The importance of social science theory in guiding population health research: A program of research on social inequalities in smoking

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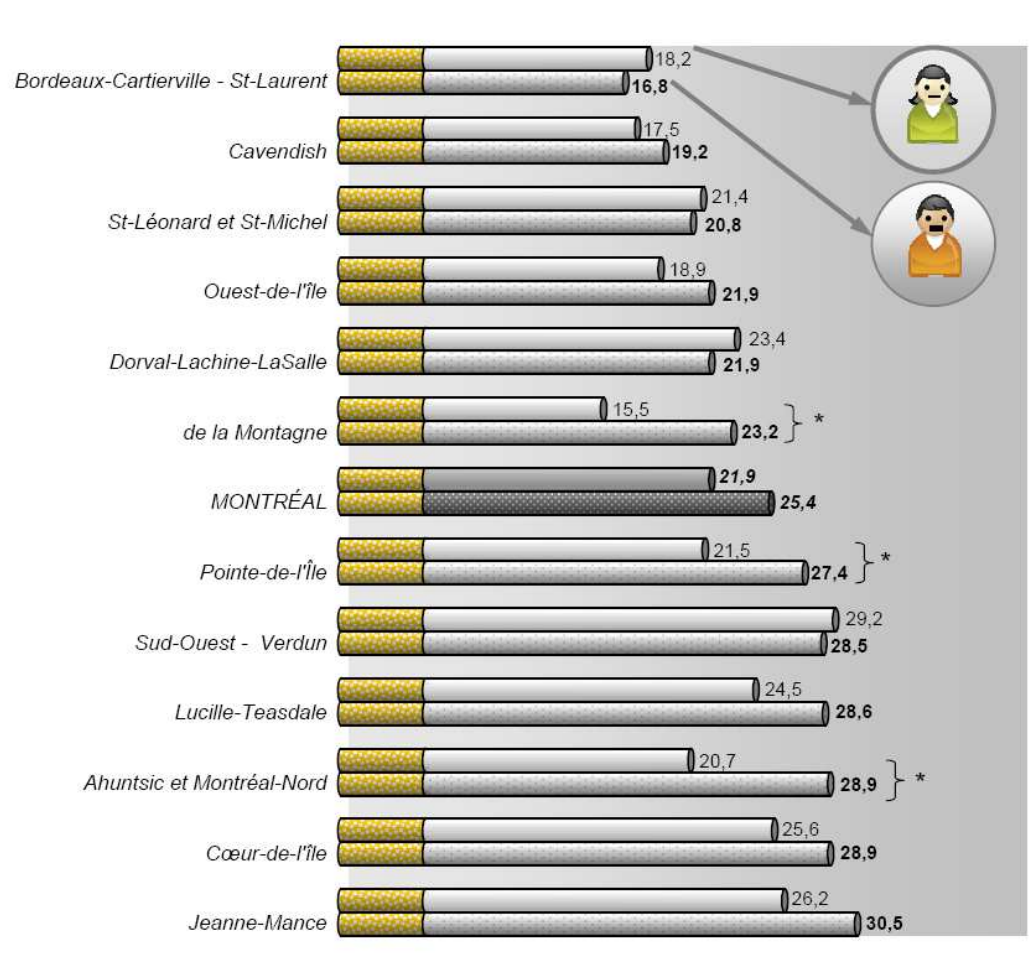
Some quintessential questions for public/population health

1. **How do we know what to intervene on?** (Moving beyond individual, behavioural risk-factor models)
   - **The etiological side**
2. How can we reduce the unintended effects of our population health interventions?
   - The intervention side

1. How do we know what to intervene on?

- **Social inequalities in health outcomes.**
- Something other than the material/behavioural dichotomy inherited from the Black Report.
- Both the social structure and individual agency in relation to social inequalities in health (Pierre Bourdieu, Anthony Giddens).

Proportion of smokers, men/women per CSSS, Montréal, 2002-2007



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My answer: The local production of social inequalities in smoking

- A multitude of studies have empirically demonstrated social inequalities in smoking based on place of residence.
- There are numerous hypotheses regarding the reasons for these inequalities.
- There is confusion regarding compositional and contextual explanations for these social inequalities in smoking.
- We do not yet understand *how* neighbourhoods create social inequalities in smoking.

The general hypotheses of the framework

- At the individual level, smoking is the cumulative result of multiple processes that involve the individual in relation with his/her environment: social inequalities in smoking are socially produced.
- The role of contextual factors in explaining social inequalities in health is not limited to the residual variance left over after having controlled for compositional factors: the composition and context are in interaction with one another.

How do we define neighbourhood?

- More than a unit of analysis.
- A unique system of resources and social relations, relating to health, based on geographic regions.
- A network of spatial distribution through which resources are put at the disposal (or not) of people to produce health (or illness).

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Pierre Bourdieu and « La théorie de la pratique »

- Capitals explain the basis of social inequality.
- Makes the link between how social relations, through power, ascribe certain lifestyles and lead to social inequalities and potentially inequalities in health.
- *Habitus* : "a socialized body, a structured body… a system that is socially constituted of structured and structuring dispositions that are learned through practice".

Structuration Theory – Anthony Giddens

- Neither entirely structuralist nor voluntarist: seeks out configurations of social relations that move people to act in ways that produce the effects we observe. Practices emerge from structure, reproduce structure and can transform structure.
- Social structure : "The rules and resources in society."
- Social practices : "The activities that make and transform the world we live in."
- Agency : "The ability for people to deploy a range of causal powers."

What do we mean by unequal?

- Inequality of what? Structure, practices and agency. Issues of accessibility (constraints and opportunities – A. Giddens)
- *How* do capitals (P. Bourdieu) and resources influence social inequalities in health, not just *which* capitals and resources influence social inequalities in health.
- Most empirical research on health inequalities puts too much emphasis on the redistribution of goods and not enough on what people are actually able to do with these goods – capability (A. Sen)

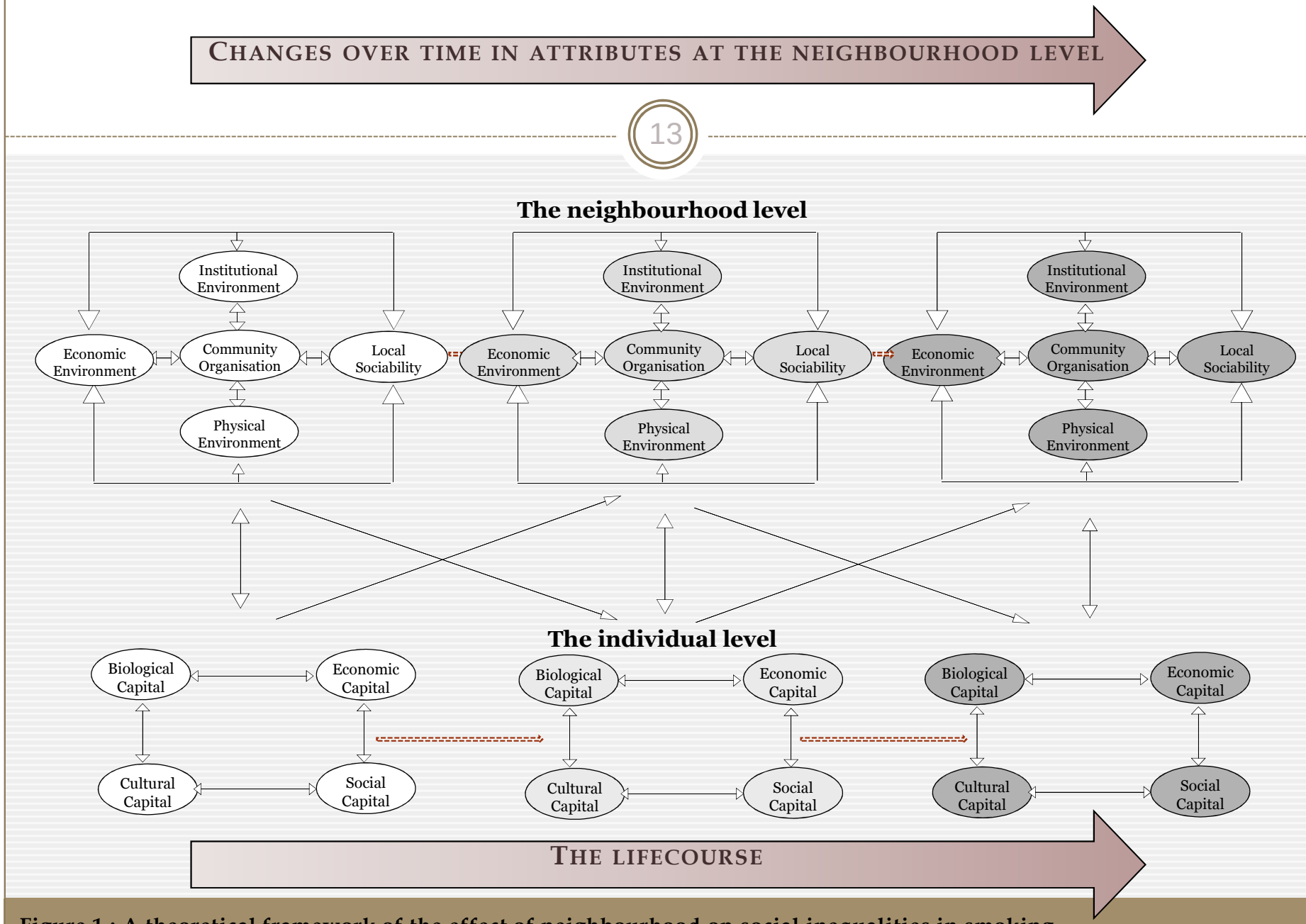
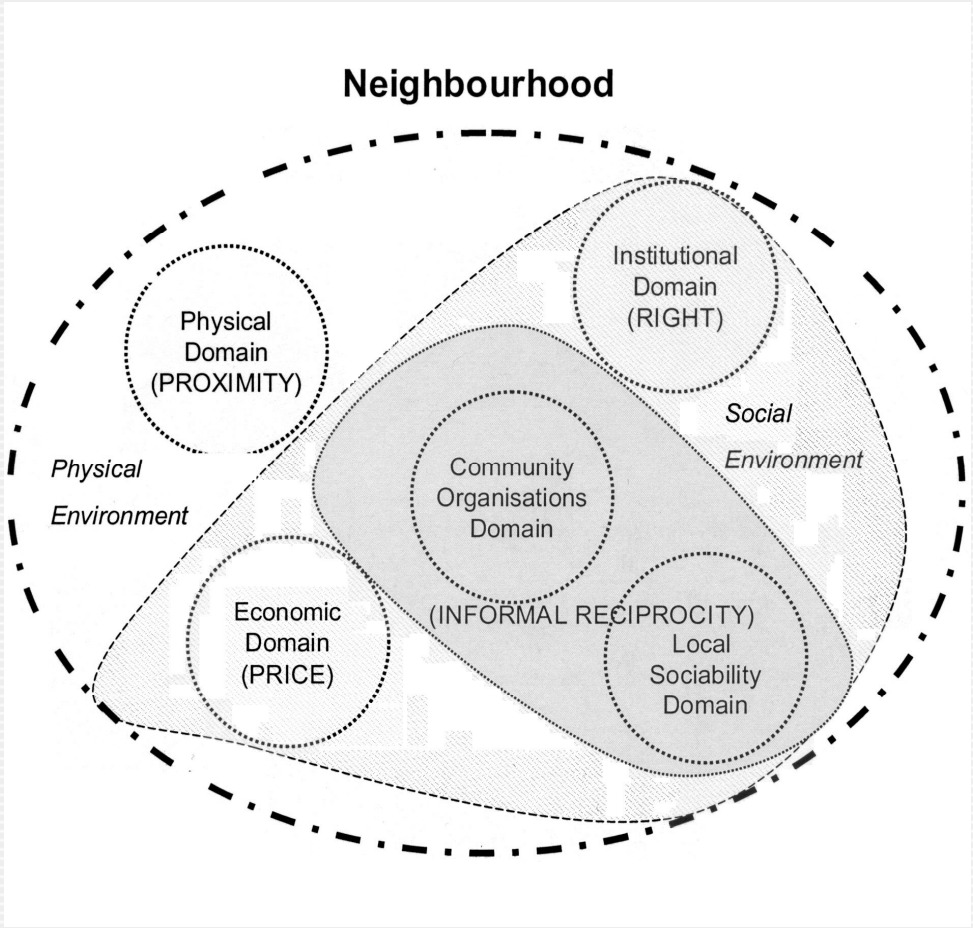


Figure 1 : A theoretical framework of the effect of neighbourhood on social inequalities in smoking

Neighbourhood environments and rules of access (Bernard et al., SS&M, 2007)

Legend :

Four sets of rules (indicated in brackets) determine access to neighbourhood resources coming from the physical as well as from the social environment. The latter influence comprises four domains. Two of these domains (indicated by the dark shading) both obey the rule of informal reciprocity.



Last thoughts on the framework

- Social inequalities in health research focuses too much on the redistribution of primary goods rather than what people are able to do with these goods.
- We need to improve our understanding of the conditions that would permit people to better transform resources (and capitals) into improved health (Bernard et al., 2007).
- Individuals have capabilities, social classes have capitals, neighbourhoods have resources and opportunity structures.

The project (ISIS 2011-2015)

- 2 cohorts: 35 CLSC sectors. One cohort of 2098 18-25 year olds.
- 3 data bases: Individual-level questionnaire. Neighbourhood-level observation grid. Neighbourhood level administrative database (MEGAPHONE).
- Data waves every two years at individual level.
- Evaluate change in individual and eventually neighbourhood-level change over time.

2. How can we reduce the unintended effects of our interventions?

- **Empirical evidence of growing social inequalities in smoking based on socio-economic status.**
- Young adults in their early 20s have the highest smoking prevalence of all age-groups (smoking prevalence in Canada highest for people between the ages of 20-24; 28%).
- A questioning of the role that public health may be unknowingly playing in the deepening of social inequalities in youth smoking.

Inequalities in smoking as a function of education, Canadian men

Men	PR 1974	PR 1996	PR 2005	RCI* 1974	RCI* 1996	RCI* 2005	ACI 1974	ACI 1996	ACI 2005
Heavy smokers (>10)									
Less than secondary	*2.05*	*4.81*	*8.19*	***-7.93***	***-19.48***	***-26.90***	***-3.42***	***-4.40***	***-4.74***
Secondary	*1.69*	*3.10*	*4.57*						
Post-sec cert or dip	*1.50*	*2.90*	*3.98*	***(-8.7, -7.2)***	***(-22.5, -16.5)***	***(-28.5, -25.4)***	***(-3.7, -3.1)***	***(-5.4, -4.0)***	***(-4.7, -4.1)***
University degree	*1.00*	*1.00*	*1.00*						
Never smokers									
Less than secondary	*0.54*	*0.37*	*0.40*	***8.01***	***14.86***	***12.30***	***2.04***	***5.23***	***3.58***
Secondary	*0.65*	*0.61*	*0.64*						
Post-sec cert or dip	*0.70*	*0.62*	*0.68*	***(6.9, 9.1)***	***(12.7, 17.1)***	***(10.9,13.7)***	***(1.8, 2.3)***	***(4.5, 6.0)***	***(3.2, 4.0)***
University degree	*1.00*	*1.00*	*1.00*						
Former smokers (% of ever smokers)									
Less than secondary	*0.53*	*0.60*	*0.57*	***13.13***	***10.70***	***10.17***	***3.84***	***5.07***	***6.09***
Secondary	*0.70*	*0.76*	*0.73*						
Post. Sec cert or dip	*0.77*	*0.76*	*0.80*	***(11.9, 14.3)***	***(9.2, 12.2)***	***(9.5, 10.9)***	***(3.4, 4.2)***	***(4.4, 5.8)***	***(5.6, 6.5)***
University degree	*1.00*	*1.00*	*1.00*						

ACI, absolute concentration index (with 95% confidence intervals); PR, prevalence ratio; RCI*, relative concentration index x 100 (with 95% confidence intervals) 1974-2005, stratified by gender.

Smith, P., Frank, J., Mustard, C. (2009). Trends in educational inequalities in smoking and physical activity in Canada: 1974 2005: Journal of Epidemiology and Community Health, 63, 317-323.

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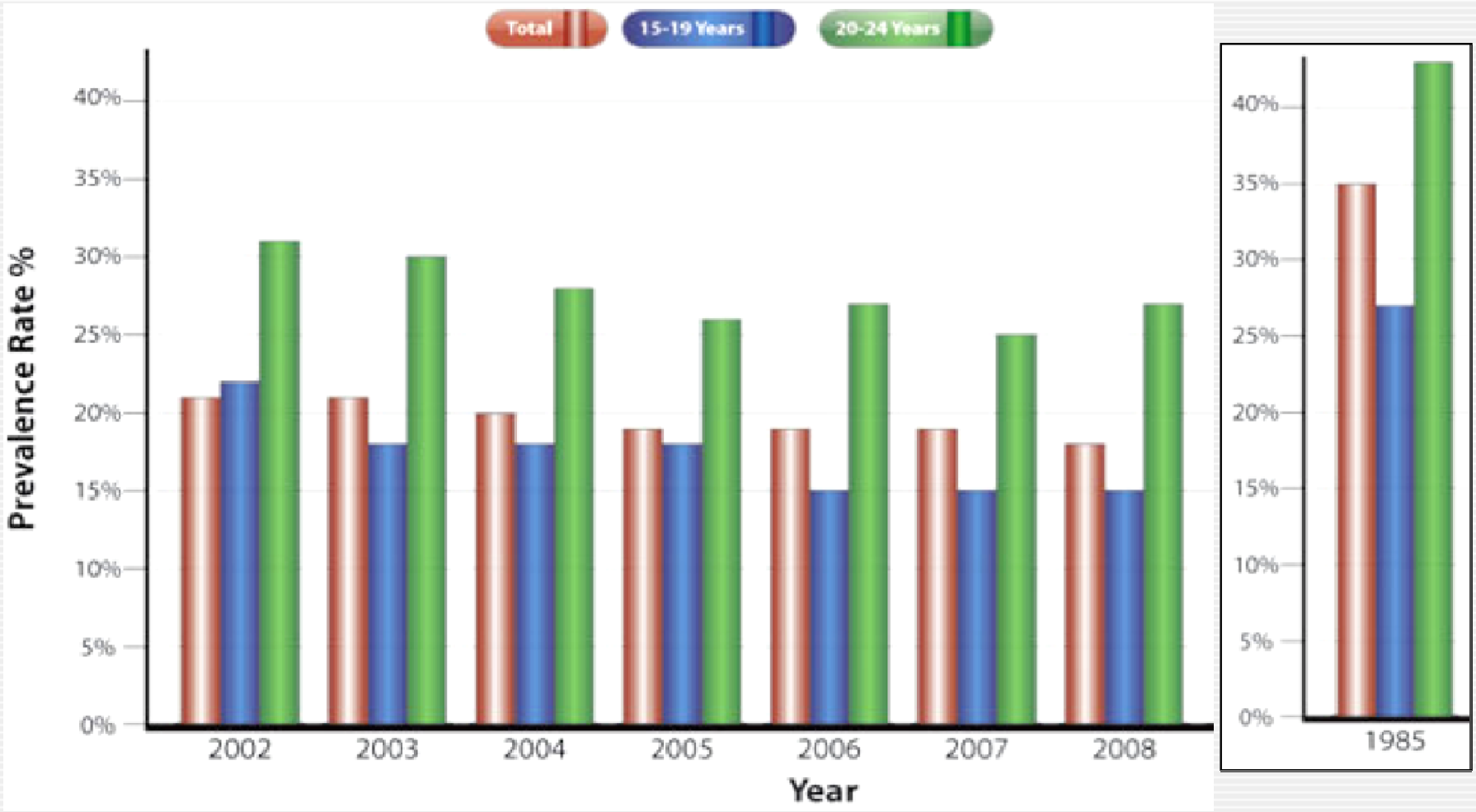
Prevalence of smoking in Canada by age (CTCRI, 1985-2008).



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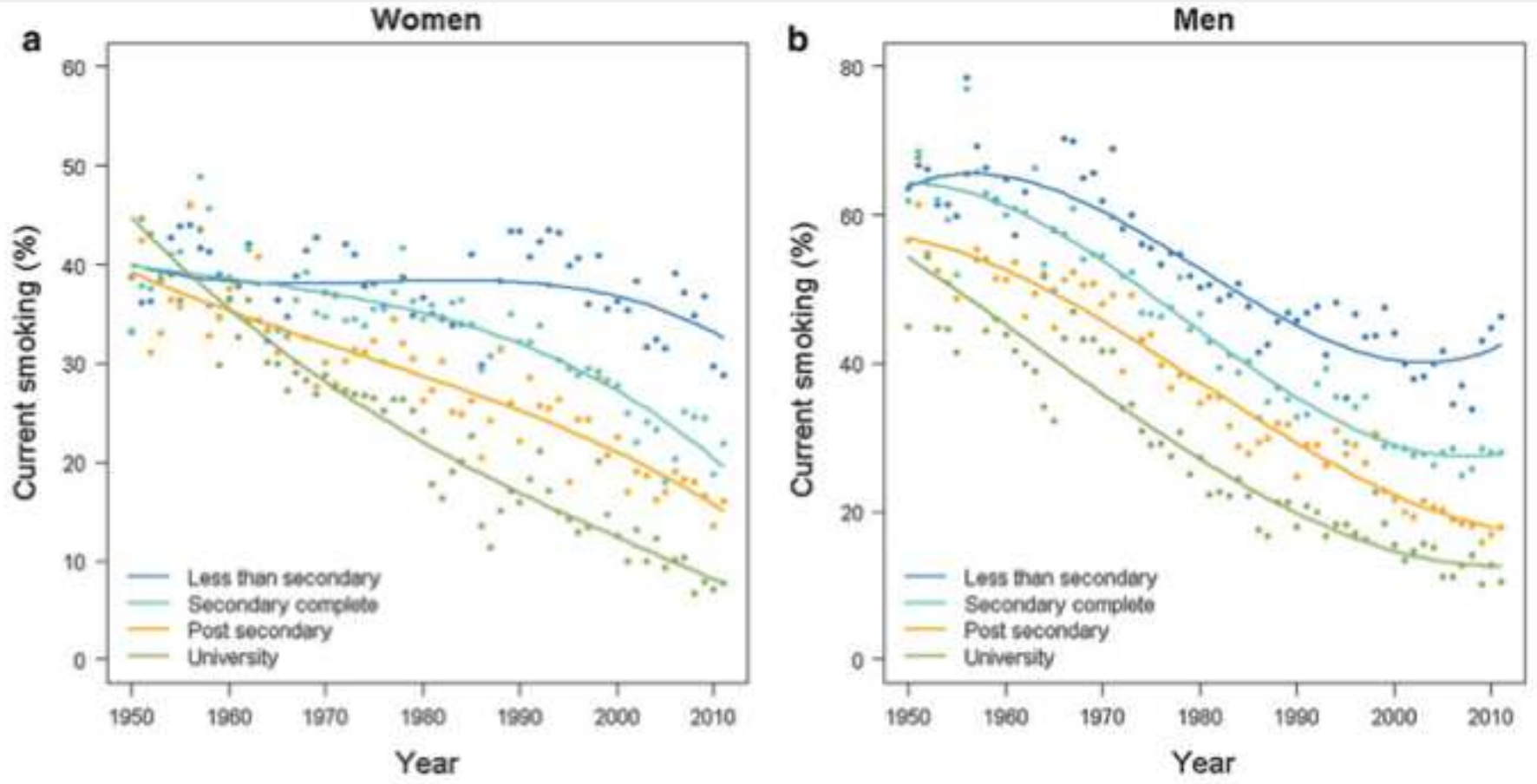
Smoking prevalence by education level in Canadian men and women



Corsi et al., 2014

Our project's objectives

- To begin to start answering the question: “How may the discourses mobilised by public health be “creating” marginalised youth smokers and perhaps sustaining their status as smokers”?
- To discuss tobacco practitioner discourse as formal systems of knowledge.
- To map out the global system of knowledge practitioners use to talk about their practice with youth smokers as well as youth smokers themselves.

Our project

- Canadian Institutes of Health Research (CIHR) Operating Grant (2007-2009) with K. L. Frohlich, B. Poland, E. Mykhalovskiy, J. Johnson & R. Haines-Saah as Investigators.

- Individual interviews with tobacco control practitioners in Vancouver (13) and Montreal (12). Interviews investigated how youth smoking was understood, and inquired about how practitioners' work in tobacco control addresses youth who smoke.

Some background on the creation of a smoking class

- A short history of smoking in the 20th century (Rudy, 2005).
- De-normalization policies.
- Stigmatization outcomes (Bell et al., 2009; 2010).

Foucault and Governmentality

- Governmentality depends on systems of knowledge and truths to constitute and define the object of its activities.
- Through governmentality both coercive and non-coercive strategies are urged on individuals to improve their health.
- Governmentality: includes a wide range of control techniques and applies to a wide variety of objects from one‘s control of the self to the biopolitical control of populations.

Governmentality and class relations

- Class relations not an analytic concept within governmentality.
- Public health work drawing on bio-power has "under" addressed class stratification in its effects.
- How public health messages are delivered and taken up by individuals differently, based on social class, is rarely discussed.

What did we hear from practitioners? Explanations of youth smoking.

Example 1:

"…it's a higher risk population that takes the chance, yeah. I have this one sheet that shows that smoking can be co-related to skipping, lateness, all kinds of high risk behaviours, a whole page of them, early sexual activity, so all of those factors although tobacco is also co-related to a lot of other things, you know, like family issues."

What did we hear from practitioners? Explanations of youth smoking.

Example 2:

"…among those youth often they consume other substances. They will also consume alcohol, they might also have a propensity to have other behaviours a little bit more…less social. So it is often this same type of youth that will have multiple problems, and this often starts with smoking. So I find that this is a…if we could see it like that…an opportunity to screen for other problems."

What did we hear from practitioners? Explanations of youth smoking.

Example 3:

"I think that it's certainly the kids that are marginalized for whatever reason that they've…they're coming from homes where there's open smoking in the home, over their lifetime, so essentially they've been exposed to second hand smoke and probably somewhat conditioned, you know, almost tolerant of it. And maybe even craving…if they have a bit of an addictive… propensity I guess. Then I think some of its culture and some of it is genetic… the jury's out on all that stuff."

What did we hear from practitioners? Dealing with youth smoking.

Example 1:

"The one thing that we most desperately need in this province is funding for NRTs, nicotine replacement therapy or pharmacotherapy, Zyban, Champex, we need that because it was, it was a lot easier helping people quit that we would sort of call the low hanging fruit, we could easily help that population but now we're getting into the really hard to reach populations, people that have got a lot more problems and issues, mental health and addictions, um, lower socio-economic status and so these people really need something more than just a counseling session or a brochure, they need medication."

What did we hear from practitioners? Dealing with youth smoking.

Example 2:

"…we need to help children understand that there are dangers in smoking and help them figure out how to make decisions. So we really look at it as a decision-making model more than anything…and how do you say no. You know if you get into situations, so it's really based on critical thinking and decision making. Well I think what works well is really letting kids get the information and having…giving them some decision-making techniques, and helping them understand that they're the ones that make the choices."

Concluding thoughts

- Tobacco control seems to have worked primarily at the level of middle class youth.
- Respondents do not draw on an explicit discourse of social class to describe youth smokers.
- There is an intersection of risk discourses and discourses of marginalization that constitute the youth smoker as a particular risk "package".
- Overall, tobacco control discourse is constituting the youth smoker as a classed subject.

Conclusion and discussion

- A better theoretical understanding of the ways in which social inequalities in smoking come about can help practitioners and researchers develop more appropriate interventions to reduce these inequalities.
- Theoretical work on the role that reflexivity can play in health promotion practice and research may be able to help health promotion interventions from inadvertently augmenting the same inequalities in health that it is striving to reduce.

THANK YOU !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rauchen die unheilbare und tödliche
Lungenkrankheit COPD aus.
LUNGENLIGA ZÜRICH