4. The Scientific background of the lifestyle concept**

In health research the concept of "lifestyles" was reintroduced into scientific discussion in connection with criticism of the risk-factor model. At the turn of the century social medicine and epidemiology had a relatively easy task in identifying the pathogenic factors causing the infectious illnesses of the time; but now the pattern of illness in highly industrialised states has changed radically — for example the increase in cardiovascular disease and various forms of cancer etc. — and this has reduced the predictive reliability of classical medicine. The so-called "civilisation diseases", as the name suggests, cannot be subjected to the type of analysis and therapy favoured by medicine, which is exclusively aimed at the individual. These are not just diseases *caused by* civilisation, but clearly also diseases *of* civilisation, which receive their expression in individual cases. The term "psycho-social factors", which is used to explain, for example, cardio-vascular diseases, is a whole complex of factors influencing our health which are to be found largely in the social, political and cultural side of life. These factors influence the everyday behaviour of people at their place of work, their place of education, in the family, their leisure activities, without it being possible to influence the often detrimental effects on health in individual cases. Health risks are not only to be ascribed to individual behaviour, but, particularly in industrialised societies, have largely social, political and cultural causes.

In the risk-factor model, health-risk behaviour is only examined on the level of individual patterns of behaviour, and it is assumed that these can give rise to specific illnesses. The assumption is made that we are entirely free to make a choice for or against health; at least it is assumed that the individual can reduce the risk to his or her health by making appropriate decisions, for example in areas like nutrition, consumption of tobacco and alcohol, amount of exercise taken. Prevention and intervention programmes have however shown, by their partial lack of results, that the social dimension of health, that is, above all, the conditions and lifestyle of individuals and groups within the population, have a considerable influence on the genesis and the treatment of "civilisation diseases".

The rediscovery of a health system which had been temporarily neglected — namely social networks like the family, neighbours, friends, leisure groups etc., in which people exist as social beings — a rediscovery which was expedited by the failure of these studies — has focused attention on the sociological and socio-epidemiological factors linked with the occurrence, development and treatment of health-risk behaviour. Terms like "lifestyles", "living conditions", "quality of life" are now being used with increasing frequency in discussions on health promotion and health education.

As far as the meaning of the concept of "lifestyles" is concerned, its introduction into health promotion and health education programmes has been difficult:

— In Anglo-American usage the term "lifestyle" has, since 1970, appeared increasingly frequent in scientific literature on health problems. Without taking into account its sociological history, the word "lifestyle" is generally taken to mean here a special form of behaviour, for example smoking, drinking alcohol, etc. In connection with the commercial exploitation of health problems in the form of fitness programmes, "lifestyle programmes", anti-smoking or drinking therapy, etc., the excessive use of the term "lifestyle" has unfortunate connotations for health educators. This fashionable use of a genuine sociological term seems to them to be inappropriate for health promotion programmes. However, the term continues to be used in specialist literature without any sociological or socio-psychological basis. The confusion and ambiguities found there only make the task of establishing the term's conceptual meaning even more difficult.

— In German, the term "Lebensweise" has a sociological tradition stretching back to Max Weber (other authors trace it back as far as Marx). However the term has been used relatively infrequently in recent times. The use of the term "Lebensstil" to translate the word "lifestyle" occurs mainly in the area of research into young people, where it is used to denote specific "subcultural lifestyles" of individual groups of young people.

In French the term "style de vie", were it used to translate "lifestyle", would have strong associations with certain advertisements and would suggest a stylish way of living in the sense of fashionable, status-conscious. The translation "mode de vie" would seem more appropriate even if this does not completely cover the meaning of "lifestyle". There are similar problems for other European languages, and the precise concept therefore has to be established for each country.

These conceptual difficulties have, however, in the unanimous view of the participants of the meeting, no significance for assessing the health-risk problems and relating them to the socio-structural conditions in the individual countries of Europe.

### **5. The suggested lifestyle concept of the Regional Office for Europe of the WHO**

In the section on lifestyles in the Regional strategy: "Health for all by the year 2000" it is pointed out that this concept represents an approach which is intended to contain both individual and community-oriented elements. Lifestyles cover occurrences which are intervening variables between individual behaviour and the social, political and cultural conditions in which it occurs; lifestyles as a mediating sociological concept which fills the gap between the individual and general social institutions and systems of values. In this sense, lifestyles are to be determined both in relation to their individual and their collective manifestations.

In addition to this, the concept of lifestyles tries to see health-behaviour as one element in a whole repertoire of behaviour patterns; it is mutually interdependent with other values, norms and behaviour patterns and can only be isolated from these for analytical purposes.

Lifestyles in industrialised societies are significantly determined by the division of the day into work and leisure; but an important structuring effect is created by the socio-ecological centres of daily activity (place of work, home, lodgings, public transport system, etc.) and by more peripheral areas of social interaction (leisure centres, cultural institutions, etc.); access to the latter has an effect on the use of leisure time and therefore on the possibility of effectively compensating for stress created in the former.

The lifestyle of a *social group* characterises the totality of patterns of meaning and forms of expression which are produced by a group in the course of collective efforts to cope with the demands and contradictions of the social structures and situations common to all members of that group. The lifestyle brings together efforts related to the demands made, i.e. the external (social, political economic and cultural) conditions and efforts related to the subjective situation and condition. In the lifestyle is

expressed under what conditions a social group acts or reacts in a particular way, i.e. the lifestyle tells us in which directions a group tends to develop its behaviour in the ongoing process of coping with the conditions in which they live. These tendencies, in the forms of common social values, norms, language forms, interaction rituals etc., provide a reservoir for individuals or sub-groups which they can draw on for their personal and social identity; it makes it possible for them to give some sense and meaning to their specific situation.

The lifestyle of an *individual* characterises the totality of normative behavioural structures which is developed in the course of his or her life in the ongoing interaction with his or her social and natural environment. Subjective motivation and also potential action are expressed through the lifestyle and are used by the individual according to the social situation. The individual's lifestyle contains variations, additions to and omissions from the collective lifestyle which are specific to that individual's personality; nevertheless the individual remains linked to his particular social group — i.e. any change in his or her lifestyle is bound by the collectively developed framework — unless, with this change, there is also a change of the social group, or it is the group which wishes to undergo such a change.

This concept of lifestyles creates a close link between the living conditions of an individual, his activities and socially formed strategies for coping with life. Characteristic for this is the linking of individual and collective lifestyles in relation to the particular socio-structural conditions in which the individual lives. Individual behaviour is understood as being largely socially determined — with the implication, among others, that to change it, social changes are necessary. Thus the message for health promotion and health education is that *integrative strategies* for prevention and intervention must be developed — strategies whose chief characteristic is that they link up the various social sectors and are also effective within them.

## **6. Assessment of the lifestyle concept from the point of view of health policy and social policy**

Before the working groups held a detailed discussion of the concept as presented in the background papers, and considered how it could be further refined, the plenary session made a general political assessment of the lifestyle approach as far as health promotion programmes were concerned.

The approach advocated by the Regional Office for Europe, which looks at health as a social concept, as an ideal which is in daily use, was basically welcomed by the participants in the conference. Both the theoretical and strategic approach of the Regional Programme "Health education and lifestyles" were given complete support. The programme of health policies presented here was seen as showing up the weaknesses of a health

policy aimed at the individual and as offering a convincing way of overcoming these.

The concept of "lifestyles" as a central category for health measures represents a concept which manages to establish the positive elements of health behaviour in all their complex interrelations. The development of lifestyles which are conducive to health offers health education a positive, forward-looking attitude. In view of the structural crisis faced by industrialised societies, the central task for health education should not be patching up ruined lives but rather *developing lifestyles and living conditions conducive to health*. A strategy like this can make a constructive contribution towards tackling environmental and living conditions which endanger health.

Nevertheless, the expectations connected with the concept have to be measured against the economic, political and social realities in the various countries of Europe. While structural problems in the highly developed industrialised countries have led to a considerable restriction of the financial possibilities for changes in the health system, the less industrialised countries have seen the economic recession seriously reduce the material and financial possibilities of further development of their health system. In addition to this it should be a cause for concern that the "over-developed" industrial states are with increasing frequency exporting dangerous products (alcohol, tobacco, medicaments etc.) — and with these the associated lifestyles — into less developed countries. This is not just true within Europe, but also increasingly true of relations with Third World countries. Compared with short-term economic strategies, the lifestyle concept, which aims at continuous, long-term processes of development, has a position which makes it difficult to include in everyday political discussions and controversies.

Another possible difficulty in realising the concept in terms of health policy stems from the fact that the *promotion* of health is rarely seen as the *main* strategy of health policy. The health system is largely geared to the medical profession, and this means that health policy is geared to illness, with concomitant effects on the funding of medical provisions. This reduces the funds available for health promotion. Thus the furthering of health and lifestyles as a political programme must develop new ideas on the role for the medical profession within the health system.

The concept of health as a matter of public responsibility represents a political programme the implications of which need to be carefully examined. The approach which tries to extend the active involvement and choice of the population at large, to return a considerable degree of self-determination in health matters into lay hands, but at the same time to emphasise the public and the state's responsibility for creating the correct framework for lifestyles conducive to health, implies a strategic balance which, when attempts are made to realise it politically, is bound

to produce clashes with the long-established structures of health care in the various countries of Europe. On the one hand the introduction of the lifestyle concept could be at the cost of increased social control over the everyday activities of the population; this would occur if health became — more or less covertly — changed into a totalitarian concept imposed by the state on the population. On the other hand, the lifestyle concept could also be misused to continue the individualisation of social health problems; this would occur if health was regarded as mainly a matter of the individual creating for him or herself a lifestyle which accords with the established standards. The danger of both sorts of imbalance has to be taken into account when the concept is being converted into health and social policy. Precisely because of the present economic difficulties of many countries in Europe the lifestyle concept has to be implemented with great care. Given the political, social and cultural diversity of the region, national differences have to be taken into account — and here the European Regional Office of WHO can offer invaluable assistance.

## **7. Socio-epidemiological assessment of the lifestyle concept**

Just as the lifestyle concept represents a relatively new approach for health promotion and health education, so too socio-epidemiology is in the early stages of its theoretical and methodological development. Although in the last century it made a valuable contribution towards eradicating endemic diseases in the countries of the industrial revolution, its importance in the health system dwindled as conditions in the cities improved as far as hygiene was concerned. Hand in hand with the establishment of basic health provision for the population went a gradual individualisation of the medical system, which took less and less account of the social causes of illness and also of health behaviour. Only recently — as part of the critique of curative medicine — has classical epidemiology been seen to try to include social, ecological and economic conditions in its analyses and strategies. Stimulated by research into stress — partly also as a critique of the latter — socio-epidemiological studies have come to the forefront of attempts by scientists to combat the spread of "civilisation diseases" in industrialised societies.

The scientific approach of socio-epidemiology is based on a critique of classical epidemiology and traditional sociological sciences. The commonly observable gap between the medical and sociological disciplines is caused, among other things, by the fact that each side often lays claim to the exclusive rights of analysis and interpretation of health and sickness behaviour. By contrast, socio-epidemiology attempts to emphasise the complimentary nature of various disciplines and to put them to use in overcoming health problems in the various societies involved. The development of theoretical bases and new ways of empirically testing these are at present of primary concern for socio-epidemiology.

In advocating an ecological orientation of socio-epidemiological ideas, this approach coincides with the basic assumptions of the lifestyle concept. The available research results point to the necessity of an increasing emphasis to be laid on the social dimensions of health. But at the same time they have made clear that health promotion and health education need a basic theoretical and methodological conception if they are to succeed in producing well thought-out strategies of prevention and intervention. One of the reasons for the lack of effectiveness of strategies employed hitherto is seen as being the fact that they were tried out in reality without sufficient thought having been put into the concepts on which they were based. The failures caused by this were blamed on health promotion per se, without it being made clear that this was a case of the chosen strategies not being based on a sufficiently refined scientific foundation.

The socio-epidemiological contribution could complement the lifestyle concept by further developing the link between the classical medical and sociological approaches and research strategies. Before this occurs, the sociological contribution to health promotion and health education would have to be more precisely determined. Eventually such an approach leads to a theoretically and methodologically well-founded choice of strategies for prevention and intervention.

### **8. Socio-psychological assessment of the lifestyle concept**

The increase in psychosomatic disorders led at an early stage to theoretical consideration by socio-psychologists of which factors and events in the course of an individual's socialisation process can be linked to these disorders. The various analytical and therapeutic models (from psychoanalysis to special forms of psychotherapy) which have been developed hitherto still relatively rarely include in their approach the social conditions in which the individual concerned lives.

The controversy over the medical or classical psychiatric treatment of psychosomatic disorders led to the development of a socio-psychologically oriented psychoanalysis which aims to answer the question of the development of the individual's relationship with his or her body and how this development takes place in, and/or is influenced by, the social conditions at the time. A socio-historical analysis of industrial societies shows that as industrialisation and rationalisation of work and living processes increases so the division between the individual and his or her body also increases. This division is reinforced by curative medicine, which sees in the patient a body or part of a body which, with the help of sophisticated technology is to be put back in order.

At the level of social actions the division between the individual and his or her body is seen in the introduction of the role of the sick person.

(Interestingly enough there is no corresponding role to that of the patient or ill person in the form of the role of a "healthy person".) In this role, especially in the case of psychosomatic disorders, the body is often instrumentalised for social and psychological purposes. Connected with illness and assumption of the role of the sick person there are needs for compensation vis a vis injuries produced in everyday life. Lifestyles or living conditions leave their stamp on subjective feelings of well-being. For the social psychologist the vital question is what strategies individuals develop in order to retain their personality (identity) in the face of the demands and contradictions of society.

In health education for some time now the question has been asked as to what extent behaviour which puts health at risk (e.g. smoking, alcohol consumption, unbalanced diet etc.) is to be interpreted as a reaction to the social, economic, ecological and political conditions in which individuals live, a reaction for which, at least subjectively there is no available alternative. Compensation for situations of social conflict by risk behaviour represents for industrial societies a phenomenon of epidemic proportions. Clearly such behaviour hides a purpose and a function which can only be revealed by a detailed analysis of the living conditions and lifestyles of the population. A detailed socio-psychological analysis of the origins and dynamics of health-risk behaviour must therefore take into account the fact that under present conditions the question of a change in people's relationship to their bodies is not essentially a psychological one. Health as a social phenomenon implies the political context for its definition. What health is — and above all, to whom it can be useful — must be discussed at a political level. For the individual, the question which arises is whether health represents a value per se, or whether it is essentially functionalised, i.e. has the nature of a good. From a socio-psychological point of view the problem of social control has to be included in the discussion of the question of a changed attitude to our bodies.

### **9. Refinement and further development of the concept of lifestyles in health promotion**

The discussions in the working groups and the final plenary session covered questions such as to what extent the lifestyle concept can serve as the basis for health promotion programmes at national and international level, what additions and refinements should be taken into account in future work, and what priorities should be recommended to WHO-EURO for preparation of the contents of the 33rd meeting of the Regional Committee in Madrid in 1983. What follows is a resumé of the results of these discussions.

### 9.1 Health promotion and lifestyles — mediating concepts

In order to encourage the development of healthy lifestyles it would appear appropriate to identify those elements in the environment which provide a framework for the development of relevant behavioural strategies: socio-economic living conditions (what money is necessary in order for an individual to live healthily and does he have this money at his disposal?), time (do healthy lifestyles require extra time and how could this extra time be integrated into the time-budget of the various social groups?), social values and their legitimisation (what value is attached to a healthy lifestyle in the various social groups and how are these values legitimised?), informal system of social support (what social networks with what structure and functions are at the disposal of individuals, according to their social position, and what use do they make of them?), resources (what human and material resources in the lay system contribute to the development of healthy lifestyles? — e.g. what importance and function do women in various social groups have in the area of preventive health measures?). An analysis of living conditions and lifestyles differentiated according to social class can help to remove the middle-class orientation which the lifestyle concept still retains. Its applicability depends on a realistic analysis of the social living conditions.

Implementation of the concept largely depends on whether plausible strategies for health promotion are successfully developed which emphasise the integrative and mediating quality of the lifestyle approach where health and social policy are concerned. While the lifestyle concept forms a bridge between individual or collective behaviour and its socio-structural context, health promotion reflects the need for a new public health policy which lies somewhere between concrete health education measures and general state activities; without doubt, for example in the field of legislation, measures are necessary which bring about an improvement in the quality of life in industrial societies (e.g. for the sectors environment, work, social and health insurance, family law etc.)

The main aim of health promotion programmes is seen as being an improvement in the quality of options for the development of lifestyles which are conducive to health. Because of the way social, economic, ecological, and cultural living conditions differ it can be assumed that there does not exist *one* healthy lifestyle which is equally valid and equally achievable by all sectors of the population. The complexity of industrial societies results in a *pluralistic concept of health promotion* which is flexible enough to reflect the variety of lifeforms within countries and regions.

### 9.2 Distribution of resources within the health system

It is to be assumed that financial and material resources allocated to the health sector in European countries will not be significantly increased.

What appears to be happening, on the contrary, is that, because of economic crises, funding for health promotion and health education often is among the first areas to be reduced. The precipitate cutting of resources often obscures the prospects of structural alterations in the health system, for example the possibility of reallocation of resources. However, one should be clear that the health system does not exist in a political vacuum but is exposed to continuous influence from very varied political interests and groups. Health promotion and health education are also genuine political activities which are judged by their economic and socio-cultural effects. Against the background of continued widespread support for curative medicine, the social orientation of prevention and intervention resulting from the lifestyle concept has to be seen as an approach which at least partly challenges the present organisational form of the health system, i.e. it becomes the object of political controversy -- and here the related question of a redistribution of financial, material and staff resources undoubtedly plays a significant role.

A greater emphasis on, and a greater integration of the lay system in the public health system, a redefining of the roles of the professional in prevention and intervention programmes, a shift from the classic, clinically oriented approach to social and ecological strategies of health promotion, and a basic rethinking of prevention and intervention are all seen as areas in which available resources and existing legislation should be carefully examined; this applies even to the organisation and administration of the areas whose structural usefulness at times must be doubted.

At the same time, however, it is possible to observe that exaggerated and unrealistic expectations are made of health promotion, in particular concerning the solving of structural social problems. The social problems and risks to health resulting from long periods of unemployment in many industrialised countries can hardly be mitigated by health education programmes. Here we have a structural problem of *society* which must be solved at this level; the increase in psychosomatic ailments among the unemployed is a result of an economic crisis, and at best only the symptoms can be dealt with by health measures. The limits of health promotion are largely drawn by structural living conditions.

### **9.3 Measures at national level**

The structure of the living conditions and quality of life of a society is created by political, legislative and economic decisions at national level. One can assume that in Europe, whatever role is played by regional or local institutions in helping to form the health system, there is an overall state responsibility for health policy, and this is expressed in the form of framework conditions for health provision. These may differ from country to country and are the result of an interplay between various differing

organisations, pressure groups and state institutions at all levels of the health system.

It is therefore necessary for complementary strategies for health promotion to be developed which link together and make compatible local, regional and national programmes. At national level a network — as it were — of health promotion must be developed which balances activities in the extent to which they are centralised/decentralised, active/passive, professional/lay, state/local. What is not advocated is a thoroughly organised system which lays down every step and every detail, and which in the last event cannot avoid taking on a totalitarian character; what is meant is rather a national "early warning system" which is capable of pointing to shortcomings, recommending solutions and common activities, and suggesting new ideas and possibilities for interlinking of sectors etc. It should promote communication and cooperation between the various organisations and groups which are active in health promotion.

As an example of a possible organisational form for such a network the Canadian programme for health promotion was presented and discussed. Its strategy is based on two basic decisions which were made by the appropriate political bodies:

(a) The basis for the content and strategy of national health promotion measures should be the involvement of those whom they are aimed at in the development and implementation of such measures and the principle of self-help and mutual support.

(b) In order to encourage the population to become directly involved, there should be widespread public discussion of the socio-structural conditions for and the consequences of lifestyles conducive to health.

Based on these two principles the Canadian Institute for Health Promotion establishes contact with the various social groups in order to discover with them what interests and needs they have where health promotion is concerned, where the emphasis should be put, and what can be done; after the necessary decisions have been reached, these groups are provided with financial and material resources so that they can develop a practical and grass-root approach; at the same time attempts are made to establish a network for communication and cooperation among the individual groups; and attempts are also made to tap additional resources for health promotion and make these available to the groups. Initial experience with this approach has been good: there were initial problems in reorganising the tasks and function of the institute — not all those concerned were entirely happy about the reduction in possibilities of control and the handing over of powers of definition to the population at large. However, it has now been realised that a central institution can successfully initiate and coordinate health promotion programmes at the various local and regional levels.

#### **9.4 Measures at local level**

Lifestyles are developed where people live, work, grow up, are educated and spend their leisure time: in the local community. Local institutions, organisations and groups are the organs of practical health promotion. Their activities are, on the one hand related to national programmes; on the other hand they relate to local conditions and needs. In their capacity as creations of the state they have formal authority, in their capacity as non-state organisations they have social authority to contribute to the development of lifestyles conducive to health within the framework of a national programme.

Health shops, home-based services, psycho-social advice centres, self-help groups, clubs, professional associations, schools, further education institutes, firms, churches etc. are important targets for health promotion programmes. At the same time these are the institutions which offer the framework for the development of healthy lifestyles. Social and cultural values, general attitudes and types of behaviour, coping strategies and attitudes towards one's own body, apart from being developed in the family, are developed in the social institutions of the community.

The potential for social activities within the community, whether at the level of groups of friends or neighbours or in clubs, social groups and other networks provides the basis for the creations of lifestyles conducive to health. The inclusion of all sectors of the population in such programmes and activities should be particularly promoted because of its socially integrative effects. Above all this applies to young people and old people who would otherwise run the danger of being socially isolated.

Initiatives and social movements at local level concerned with problems related to health and the environment in general and also with specific forms of health provision (women's movement, "alternative" health shops and health-food shops), represent an innovative and creative approach which is closely geared to the actual needs of those concerned and, as such, can supplement traditional forms of health promotion. They have done a lot in developing a critical consciousness among the consumers who have come under their influence.

#### **9.5 Involvement of decision-makers**

There is no doubt that the development of lifestyles conducive to health can only be achieved if the population at large can be involved in the process. Social responsibility for the health of the population is a matter for all groups in society. It is thus necessary to find methods of ensuring that those concerned are involved in decision-making processes on health promotion at local, regional and national level. Participation of this kind could go a long way towards reducing the gap between the lay system and those who make the decisions — a gap, incidentally, which is still respons-

ible for a number of negative developments in health provision.

The practical competence in health promotion and education to be found in the lay system, particularly in the active social groups, is a vast reservoir which should be drawn by being integrated into the planning and realisation of activities in this field.

### **9.6 The role of the professional system**

The social concept of health constitutes an approach which does not replace traditional forms of health promotion and education but rather supplements them. The professional medical system has hitherto concentrated on individuals and on illnesses. It is therefore necessary to stress, in contrast, the social context of illness. The lifestyle concept, particularly because it links concrete forms of behaviour with living conditions, brings with it a strategy for health promotion which highlights the various roles which lay and professional people play within the public health system. These roles are not in competition, but rather complement each other.

Integration of the lifestyle concept into health promotion and health education must not, however, lead to the designation and special training of "lifestyle-experts". The social dimension of health derives from the living conditions and lifestyles of the population at large. Only through cooperation between the lay system and the professional system can the factors be identified and the strategies developed which will result in lifestyles conducive to health. It is the capabilities of the lay system which play a crucial role in realisation of the lifestyle concept.

### **9.7 Research problems related to the lifestyle-concept**

Research into the living conditions and lifestyles of various groups in the population is a task which is being undertaken by the social sciences. Empirical studies are being carried out into a whole series of aspects and the results of these can be brought together under the heading "health". Such a "secondary analysis" of available empirical data provides an important basis for assessing the life-situation of differing social groups.

A detailed analysis of the link between living conditions or lifestyles and specific manifestations of health behaviour, taking into account clinical and social aspects, constitutes a central aspect of socio-epidemiological research. It would therefore seem to be necessary to establish socio-epidemiology at the centre of empirical investigation of the lifestyle concept and to supply it with the necessary financial, material and staff resources. The fact that socio-epidemiological research combines clinical and social aspects of health behaviour makes this discipline extremely relevant for basic and applied research.

In addition to this, if a network were to be developed which brought together existing investigations, projects and programmes of relevance

for the lifestyle concept, this could provide important stimulus for research programmes. National and international cooperation in this area should continue to be encouraged.

Scientific investigations into lifestyles and health are confronted with a number of methodological problems. The complexity of the area is such that it is appropriate to employ a variety of methods, ranging from a quantitative approach (e.g. representative surveys) to qualitative studies (e.g. biographical analyses or direct observation).

### **Recommendations**

The development of a social concept of health initiated by the Regional Office for Europe of the WHO, was welcomed by the participants at the meeting and given wide support. There was agreement that one basic prerequisite for realisation of the concept as presented and discussed is the maintenance of peace in connection with efforts to achieve nuclear disarmament. The following recommendations were made for future work in the "Regional Programme for Health Education and Lifestyles":

- Continuation of refinement of the lifestyle concept, in particular taking into account secondary analyses of available research projects and data which are of relevance to the context of Health and Lifestyles.
- The promotion and spreading of the lifestyle concept within the European Region, above all by organising and participating in conferences, seminars and workshops dealing with health-promotion and health policy.
- The setting up of national and international networks for health policymakers, health-educators and scientists, in order to lend sustained support to national approaches to the development of programmes for health promotion and lifestyles.
- The development and implementation of a research programme on "Socioepidemiology" at national level and the establishment of an exchange of ideas and experience on theoretical and methodological concepts within the European Region.
- The development at local authority level of prevention and intervention strategies which start from the living conditions of the population at large and are planned and implemented with the active involvement of those concerned.
- The initiation of broad-based public discussion on the link between living conditions, lifestyles and health, in order to make public the social concept of health in close cooperation with the media, politicians, professional people and the population at large.