DEBATE

Towards a relational health promotion

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SUMMARY
The Ottawa Charter for Health Promotion exhibits a substantialist approach to the agency-structure dichotomy. From a substantialist point of view, both individual agency and social structure come preformed and subsequently relate to and influence one another, starkly positioning the choices made by individuals against the structured sets of opportunities and constraints in reference to which choices are made. From a relational perspective, however, relations between elements, not the elements themselves, are the primary ontological focus. We advocate for a relational approach to the structure–agency dichotomy, one that locates both agency and structure in social relations and thereby dissolves the stark distinction between them, suggesting that relational theories can provide useful insights into how and why people ‘choose’ to engage in health-related behaviours. Pierre Bourdieu’s theory of practice, predicated upon the notions of field, capital and habitus, is exemplary in this regard.

Key words: structure–agency; substantialism; relationalism; Ottawa Charter

INTRODUCTION
Investigating the nature of health inequities is central to both of our research programs, and we enthusiastically support the notion of implementing policies and interventions intended to ameliorate them. You would think, then, that the quasi-discipline of health promotion to which we have recently been introduced is the perfect home for us. The participants at the conference that produced the Ottawa Charter for Health Promotion pledged ‘to respond to the health gap within and between societies’. We support this goal. Towards ameliorating said health inequities, the Ottawa Charter states that ‘health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. […] Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change’. All of this makes good sense to us—clearly multiple sectors of society must be targeted and diverse tools must be wielded in efforts to reduce persistent health inequities. But the seemingly inescapable joining of scholars and discipline has been thwarted in this instance, primarily because of a mismatch between the conceptions of individual agency and social structure central to the vision for health promotion presented in the Charter, an approach apparently rooted in ‘substantialism’, and our own emerging understanding of the interdependence of agency and structure, a perspective rooted in ‘relationalism’.

We have elsewhere discussed the distinction between substantialism and relationalism in regards to theorizing health practices (Veenstra and Burnett, 2014). Briefly, the substantialist perspective ‘takes as its point of departure the notion that it is substances of various kinds (things, beings, essences) that constitute the fundamental
units of all inquiry. Systematic analysis is to begin with these self-subsistent entities, which come “preformed,” and only then to consider the dynamic flows in which they subsequently involve themselves’ [(Emirbayer, 1997), pp. 282–283], italics in the original]. Substantialism presupposes that elements (e.g. individuals) are self-subsistent entities that can be examined independently of their relationships to other elements. From this point of view, agency ‘is commonly identified with the self-actional notion of “human will,” as a property or vital principle that “breathes life” into passive, inert substances (individuals or groups) that otherwise would remain perpetually at rest’ [(Emirbayer, 1997), p. 294]. Structure in turn is an ‘autonomous, internally organized, self-sustaining system’ [(Emirbayer, 1997), p. 294] that is distinct from individual agency, influencing it from outside or above. From a substantialist perspective, structure and agency, preformed and distinctive, are made of very different ‘stuff’.

In our reading, the vision for health promotion presented in the Ottawa Charter adopts a substantialist approach to agency and structure (see Rütten and Gelius (Rütten and Gelius, 2011) for additional insight into the Ottawa Charter’s depiction of structure and agency). For instance, the Charter claims that health promotion ‘increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health’. In other words, health promotion seeks to widen the range of opportunities available to people, to enhance their life chances, by making available health-enhancing options for action that did not exist previously. This approach starkly positions the choices made by individuals against the structured sets of opportunities and constraints in reference to which choices are made. In this vein, Max Weber’s theory of lifestyles has clearly been useful for health promotion scholars seeking to understand how and why people choose to engage in health-related practices (Abel, 1991; Cockerham et al., 1997; Frohlich et al., 2001; Cockerham, 2005, 2007; Abel and Frohlich, 2012). For Weber, lifestyles (Lebensstil) are ways of life created in the interplay between life choices (Lebensführung) and life chances (Lebenschancen) (Weber, 1978; Abel and Cockerham, 1993). From this perspective, the actions chosen by people are informed and guided by the nature of the opportunities available to them. Life chances are what they are and, in light of a prescribed range of opportunities or possibilities, a choice ‘breathes life’ into an individual and sets her or him upon the chosen path of action. Weber’s theory of lifestyles, intrinsically dualistic in nature, is consistent with a health promotion that understands action as the result of individual assessments of available options and choices made in light of them.

Weber’s depiction of lifestyles does not, however, explicitly accommodate the possibility of structural change brought about by the Lebensführung implemented by individuals, something that is obviously of central importance to a health promotion that seeks to help people exercise more control over their environments. Rütten and Gelius (Rütten and Gelius, 2011) note that ‘any theory of health promotion that does not include a concept of change is rather limited in its explanatory power’ (p. 954; italics in the original). Accordingly, Abel and Frohlich (Abel and Frohlich, 2012) advocate targeting ‘structurally transformative agency’ in health promotion theory and practice. In light of a mandate to identify and foster individual agency that can effect positive structural change, various health promotion scholars have promoted theory and research on health practices (e.g. Ecological Systems Theory) that accommodate a recursive and codependent dynamic between agency and structure. ‘Structure is not possible without action because action reproduces structure. Action is not possible without structure because action begins with a given structure that was the result of prior actions’ [(Frohlich et al., 2001), p. 768]. Importantly, aspects of the vision for health promotion presented in the Ottawa Charter are consistent with a dynamic, recursive relationship between agency and structure. The Charter tells us, for example, that ‘[h]ealth promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.’ That is to say, individual agency is constrained and enabled by structure but can also change structure.

In short, the health promotion of the Ottawa Charter seeks to empower agents to enact the kind of structural change that will subsequently increase the likelihood that health-enhancing options can, and hopefully will, be chosen by the people who are constrained or enabled by the (new) structure. This vision for health promotion
is, we think, perfectly undergirded by a theoretical depiction of a dynamic, recursive, codependent relationship between agency and structure. A framework of this kind transcends simplistic schemes focused on individual choices and actions that seemingly take place without reference to social structures (e.g. health belief model, theory of reasoned action, theory of planned behaviour, transtheoretical model and precaution adoption process model) and also objectivist schemes that overly privilege the effects of structure at the expense of individual agency ‘on the ground’ (e.g. early research on the ‘structure’ of lifestyles). In other words, it avoids what Margaret Archer (Archer, 1995) calls the fallacies of *downwards conflation* (denying causal efficacy to individual agency) and *upwards conflation* (denying causal efficacy to social structure). A recursive framework also transcends static depictions of the interplay between agency and structure that disregard process and accordingly de-emphasize the possibility of structural change (e.g. social cognitive theory and self-determination theory). This recursive vision for health promotion, multifaceted and processual, is also inherently substantialist in nature, predicated upon a dualistic visioning of individual agency and social structure that are sharply distinguished from one another.

Influenced by the ‘relational turn’ in sociology (Emirbayer, 1997; Martin, 2003; Crossley, 2010; Mische, 2011; Dépelteau and Powell, 2013), we have come to believe that a relational approach to agency and structure could contribute useful insights into how and why people ‘choose’ to engage in health-related behaviours. From a relational point of view, ‘the very terms or units involved in a transaction derive their meaning, significance, and identity from the (changing) functional roles they play within that transaction. The latter, [...] a dynamic, unfolding process, becomes the primary unit of analysis’ [(Emirbayer, 1997), p. 287]. That is to say, relations between and among elements, not the elements themselves, are the ‘realest of the real’ from a relational perspective. In regards to structure, Karl Marx, an inherently relational thinker, claimed that ‘society does not consist of individuals, but expresses the sum of interrelations, the relations within which these individuals stand’ [(Marx, 1973), p. 264–265]. For Margaret Somers (Somers, 1994), structure is ‘a patterned matrix of institutional relationships among cultural, economic, social, and political practices’ (p. 72). From a relational perspective, social structure is fundamentally composed of social relations.

In regards to agency, ‘the relational, field-theoretic point of view sees agency as inseparable from the unfolding dynamics of situations [...], much like an on-going conversation’ [(Emirbayer, 1997), p. 294]. ‘In relational terms, agency is not ‘held’ within the minds, bodies or selves of individuals but instead inheres in relations between individuals within spatial contexts’ [(Veenstra and Burnett, 2014), p. 190]. Agency centres ‘around the engagement (and disengagement) by actors of the different contextual environments that constitute their own structured yet flexible social universes [...] Just as consciousness is always consciousness of something [...] so too is agency always agency toward something, by means of which actors enter into relationship with surrounding persons, places, meanings, and events’ [(Emirbayer and Mische, 1998), p. 973]. Agency is never ‘free’ of structure (Emirbayer and Mische, 1998). Indeed, one could even argue that agency and structure are to a degree composed of the same ‘stuff’. In other words, we advocate committing what Archer (Archer, 1995) calls the fallacy of *central conflation* (where agency and structure are not sufficiently distinct from one another). A relational understanding of agency as thoroughly intersubjective in nature is clearly incompatible with the substantialist depiction of individual agency as something which is fundamentally distinct from structure.

We submit that frameworks utilizing relational ontologies and epistemologies may be better equipped than substantialist ones to explain how and why people ‘choose’ to engage in health-related ‘behaviours’. The practice theory of Pierre Bourdieu, predicated upon the notions of field, capital and habitus, is exemplary in this regard. For Bourdieu, the notion of an overarching ‘society’ is replaced by the notion of multiple fields, the latter “an ensemble of relatively autonomous spheres of “play” that cannot be collapsed under an overall societal logic” [(Bourdieu and Wacquant, 1992), p. 16–17]. Fields, inherently relational in nature, are the primary structural contexts within which practices, including health-related practices, attain their logics. A field is a configuration of objective relations between positions, a space of ‘distinct and coexisting positions which are exterior to one another and which are defined in relation to one another through relations of proximity, vicinity, or distance, as well as through order relations, such as above, below,
and between’ [(Bourdieu, 1996), p. 11]; italics in the original]. It is a distinct social microcosm endowed with its own ‘rules, regularities, and forms of authority’ [(Wacquant, 1998), p. 7]. Penetrating all domains of social life, Bourdieu identified a wide array of fields in France, including the scientific field, the literary field, the religious field, the juridical field, the political field, the field of journalism, the field of painting, the field of the institutions of higher education, the field of comic strips, the field of pop art and the field of contemporary physics, among others.

For each position or class of positions in a field, there is a habitus, ‘this generative and unifying principle which retranslates the intrinsic and relational characteristics of a position into a unitary lifestyle, that is, a unitary set of choices or persons, goods, practices’ [(Bourdieu, 1998), p. 8]. That is to say, habitus is the mechanism by which a homology, a kind of isomorphic relation or one-to-one correspondence, between the structure of positions and the structure of practices in a field is established. ‘But habitus are also classificatory schemes, principles of classification, principles of vision and division, different tastes. They make distinctions between what is good and what is bad, between what is right and what is wrong, between what is distinguished and what is vulgar, and so forth’ [(Bourdieu, 1998), p. 8]. In other words, habitus comprises deeply held tastes, dispositions and inclinations developed via processes of socialization in fields, ‘a set of historical relations “deposited” within individual bodies in the form of mental and corporeal schemata of perception, appreciation, and action’ [(Bourdieu and Wacquant, 1992), p. 16]. It is infused and embodied in the individual self but is not itself the ‘source’ or ‘essence’ of individual agency. Rather, agency arises in practices that emerge in the interplay between field, capitals and habitus.

Although other scholars within and outside of health promotion have found Bourdieu’s theory of practice unsympathetic towards the possibility of social change (Lash, 1993; Williams, 1995; Abel and Frohlich, 2012), we suggest that his relational framework of fields, capitals and habitus can accommodate change, albeit perhaps not as straightforwardly as health promotion researchers and practitioners would wish. On the one hand, the fields themselves ‘arise, grow, change shape, and sometimes wane or perish over time’ [(Wacquant, 1998), p. 8]. For instance, the parameters of fields are frequently under challenge and their boundaries are often in a state of flux (e.g. when disciplinary boundaries in universities change or dissolve over time). Fields can lose their internal coherence and splinter into new fields (e.g. the growing gap between the disciplines of sociology and anthropology) or join to form new fields (e.g. the recent development of disciplines such as gender and women’s studies). The capitals at stake in fields are also frequently contested, and new sets of capitals can emerge as ultimately important in a field thereby changing the nature of its constitution from within. In short, fields are dynamic, fluid and changeable.

Within fields, attention to harmony or disharmony between habitus, capitals and fields ‘allows us to elucidate cases of reproduction—when social and mental structures are in agreement and reinforce each other—as well as transformation—when discordances arise between habitus and field—leading to innovation, crisis, and structural change’ [(Wacquant, 1998), p. 9]. A relational approach sees opportunities for social change in the relationships formed between people, places, spaces, histories, dispositions, beliefs, meanings and events. In contrast with substantialist approaches that seek to effect change through direct modification of ‘elements’ causally related to health, a relational approach proposes that social change can be fostered in relations of harmony or disharmony between the social constitutions of agents (their habitus), the make up of the spaces within which they operate (fields) and the capitals that inform and enforce the mores and regularities of the fields.

In conclusion, we find the health promotion of the Ottawa Charter to be inherently substantialist in its depiction of agency, structure and the interplay between them. This effectively means that the multitude of relational ideas and frameworks in sociology, including those of Pierre Bourdieu, are not fully accessible to this manifestation of health promotion. While we do not know just what a relational approach to health promotion would or should look like in a re-envisioned Charter, we find promise in the utility of the conceptual triad of fields, capitals and habitus to aid in thinking relationally about health practices and social change (also see Williams, 1995; Nettleton and Green, 2014; Veenstra and Burnett, 2014). By mandating a substantialist visioning of agency and structure, the health promotion of the Ottawa Charter has effectively shut itself off to some of the more thrilling sociological theory initiatives of the last century. Embracing the relational turn in
sociology could, we think, enhance the ability of health promotion researchers and practitioners to illuminate the logics of health-related practices and devise ways in which to promote healthful social change.

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REFERENCES


