

THE MEANING OF HEALTH IN AN INNER CITY COMMUNITY

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[Yeh...so tell me what health is?] Health – I should've looked this up in the dictionary and give you a definition! [No way! I want to know what you think it is – 'cos everyone thinks it's something else – and it's okay what you think.]

In spite of the increasing numbers of articles defining, analyzing and explaining the concept of health, there is little agreement among professionals as to what health actually is (Payne, 1983; Smith, 1983; Van der Geest, 1985; Winstead-Fry, 1980). This gap is becoming increasingly awkward with the World Health Organization's new goal of "health for all by the year 2000." The question is, if we do not know or cannot agree what health is and if health cannot be operationalized, then how can "health for all" be attained?

This vagueness is disconcerting when health professionals are given the task of promoting and maintaining health, as well as caring for the sick. It is clear from the literature that lay persons (i.e., consumers of health care) also have divergent notions of what health is and that these perceptions of health frequently differ from the health care providers' definitions (Baumann, 1961; Maddox, 1962; Shaver, 1985; Smith, 1983; Tessler & Mechanic, 1978; Tripp-Reimer, 1984). It is also apparent that health care providers ethnocentrically assume that they are the "experts", and it is their responsibility, and privilege, to inform the consumers on matters pertaining to their state of health. After reviewing published definitions of health, Keller (1981) concluded her article with this assumption:

Consumers at present are unable to identify what their ultimate goal for health might be and for what they should hold health care professionals accountable.

The purpose of this research was to elicit the emic perspective of health from persons using anthropological methods of unstructured interviewing techniques. A model was then developed, and the relationships between

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variables were tested. In the last section of this paper, questions and hypotheses arising from these data are presented for further research and the refinement of the model, and the lay perceptions of health are compared with definitions of professionals.

Literature Review

In spite of numerous attempts to define health and the existence of a multiplicity of definitions (Keller, 1981), a concise, operational definition of health is still lacking. The flexible and loose use of the term "health" has resulted in ambiguity and vagueness (Cardus, 1973; Dolfman, 1974; Kottow, 1980) and multiple meanings have caused gaps, conflicting priorities in programs and confusion for the consumer (Keller, 1981).

The epistemological assumptions in many definitions of health have been analyzed to clarify the differences in meaning. Blum (Schelenger, 1976) has identified seven major perspectives inherent in definitions of health.

- The medical perspective, focussing on the detection and alleviation of disease.
- The public health perspective, focussing on the prevention of disease, rather than curing the disease.
- The humanitarian perspective, in which man and his optimal well-being are of primary importance.
- The economic perspective, of which the prime aim is to reduce productivity losses.
- An adaptive perspective, or the optimal fit of man to the environment.
- A philosophic view, or the realization and attainment of maximal potential.
- The ecological perspective, or the interaction of man and the environmental ecosystem.

There are also different components of the concept of health. For example, Boorse's (1977) definition suggests that health may be considered a physical state: "Health is a biological function and statistical normalcy." Others may consider health to be a physiological and psychological concept. The World Health Organization's 1947 definition fits into the last group: "Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity." Occasionally spiritual health is added to these domains: "Health is man's best physical, mental and spiritual expression in building an efficient society" (Goodrich, 1932).

The method by which health is attained is also reflected within definitions of health. For example, Illich (1976) stated that health is a personal task, which results "from self-awareness, self-discipline and inner

resources. . . ." As well as individual responsibility, he noted that health is also a relative state, culturally defined and varying according to the belief systems between cultures.

Fox (1977) noted that the notion of "quality of life" is often used synonymously with health. This practice enables the political correction of societal injustices by the justification of therapeutic rather than punitive measures. Thus, health is viewed as an "ideal" societal state beyond the direct control of the individual.

Finally, health may be regarded as a holistic, inclusive state within a domain so vast that the individual responsibility for health is minimized or removed. Knight (1974, p. 247) defined health as "harmonious integration of the person within himself and within his society, nature and cosmos." This concept of health makes it a state largely endowed upon the passive individual depending on his or her position in this vast realm.

Many authors have noted that a discussion on health inevitably involves a discussion of illness and disease. Noting the discrepancy between the scientific or the objective (i.e., etic) and lay or subjective (i.e., the emic) definitions of health, Tripp-Reimer (1984) presented a model that accommodates both the etic and emic perspectives on disease – non-disease and wellness – illness dimensions. The model contains quadrants. Two of the quadrants are agreements between the provider and the client (self-report of health and absence of pathology, or illness and pathology), and the other two quadrants are discrepancies between the provider and the client (i.e., illness and absence of pathology, or pathology and absence of illness).

Few researchers have examined correlates of perceived health status among lay persons. In 1961, Baumann examined conceptions of health among patients (again a population without health) and medical students. She found that their definitions of health fell into three categories: (1) a feeling state orientation, or a general feeling of well-being; (2) a symptom orientation, or the absence of symptoms or illness; and (3) a performance orientation, or the attainment of a competent level of physical fitness. Most importantly, she noted relationships between educational levels and the orientation to health in subjects of different socioeconomic status.

In a study of the elderly, Maddox (1962) noted that perceived health status was correlated with low morale, and health was considered less positively among persons with a history of depression. Tessler and Mechanic (1978), in a large survey in 1978, found that psychological distress was a statistically significant correlate with perceived health status. The greater the subjects' psychological distress, the poorer the subjects rated their health.

From the previous studies it is noted that although important relationships concerning health have been identified using lay persons as subjects, many questions remain unanswered. Idler (1979) has also noted the dearth of literature in this area and recommends the importance of using laity as subjects because this strategy ensures the research will "remain relevant to social reality."

Research Setting

This research was conducted in a neighbourhood on the periphery of newly constructed downtown high-rises in the centre of a large northern Canadian city. This area is an older part of the city, consisting of single family dwellings, boarding houses, bars and small stores. Many of these are decaying, with some buildings condemned or recently replaced with high-rise apartments or light industry. The area is inhabited largely by elderly long-term residents of Ukrainian or British descent, by middle-aged single males (who reside in boarding houses), retired from or between casual jobs in northern Canada and by Native Indians. The area also includes a large Italian and Chinese district and many recent refugees from Indochina and Europe. The population is older than the city average and much below the mean socioeconomic level. The presence of transients with no fixed address, of conspicuous prostitutes and of drunks in the street has resulted in the labelling and stigmatizing of the area as "skid row."

The area has been recognized for a number of years as a "health problem" area that is under-served by physicians. In 1979, a community-based health care clinic was opened, and the current research project was organized at the request and sponsorship of this clinic. The overall purpose of the research was to understand the community health needs from the people's perspective so that a health promotion program based on the concept of neighbourhood health workers (as presently used in Third World countries) could be implemented. This article reports on a part of this project: the perceptions of health in the community. Some of the questions asked to elicit this information were: What does good health mean to you? How do you know when you are healthy? and, What do you do to stay, or to become, healthy?

Method

As the review of the literature revealed little information regarding lay perceptions of health, inductive qualitative methods were considered most appropriate (Buzzard, 1984). Open-ended unstructured interviews would enable responses to be obtained with minimal imposition of an *a priori* framework. This approach differs from quantitative survey techniques in which the researcher constructs a conceptual framework, identifies the significant variables prior to the collection of data and then measures the distribution of these identified health beliefs in the population.

Data for this project were collected by three lay community members. The interviewers spent the first two weeks of the project in a training program which included instruction in basic interviewing and observational techniques, introduction to the theories of illness, traditional medicine, health behaviours and the process, problems and ethics of field work. Provided the informant consented, interviews were tape recorded, and the interviewers also recorded observations and their more subjective impressions in a diary.

Theories of illness causation include categorization of etiology of illness into supernatural, non-supernatural, ultimate and immediate causes (Morley, 1978, p. 2), and this orientation was important to inform the interviewees that we were not only interested in the "correct" medically recognized causes of illness.

The use of trained community members has been used previously to interview informants. Nichter (1984) noted that the use of a participatory research team is the first step towards community involvement. Furthermore, the use of open-ended interviews reduces the distortion of survey data resulting from "errors in the linguistic and conceptual intelligibility of survey questions, interview questions involving culturally sensitive subjects, informants' fears of repercussions for responding negatively to questions posed by outsiders, the dynamics of image management, etc." (p. 238).

The transient nature of the population and the attitude of suspicion towards researchers indicated that snowball sampling techniques would be most appropriate. Initial interviews were conducted with persons who already had a trust relationship with clinic personnel. At the conclusion of these interviews, those subjects were asked to refer the interviewer to another informant. Thus, social networks were followed, rather than selecting a probability sample.

It was intended that two (or more) interviews would be conducted with each informant. The purpose of the first interview was to establish a trust relationship with the subject, to obtain demographic information and a life history and to allow the subject to become accustomed to the interview procedure and the tape recorder. The second interview was conducted to obtain information about perceptions of health and use of the health care system. If the informant was a transient and only one interview was possible, the content of the two interviews was combined. Interviews were conducted with a total of 93 persons (47 male and 46 female) in a high-rise apartment building for the elderly, in a male transients' shelter, in a day shelter for women, in private residences and on the street. Forty-nine informants were aged between 20 and 59 years, and 44 were 60-89 years.

Eighteen informants were Native Indian, 26 identified themselves as Anglo-Canadian, five were French Canadian and the remainder were of European ethnic origins. Approximately half of the sample had less than grade eight education, and six people had some university education. Most of the informants who were employed worked in non-professional occupations; 15 were retired and 15 were unemployed.

Data analysis

All interviews were transcribed and coded according to common characteristics. Content analysis was performed according to the rules of parsimony, with the data sorted initially into broad themes and then coded into smaller categories (Field & Morse, 1985). The categories were then described, labelled and relationships between the categories were explored.

Results

The first categorization of responses was into three groups: those responses that attributed health to both physical and mental parameters, those that denoted health was either physical or mental dimensions and those that stated that the physical and mental parameters of health were separate (see Figure 1).

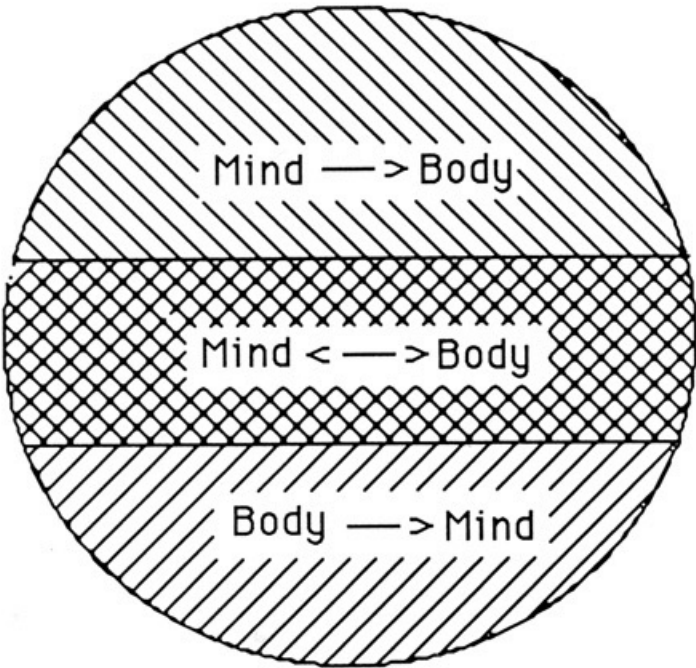


Figure 1: Holistic Concept of Health: Interaction Model

The inclusive (holistic) perception of health

I think health is a total picture of a person. It's not just a physical thing. I think it's the whole package.

Health... is not just physical health – but mental and spiritual health as well... the whole person is what health is about.

These were typical statements of those who presented a holistic (mind and body) definition of health. However, there was agreement concerning the interaction between the mind and the body. Many informants suggested time-sequence and conditional relationship between the mind and the body. For example, some stated if the mind was healthy, then the body would be healthy, and others suggested the reverse.

The first group suggested that mental health was the most important aspect and that physical health was not possible without it. That is, the mind affects the body:

All the body depends on your brain... with a healthy mind... the remaining part of the body will be healthy.

If you want to do something, you forget you are sick. Sickness, troubles, ... you have to forget all that.

Your mental health is how you think. I guess if your mental health got dragged down, then your physical, in turn would get dragged down, too... and if your mental health is good, then your physical health is good too.

Lack of health was seen by this group as failure of the "mind over matter":

No-good [sic] health is when you'd be preoccupied with headache or toothache.

You can depress yourself into a sickness.

Now he does not go to doctors but is able to control his health by his own mind. When he's feeling bad he does not take pills, but tries to relax, take a good rest, and re-think his life in his mind [interviewer's notes].

The second group suggested a reverse interaction, that physical health is essential for mental health:

If I don't have pain, I feel real happy.

Feeling good depends on how my back and legs feel.

Furthermore, physical comforts may be used to reduce psychological distress. Eating was most commonly mentioned:

When she gets under stress, she eats.

I know when I'm depressed, I pig-out a lot. I could eat two boxes of chips – I eat like a pig!

Only a few respondents suggested this interaction could go either way; that the mind or the body could be the determinant of health:

If you're physically ill, it will lead to emotional illness...if you are emotionally ill, it can lead to physical illness...they're related.

Separate (mind-body) perception of health

Many informants did not suggest an interaction between physical and mental health. They stated that these two components were separate, or they cited only physical or only mental indicators of health.

Physical health.: Health within this category consists of many components. The first is environment, or perhaps the ecological perspective. Health is derived from having a warm, clean place to live, fresh air, sunshine and "good", clean water to drink. An elderly man in a high-rise apartment said, "You need lots of fresh air, but we don't get much, anymore."

The second aspect is nutrition. Some informants suggested that "health was the ability to eat." In these cases, health was measured by whether or not they were able to eat food. This was not surprising as some of the people interviewed were alcoholics or elderly, frail folk.

Discriminative eating also contributed to health. This was avoiding junk foods and by eating wholesome foods: "Health is eating wholesome." Informants reported that food should be fresh and preferably organically grown. Store-bought or canned foods were considered to be low in vitamins or even poisonous. Food also had to be in the right quantity – plentiful enough and yet overeating was to be avoided. Vitamin and herbal supplements are included in the nutrition category because they were used as a food or a food-substitute.

The third aspect, sleep, was interesting as it was considered to be both necessary for health and an indicator of good health. In other words, if you are able to sleep, then you are healthy; and, if you are healthy, then you are able to sleep. Again, the quality of sleep was important.

It's not the length of the sleep that counts, but the depth of sleep... some people can sleep for twelve hours, another one can sleep for six hours. That very deep sleep for six hours is better than twelve hours.

The fourth component was physical control, which was discussed on four levels: mobility, work, walking and exercise. The first, mobility, is simply the ability to move around. Being able to perform normal activities of daily living was perceived as an indicator of health.

Well, I can't describe it [being healthy] because I haven't got it, but the [healthy] person can get around by himself. . . do everything himself!

The next level, work, is both an indicator of health and necessary to maintain health. As an indicator, informants reported.

Health is being able to work every day, and make a proper living for myself.

Work is described as a way to maintain health.

When people work – not laze around – work is healthy... work is good for people.

The remaining two types, walking, and exercising, are ways informants used to remain or become physically fit – a condition equated with good health.

My mother is in the nursing home – I walk there and back – and I find that keeps me healthy. I don't know why.

Walking keeps my blood circulating a little better, you know. And it keeps this arthritis out of my system – the pains... you're loosening up your muscles beyond the control of arthritis.

Every week... I went to the stadium and did weight-lifting – really stressed my body – really fully worked out. And sometimes I went swimming.

The last category in physical health was absence of disease. Informants stated:

I tell you, when you're healthy, you're not sick!

Only one informant suggested that it was necessary to have a check-up to make sure you're not sick, implicitly differentiating between disease and illness.

Psychological (mental) health: Health perceptions in this group could be sorted into six domains: energy, the ability to cope, control of the body, religion, spiritual health and happiness. The first, labelled "energy", is described differently from the energy derived from exercise. It is the energy to care for and to feel for oneself:

Health is keeping us lively, eh?

Well, being healthy to me, is I can always do everything I want in the world.

Closely allied to energy is the ability to cope, to psychologically handle day-to-day stressors. It was expressed as "coping with life":

Good health is when you don't have to worry about your health... Your state of health doesn't hinder the things you wanna do.

A healthy lifestyle was described as control, the adoption of religion and good interpersonal relationships. Control of the body was essential for health because lack of control, especially towards gambling and alcohol, was perceived as a threat to health:

I went through quite a life over gambling... like if a person can't control themselves, then it's a sickness.

A large number of informants reported on religious and spiritual health, which was sometimes differentiated from "emotional" health. Praying was perceived to be healthy, and religion was seen as a way to obtain health.

I found myself – I found my way of religion, my way of living. I felt better – you start looking after yourself.

Love and close and harmonious relationships with others was also important.

Good health is being able to have a relationship with people.

With health, you've gotta have love, you gotta love one another more – get more love in the family.

One foster mother explained the consequences of children not being loved:

Oh sure, that's related to health! If you don't love 'em [kids] they think nobody wants them, eh? They go in the corner, sit down there... they just worry and what they do is just pee in bed.

The last aspect of health in this category is happiness. This was both seen as the outcome and an indicator of health, for example, "if you are healthy then you are happy."

I'm very happy when I'm healthy... you're happy, you're healthy, nothing bothers a person.

In summary, the components of the psychological definition of health were: energy, coping, control of the body, spiritual love and happiness.

Discussion

From the preceding analysis, it is evident that health is a multifaceted and expansive concept. In this study the lay concept of health consists of both criteria traditionally used to measure health and health promotion strategies. Van der Geest (1985) noted that this "second hand" use of the term healthy (as it applied to healthy air, healthy food and so forth) is derived from the relationship between the physical state and dependences on the environment to achieve or maintain that state.

In 1981, Keller examined 42 professional definitions of health. Content analysis was performed on these definitions (Keller, 1981). Keller's categories were not used for this analysis because using *a priori* categories violates inductive approaches where such categories must be derived from data. However, a comparison with Keller's categories (Table 1) shows that professional perceptions of health and lay perceptions of health contain commonalities within broad biological-psychological-holistic dimensions.

Aspects of physical health not specifically included in the professionals' definitions were nutrition, sleep, exercise and work. Although these may be argued as being a means to an end, they were presented by lay informants as an indicator or state of health. Heredity and adaptation are two concepts in the professional definitions that were not included in the lay definitions:

The whole person is what health is about. I'm not sure if I think a good doctor will acknowledge that, you know. I don't expect the doctor to be a spiritual adviser or a counsellor... [But] I think any health professional should understand these elements of health are very important.

Table 1***Comparison of Professional and Lay Definitions of Health***

Components of Health	
Professional	Lay
Physical/Biological	Physical
Heredity	—
Adaptation	—
—	Nutrition
—	Sleep
Opposite of (or Freedom from) Disease	Not Being Sick
Daily Living/Activity	Ability to Move Around
	Working
	Walking
	Exercise
Holistic	Holistic
Emotional/Psychological	Psychological (Mental)
Cultural	—
Integrated Functioning	Energy
Optimal Capacity	Coping
Spiritual Spiritual	
Harmony	—
Social	Love
Self-knowledge	—
Self-realization	Happiness

¹ From Keller (1981)

Identifying relationships

In this study, emic analysis of the informants' perspectives on health provided a mechanism for obtaining the beginning stages of a health model. In addition to clarifying the dimensions of health, a hypothesis arising from these data was tested. The question is: "Is one's perception of health derived from past and/or present health status?" The hypothesis tested was: "Subjects who define health in physiological parameters are experiencing chronic or acute life-threatening illnesses or diseases." Conversely, "subjects who define health in psychological, mental health parameters are those who report that they "feel good" and do not have acute/chronic illnesses.

The hypothesis was accepted and is statistically significant ($\chi^2 = 9.905$, $df = 1$, $p < .005$), showing that there is a relationship between one's definition, or perception, of health and one's own health status.

Suggestions for further research

It is important to note, however, that these data do not show the time relationship between the individual's perception of health and health status. For example, it is not known if the individuals using a psychological, mental health definition of health will change to a physical definition if and when they become sick. Furthermore, it is not possible, from these data, to derive gradations of perceptions of health and correlate these scores with a gradation of perceived and real health status. It is recommended that a quantitative survey be conducted using a probability sample to test important insights into the relationships suggested in this study.

Another question to be examined in future research is: Is there a relationship between a person's perception of health and health care-seeking behaviours? For example, are those subscribing to a physical model of health more likely to utilize the medical system and display patterns of early utilization and compliance with treatment than those who view health as a psychological state? Is there a relationship between those persons using a psychological model and individual coping, religion, home remedies, support networks and the timing of entry into the health care system? And do those persons who believe in the holistic model utilize both systems, selectively choosing from each depending on needs?

Further research, both longitudinal and survey studies, will be needed to test these questions. However, the beginning plan of this research and the development of these questions would not have been possible without this initial qualitative work.

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RÉSUMÉ

L'idée que les residents de quartiers pauvres des villes se fait de la santé

Les données de santé obtenues de 96 résidents de quartiers pauvres des villes ont été analysées par des méthodes anthropologiques. Les renseignements recueillis démontrent que les personnes interrogées considèrent la santé comme un concept complet physique et mental ou bien un concept uniquement psychologique ou uniquement physique.

Parmi ceux qui ont donné un rapport sur la définition totale les uns suggèrent que l'esprit influence le corps alors que les autres suggèrent une interaction contraire. De ceux qui optent pour une définition distincte de l'esprit et du corps la différence majeure est la présence de maladie chronique ou maladie grave du sujet. Les handicapés par exemple offrent une définition physique ("corps") alors que les personnes en bonne santé suggèrent une définition psychologique de santé mentale (esprit). Ce classement offre une statistique significative ($\chi^2 = 9.905$, $df = 1$, $p < .005$). Cette recherche démontre qu'il y a relation entre l'idée qu'on se fait de la santé et son propre bien être.