

## **Working Paper 76**



# **An examination of perceptions of roles and responsibilities for health amongst the general public**

**Report prepared for the Welsh Assembly  
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Mae CISHE yn gwneud ymchwil rhyngddisgyblaethol sy'n arloesol o ran ei methodoleg. Mae hefyd yn cydlynu'r ymchwil honno, gyda chyfraniad cryf o'r gwyddorau cymdeithasol ac ym meysydd perthynol biofeddygaeth, gwasanaethau iechyd, iechyd cyhoeddus a biofoeseg. Rydym yn gwneud ymchwil o'r radd flaenaf yn rhyngwladol ac yn ei hyrwyddo, gan roi pwyslais ar fynd i'r afael ag anghydraddoldebau iechyd a sicrhau bod ein hymchwil yn cael effaith ar bolisi ac ymarfer yng Nghymru a thu hwnt.

**Abstract:** The need to develop our understanding of public perceptions of roles and responsibilities for health underpins a number of key policy developments in the UK (Wanless, 2004; Welsh Assembly Government, 2003), particularly in light of an increased focus on the relationship between the state and the individual in health improvement action (Halpern, 2003). Research was commissioned by the Welsh Assembly Government to explore perceptions of responsibility at different levels including individual, organisational and state roles and responsibilities for health improvement amongst the general public and key stake holders.

This report focuses on the focus group study with member of the general public across Wales in 2005. Participants (n = 101) included a range of age groups and family backgrounds, with 57% female. A broad range of socio-economic backgrounds were represented. A semi structured schedule, newspaper headline prompts and a prioritisation task were used to guide the discussion. Group discussions were audio taped and transcriptions were analysed with main themes identified and validated by a second researcher. Areas of consent and disagreement within groups were identified and key areas of similarity and difference between socio-economic groups identified.

Participant's understandings of personal responsibility for health were associated with socio-economic position and, to a lesser extent, with age. Issues associated with health communication, family processes, social capital, instrumentation, individualisation, social values and personal morality were used to explain and justify health protective and risk behaviours. The tension between what were seen as the responsibilities of the state and maintaining personal freedoms highlighted further differences between these groups. These results raise a number of implications for public health practice, with lay perceptions reflecting current policy debates.

**Keywords:** Health inequalities; focus groups; lay perceptions; responsibility, health improvement.

**An overview of the three studies on the views of the general public and statutory and non statutory organisations can be found at:**

[www.wales.gov.uk/cmoresearch](http://www.wales.gov.uk/cmoresearch)

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**The views expressed in this report are those of the authors, not necessarily those of the Welsh Assembly Government.**

## **Executive Summary**

### **Background**

The need to understand public perceptions of roles and responsibilities for health is highlighted by a number of key policy developments in Wales and England (Welsh Assembly Government, 2003; Wanless, 2004). This need has been underlined by recent debates concerning the relative role of individuals, groups, organisations and the state in health improvement action (Halpern et al, 2004, Bennett and Murphy, 1997, Williams, 1998).

### **Methods**

Twelve focus groups were conducted across the three National Public Health Service areas across Wales. Participants (n = 101) covered a range of gender, age, ethnic and socio-economic backgrounds. A semi-structured interview schedule, newspaper headline prompts and prioritisation task were used to facilitate discussion on how individual and collective roles and responsibility for health are understood and enacted. Each group was audio taped and transcribed and these transcripts were then analysed for key areas of consensus and disagreement both within and across groups.

### **Results**

#### **Individual responsibility for own health**

All groups acknowledged that individuals could take more responsibility for their health, although older participants and those with poorer health were more likely to enact such responsibility. Less affluent participants highlighted more uncertainty about risk information, perceived more short term social, physical and financial costs associated with health protective behaviour change, placed less value on long term probabilistic health benefits and held more fatalistic beliefs.

#### **Individual responsibility for the health of others**

The majority highlighted social relationships with friends and families as impacting on roles and responsibilities for health. Unhealthy normative peer influences were thought to undermine young people's ability to take responsibility for their own health, whilst gender socialisation was thought to limit males. The family was identified as the main context where individuals could take on roles and responsibilities for the health of others and promote well being. There was a moral imperative to protect the health of children, whilst reciprocal family relationships facilitated protective behaviours. Increased economic demands, changes in family structures and practices impacted on the ability of participants to fulfil these responsibilities.

#### **Individual responsibility and social and economic change**

The increased marketing of unhealthy products were seen to incentivise risk behaviours, appeal to children as consumers with their own resources and to undermine parenting, particularly for those from less affluent backgrounds. Technological changes, particularly changes to food production and availability were seen to have major health implications.

Technological advances were also seen to have reduced opportunities for physical activity in everyday life and to have encouraged a sedentary lifestyle amongst the young. Community relations that promoted well being and reciprocal roles were seen to be declining, predominantly amongst less affluent participants, older participants and those from ethnic minority groups, whilst the workplace was thought to be driven by instrumentality and profits, with little concern for employees' well being.

### **Individual responsibility and structural determinants**

Those from more affluent backgrounds focussed on the responsibilities of the individual for betterment and health improvement, with an emphasis on equal capabilities and opportunities. Less affluent participants and to a lesser extent those from ethnic minority groups and from rural areas, raised concerns about aspects of their physical environment, such as employment, safety and housing. This was accompanied by a greater reliance on organisations, local services and facilities to maintain health. Those experiencing inequalities expressed feelings of marginalisation and stigmatisation. Resistance to health promotion messages and the maintenance of risk behaviours contributed to a positive social identity and feelings of control.

### **Organisational responsibility for health**

#### **- Statutory organisations**

Roles and responsibilities for health were assigned to local authorities, health services, education services and voluntary and community services. All participants highlighted a crucial role for the education sector to provide skills based lifestyle education and supportive policy and physical environments. Less affluent participants were more likely to highlight the responsibilities of local authorities to address the structural determinants of health, to develop communities and to facilitate healthy lifestyles. Voluntary and community organisations provided an important means where by individuals were empowered and shared responsibility for health. A number of examples of effective initiatives were identified but there was concern for their long term sustainability and worries about "short termism". Nearly all participants saw the roles and responsibilities of the health service as providing effective treatment rather than health improvement. Concern was raised, particularly amongst those younger and less affluent participants as to the quality, availability and effectiveness of local health services which were seen to be driven by a target culture that emphasised outcomes over processes

#### **- Non statutory organisations**

Business was seen to be primarily concerned with profit, frequently at the expense of the health of employees and the general population. The majority of participants argued that media perpetuates unhealthy norms of behaviour. There was general agreement that non statutory organisations were unlikely to take voluntary responsibility for the health of the population and that shared responsibility was unlikely without effective legislation by the state.

## **Central government responsibility for health**

Participants from more affluent backgrounds focussed on the role of the state as a facilitator of healthy lifestyles through awareness raising and economic improvement. Less affluent participants argued for a more regulatory role and one which addressed structural determinants of health. This included improved regulation of business to improve the health of employees, legislation concerning the production and promotion of unhealthy products, economic development and the development of community based services and organisations. This contrasted with the concerns of more affluent participants regarding the unintended economic consequences of intervention in the economic market.

## **Conclusions and implications**

Individual responsibility for own health was more readily enacted by those from more affluent backgrounds, older participants and those with altered health status. Failure to acknowledge and address the psychological, social, economic and political reasons for these differences within initiatives is likely to result in increased health inequalities. Future initiatives need to be informed by formative research that examines population variation in short term and long term health benefits, barriers to change, social values, marginalisation and stigma and responses to health advice.

Responsibility for others' health was determined by the nature and quality of social relationships. The family was recognised as one of the key arenas where individuals attempted to fulfil roles and responsibilities. Initiatives could usefully be developed to support and facilitate such roles. Social relationships at the community and societal level also facilitated roles and responsibilities for health but were seen to be in decline by some. Increased consumerism, instrumentality, individualism and a decline in community values were associated with a lack of mutually understood and reciprocal roles and relationships, particularly amongst less affluent participants. The development of social capital interventions may provide an effective means of promoting mutual roles and responsibilities for health.

All participants supported a role for the education sector in health improvement and there was general agreement that effective initiatives should take a holistic approach. There was also general agreement that the state should regulate the promotion of unhealthy goods for the young. For less affluent participants, there was much more support for statutory approaches addressing the structural determinants of health and business regulation. Further research could usefully be undertaken and policy initiatives need to address the often complex relationship between social position, social values and health improvement roles and responsibilities to develop approaches that address the concerns and needs of the whole population.

## 1. Introduction

### 1.1 Policy context

The need to develop our understanding of public perceptions of roles and responsibilities for health underpins a number of key policy developments in Wales and England (Wanless, 2004; Welsh Assembly Government, 2003; Welsh Assembly Government, 2002). These have emphasised the need for “a step-change in individuals’ and communities’ acceptance of responsibility for their health” (Welsh Assembly Government, 2003:51) together with a concern for capacity building in order to “increase individual and communities’ recognition and acceptance of responsibility for their own health and that of their children” (Welsh Assembly Government, 2003: 54). However, whilst it has been argued that “people’s awareness of health issues and their motivation to change, means there is a much greater likelihood of achieving real progress” (Department of Health, 2004: 11), it has also been recognised that “in Wales too many individuals and communities accept ill health and risk taking behaviour as the social norm” (Welsh Assembly Government, 2003: 53). This has led to an increased focus on research that identifies the ‘mechanisms that strengthen the ability of groups of individuals to take collective responsibility’ (Halpern et al, 2004: 66).

### 1.2 Research context

Numerous researchers have highlighted the problematic relationship between awareness of health issues, personal responsibility and preventive health action (Connor and Norman, 2005; Bennett and Murphy, 1997) and how this is further complicated by the social position held by particular individuals and groups (Popay et al, 1998). Indeed, it has been argued that there is a need for ‘a shift away from explaining health-related behaviour simply in terms of health beliefs, towards attempting to understand the lay person’s actions in terms of their own logic, knowledge and beliefs which are grounded in the context of people’s daily lives’ (Williams, 1998: 580).

Health inequalities and their associations with key variables of class, age, gender and ethnicity have been well documented elsewhere, (Townsend et al, 1992, Whitehead, 1995, Davey-Smith et al, 1997, Karlsen and Nazroo, 2002, MacIntyre et al, 1996). However, it has been suggested that whilst socially and economically disadvantaged groups are exposed to greater environmental health risks, there is a tendency to deny or reject the existence of health inequalities to maintain a sense of individual control and to resist negative labelling (Popay & Williams, 1998; Popay et al, 2003; Blaxter, 1997; Radley, 1994; Bolam, 2004). Others have gone further and suggested that such perceptions and the inequitable distribution of unhealthy behaviours themselves are a form of resistance to dominant value systems from which the disadvantaged are excluded (Williams, 1995, Blaxter, 1997).

### 1.3 The current study

Focus group studies have proved a particularly fruitful method for examining perceptions of responsibility for health as well as its relationship to social structures and contexts (Crossley, 2003; Richards et al, 2003; Bolam et al, 2003 and 2004). As Wilkinson points out, it gives the researcher a chance to “observe the construction of meaning in action” and takes into account that people’s health beliefs are “not constructed in splendid isolation” (Wilkinson, 1998: 338). It has also suggested that social desirability may be less of a problem in particular focus groups than one to one interviews (Wilkinson, 1998). The use of naturally occurring groups provides the mutual support which enables participants to express ‘feelings which are common to their group but which they may consider deviant from mainstream culture.’ (Kitzinger, 1994: 111). The current study therefore utilises a focus group methodology with naturally occurring groups that represent a number of lived social contexts to examine roles and responsibilities for health. Its primary aims and objectives are:

#### *Aims:*

- To investigate how roles and responsibility for health are understood and to explore how these understandings are or are not translated into action.

#### *Objectives:*

- Explore ideas about what health is, what causes ill-health and how inequalities in health are produced
- Investigate perceptions of individual responsibility for health for self and others
- Investigate perceptions of others’ responsibility for self and others, including statutory and non statutory organisations.
- Explore the extent to which responsibility for health at both the personal and collective level is accepted, facilitated, resisted or constrained.
- Explore perceptions of how responsibility is or is not translated into action at the individual and collective level.

## 2. Methods

### 2.1 Research design and sampling

Focus groups were conducted in each of the 3 National Public Health Service areas across Wales. Four focus groups took place in North Wales, 3 in Mid and West Wales and 5 in South East Wales and Valleys communities. Of these, 5 were drawn from rural, 4 from urban and 3 from Valley areas. A range of naturally occurring groups were utilised, as these been shown to provide more expressive accounts (Bloor, Frankland et al. 2001) and represent 'one of the most important contexts in which ideas are formed and decisions made' (Kitzinger and Barbour 1999). In addition, attrition rates are likely to be lower as attendance might seem less daunting if participants know each other and it encourages a sense of 'shared obligation to attend' (Bloor, Frankland et al. 2001).

As a starting point the research team made contact with naturally occurring groups such as Communities First Partnerships, Healthy Living Centres and Rotary Clubs. Potential participants were identified by community gate keepers and these in turn identified further potential participants. The level of inter-group affinity across the 12 groups was assessed by the research team (Table 2). This gives an indication of the extent of ties between group members. Five groups were ranked as 'high' on affinity as most people in the group knew each other and either lived and/or worked in the same local area. A further five groups were assessed as 'medium' which indicates that there were some links between participants but there were also some strangers in the group. In most cases, participants still shared similar geographies. Finally, two groups were ranked as 'low' on affinity as participants had limited pre-existing links before taking part in the group.

Across the 12 focus groups, there was an attempt to include participants from a range of backgrounds covering SES (income, employment and postcode), age, gender, ethnicity, family composition and relationship status (see Table 1). A slightly higher proportion of females participated in the focus groups (58%) and a greater number of people under 25 (31%). About half the sample were married or living with a partner, a third were single and the remainder were widowed or divorced/separated. Approximately half the group had current child caring responsibilities (children or grandchildren under 16) and throughout the discussions it became clear that a higher number had previously been in child caring roles and were able to reflect on their parenting experiences. Participants were also able to reflect on a range of economic activities with a third currently in employment (or self-employed) and another fifth retired from paid work. A further group of participants (17%) had caring responsibilities (either for the home, friends or relatives) or were currently out of paid work because they were disabled, invalid or permanently sick. The majority of those responding 'other' were students .

Participants also cut across the full range of income categories with 29% in the lowest two groups (up to £10k) and 17% in the highest two categories (£30k or more). Whilst participants post codes showed that 27% of participants lived in the 10% most deprived wards in Wales (lower super output areas), and 23% in the 50% least deprived wards, as derived from the Welsh Index of Multiple Deprivation (2005). Multiple deprivation index measures, calculated for each participant, were located on a four point scale from most to least deprived. Modes for each group were assessed and an overall measure of deprivation allocated (Table 2). Within groups there was an attempt to maintain a degree

of homogeneity of social background to allow comparisons to be made between groups from different social context. Six of the twelve groups could be considered highly homogeneous, with participants sharing a number of common socio-economic characteristics (Groups 1,2,4,6,8,10). Four of the groups can be seen as moderately homogenous (Groups 5,7,9,11), whilst two groups included a more varied social mix (Groups 3 and 12).

**Table 1: Summary of focus group participant demographic characteristics**

Group	1	2	3	4	5	6	7	8	9	10	11	12	Total %
<b>Age</b>													
16 to 24 years	1	10	1	7	0	0	1	7	1	0	0	3	31%
25 to 34 years	6	0	0	0	1	0	1	0	1	0	0	0	9%
35 to 44 years	2	0	1	0	2	1	4	0	2	0	1	1	14%
45 to 54 years	3	0	4	0	4	0	0	0	3	0	3	0	17%
55 to 64 years	1	0	1	0	3	2	0	0	1	0	2	2	12%
65+	0	0	1	0	0	5	0	0	0	8	3	1	18%
<b>Gender</b>													
Male	0	6	2	4	4	7	0	6	0	4	4	5	42%
Female	13	4	6	3	6	1	6	1	8	4	5	2	58%
<b>Relationship</b>													
Married / Cohabiting	7	0	4	0	9	8	5	1	7	3	5	3	51%
Single	4	10	1	7	1	0	0	6	1	0	2	2	34%
Divorced/separated	2	0	2	0	0	0	1	0	0	0	1	1	7%
Widowed	0	0	1	0	0	0	0	0	0	5	1	1	8%
<b>Dependents</b>													
Children aged 16 and under	10	0	2	0	2	1	4	0	2	0	1	1	23%
Grandchildren aged 16 and under	2	0	0	0	0	6	0	0	0	3	6	2	19%
No children or grandchildren aged 16 or under	1	10	5	7	8	1	2	7	6	5	2	4	58%
<b>Employment</b>													
Retired	0	0	2	0	2	6	0	0	0	6	2	2	20%
No paid work - ill health	3	1	0	0	1	0	0	0	0	0	1	0	6%
Caring for the home	3	0	0	0	1	0	2	0	0	1	1	0	8%
Carer	2	0	0	0	0	0	0	0	0	0	1	0	3%
Unemployed	3	3	1	1	2	0	0	0	0	0	2	0	12%
Employed or self employed	1	2	3	5	3	2	2	1	8	0	2	4	33%
Other	1	4	2	1	1	0	1	6	0	1	0	1	18%
Not specified	0	0	0	0	0	0	1	0	0	0	0	0	1%
<b>Income</b>													
Less than £5,000	1	4	1	1	0	0	1	6*	0	1	1	0	16%
£5,000 to £10,000	5	0	0	0	1	0	1	0	0	1	4	1	13%
£10,000 to £14,999	2	2	1	0	1	0	1	0	0	2	1	1	11%
£15,000 to £19,999	1	1	1	0	0	0	2	0	0	1	0	0	6%
£20,000 to £29,999	1	0	1	0	0	4	1	0	2	0	1	1	11%
£30,000 to £39,999	1	0	1	0	1	1	0	0	2	0	0	1	7%
£40,000 or more	0	0	1	1	2	1	0	0	4	0	0	1	10%
Not known	2	3	1	5	5	2	0	1	0	3	2	2	26%
N	13	10	8	7	10	8	6	7	8	8	9	7	101

\*student income

**Table 2: Focus group multiple deprivation index (MDI) and affinity characteristics**

Group	1	2	3	4	5	6	7	8	9	10	11	12	Total
<b>M.D.I.</b>													
Most deprived													
1 to 190 <10%	1	0	0	0	0	0	1	0	0	0	1	0	3
191 to 380 <20%	0	1	1	0	0	0	0	0	0	0	0	0	2
381 to 570 <30%	0	0	0	0	0	0	0	0	0	0	0	0	0
571 to 950 <50%	0	0	0	0	1	0	0	1	1	0	0	0	3
951 to 1896 <100%	0	0	0	1	0	1	0	0	0	1	0	1	4
Least deprived													
<b>Affinity</b>													
High	0	0	0	1	0	1	1	0	1	1	0	0	5
Medium	1	1	1	0	1	0	0	0	0	0	1	0	5
Low	0	0	0	0	0	0	0	1	0	0	0	1	2

## 2.2 Data collection and analysis

Ethical approval for the study was firstly obtained from the School of Social Sciences, Cardiff University Ethics Committee. Informed consent was obtained from all respondents and the opportunity to conduct the focus group in either Welsh or English was offered (Appendix 1). Two groups were subsequently conducted in Welsh. Focus groups were conducted in rooms hired in the local vicinity and took place on a suitable day and time to facilitate attendance. Participants were offered snacks and refreshments to facilitate a relaxed and informal environment and were paid £15 each to compensate them for their time or for any travel or child care expenses. Focus groups lasted between one and one and a half hours.

Each group was facilitated by one of the research team, following a semi structured schedule that reflected the study objectives and previous research findings (Appendix 2). A second researcher provided support facilitation and took notes on the main themes discussed. Participants were initially presented with a number of common stimuli to facilitate discussion (Appendix 3). These provided a common framework for data comparison across groups and allowed the discussion to flow naturally from issues which are pertinent to the groups, while at the same time ensuring that key areas of discussion were prompted (Crossley, 2003). A series of real life newspaper headlines were used to stimulate discussion, following similar methods used elsewhere (Popay et al, 2003). The headlines reflect a range of health related issues including behavioural issues (smoking and obesity) as well as issues around the broader determinants of health (poverty and well-being). Each headline was discussed in the context of: relevance to the individual and group; responsibility for cause; the roles and responsibilities of individuals, groups and others in prevention; factors determining acceptance and resistance of responsibility; and translation into action/inaction.

In addition, towards the end of the focus group, a prioritisation task was provided to assess levels of group consensus around key actions needed to improve health (Kitzinger, 2003). The Chief Medical Officer for England's top ten tips for improving health

(1999) were presented alongside the alternative top ten devised by the Townsend Centre for International Poverty Research, University of Bristol. Individuals were asked to rank their top three tips from both lists and to devise their own tips if necessary, the results of which can be found in Appendix 4. Participants were then asked to work on the same task as a group. The focus group methodology present here was piloted with two groups , one in North Wales and one in South East Wales and methods were revised in light of the findings. Each focus group was audio taped and then transcribed. Welsh language group data was translated into English. Transcriptions were checked for accuracy by the main facilitator in each group. Transcripts were then analysed using a grounded theory approach (Glaser, 1992) and main themes identified. These were validated by a second researcher, with areas of disagreement resolved by discussion and mutual consent. Areas of consent and disagreement within groups were identified and key areas of similarity and difference between groups highlighted.

### 3. Results

The following section highlights the main areas of discussion about the primary causes of diseases and the main ways in which health could be protected and promoted by individuals. These factors, relating to individuals and health, social relationships, elements of context and structure, go some way to developing our understanding of roles and responsibilities for health. The ordering of these themes broadly reflects the trajectory of the group discussions as they moved from a focus on intra personal to inter personal processes, to wider social processes and then to more structural influences on health. These highlighted multiple influences with differential impacts, particularly on groups defined by socio-economic status and age. Presenting these influences separately inevitably entails an element of simplification, but in doing so we are able to develop our understanding of people's experiences of health and the everyday circumstances in which decisions are made in relation to individual roles and responsibilities for health.

#### 3.1 Individual roles and responsibilities for health

Across all 12 focus groups insights were offered into the intra personal processes through which participants understood and negotiated personal responsibility for their health. Issues related to knowledge and awareness, perceptions of media norms, interpreting information, assessments of costs and benefits and fatalistic views emerged and highlighted socio-economic status and age differences.

##### 3.1.1 Knowledge and awareness

Across all groups, there was a clear understanding of how individuals could protect their health, with discussion reflecting health promotion advice. By far the most popular 'top tips' for health were lifestyle health behaviours such as not smoking and taking more exercise (Table 2) and a number of groups discussed the importance of managing stress. It was generally recognised that *"the opportunity is there to be more healthy"* (group 5), although this opportunity was frequently not taken up. This was attributed in part to the limitations of health advice and education, particularly in relation to smoking and eating where it was thought *'leaflets never work though' 'No they don't' 'on every fag pack you buy it says a warning and everyone still smokes and stuff.'* (Group 4). Indeed, the majority of groups agreed, that in their experience, awareness and knowledge frequently did not lead to an acceptance of responsibility or action, *'you can't believe that people don't know that these days and yet you still get these youngsters smoking' 'they ignore it yes'* (group 6) and *"I think most of them know what's healthy cos there's a lot of things on the television and in papers and on adverts that to say what is healthy but whether you eat it or not is another thing"* (group 5).

This was particularly the case, when younger participants reflected on their own experiences and when parents talked about their children. Young people were thought to be less receptive to traditional health advice, *"you do see messages like that in newspapers but not a lot of them and like who reads newspapers at this age? (Group 4)* and to be more susceptible to normative pressures, doing *"just what your mates say"* (Group 2). Older participants were far more likely to express motivation to both seek out health information and to act upon it. Discussion highlighted the fact that they were more likely to be cued to action by the health consequences of risk behaviours or altered health

status, *“I was suffering with arthritis and was told at the hospital that it would be with me forever. But I read in the newspaper that if I changed my diet and did not eat meat- they talked about arthritis sufferers not being able to walk and then having changed their diets they were able to walk....I decided to change my diet. No meat no milk and now I don't have a problem at all”* (Group 12).

### **3.1.2 Competing media portrayals**

As group discussions developed, participants offered further explanations as to why they or friends and family were unlikely to take responsibility for health. All groups, regardless of background, identified television as the main media channel that influenced perceptions of normative health behaviours. The majority took the view that, alongside marketing (see section 3.3.1 ), programme content largely negated the influence of health promotion advice. This was because they created a perception of unhealthy behavioural norms and in some cases contradicted health messages. This was seen to be particularly so for children and young people who were thought to be more vulnerable to such influences, *“You only have to turn on the TV and so many programmes particularly the soaps show people drinking in their local pub”* (Group 10).

### **3.1.3 Interpreting risk information**

Although all groups highlighted media norms, it was less affluent participants who were more likely to comment on the nature of health risk messages as something which encouraged uncertainty and either justified or caused inaction, as *‘this government changes its mind so quick on what's good for you and what's not good for you.’ ‘Red meats now’ ‘They come up with these things all the time.’* (Group 1). In some cases this reflected the changing content of risk information, *‘so medical researchers, for example, when my grandfather was ill twenty years ago, so the beetroot was very bad for you, you shouldn't eat it because it increased your blood pressure and it would cause you to have heart attack and now apparently that's wrong, it's not true, you know and they tell you.’* (Group 3) In other cases discussion highlighted a problem with competing and conflicting sources of information *‘but you receive different advice from one week to the next-from here, from there.’* (Group 12) and mistrust of official sources (see section below). Over and above this, there was a sense that participants felt a sense of powerlessness in how to respond to what appeared to be a “bombardment” of risk information, *‘yeah but it's absolutely ridiculous nowadays they say you can get cancer from having too much red meat’ ‘you can get cancer from everything.’ (agreement)* (Group 3). In some cases, participants seemed cope by to accepting risk with a certain inevitability, *‘All the stuff that's been on the news like the Sudan...basically why you know, I say live life to the full and if you're going to smoke you're going to smoke.’* (Group 4).

### **3.1.4 Costs and benefits**

Lower socio-economic groups and younger participants were also more likely to highlight the immediate benefits associated with any perceived risk behaviours. These benefits largely related to socialising, physical pleasure and coping with stress and in part appear to be associated with structural disadvantage and the development of social identity (see section 3.4.3 ). In the main they were seen to outweigh any long term risks that were often presented in probabilistic terms. As one group put it,

*Participant 1 - 'it's knowing what you can handle, but it's down to the individual.'*  
*I think the vast majority of us though, would stop drinking, our alcohol intake will reduce significantly over the age of twenty five.'*  
*Participant 2 - 'I would have thought because like your body can't really take it anymore and you've got a job and you know.'* (Group 8).

Whilst another in relation to smoking stated that the benefits meant, that *'I gotta be honest, I've got no intention whatsoever of giving up fags,'* (Group 1). This lack of focus on future expectancies is perhaps best illustrated by one of the additional top tips from this group, *'enjoy life, take one day at a time, live for today, tomorrow may never come, be happy with what you've got and not fret over what you haven't.'* (Group 1)

At the same time, participants frequently highlighted the immediate costs of any behaviour change to protect health and the long term distal nature of any perceived benefits. The high costs that might be involved in giving up smoking or cutting down drinking were articulated in terms of needs and pleasure. Smoking was specifically mentioned as a coping strategy in two of the groups; for alleviating boredom by one group and for dealing with stress. *'I've had dealings with nurses on a cancer ward who are smokers and I know GPs who smoke I understand it to be an addiction but I think pressures of work may also have something to do with it'* (group 11). Whilst another highlighted the adverse effect of giving up *'I give up for 2 years and my health suffered for it so I went back on the fags'* *'They said smoking puts on 4 years and obesity puts on 9 or something'* (group 1). Alcohol use was similarly identified as a coping mechanism *'because I have a bottle of red wine every single night, but I think to myself, 'Right, it would either be that or be on Prozac.'* *I think if you drink, do so in moderation and I say 'I'm not gonna have one tonight but I do.'* (Group 11). Older and higher SES groups were more readily able to identify a range of short term incentives associated with examples of their behaviour change. These were not always health related, with examples including improved behaviour for children due to dietary changes, improved educational performance from having a family breakfast and reducing the stigma associated with obesity

### **3.1.5 The role of fate**

This discussion of costs and benefits amongst less affluent and younger participants led to a focus on personal experiences that contrasted official risk information. Fatalistic views of health outcomes were presented as challenges to the efficacy of personal roles and responsibility for health. These not only provided explanations and justifications for the continuation of risk behaviours, but seem to reflect a lack of control over more structural influences on health (see section 3.4). Whilst acknowledging a generalised risk these personal experiences frequently focussed on friends and family who defied health expectations, particularly in relation to smoking and diet. This is illustrated by one participant who stated *'Smoking I know it's obviously bad for your health and stuff but there are many other things which are bad for your health as well and it just seems to me that people are obsessed with certain things and not other things, it's like you said people can live for a long time smoking, I think if you enjoy it go for it.'* (Group 8). In relation to diet as one participant put it, *'Cholesterol is very bad for you and if you've got high cholesterol you can then have a heart attack and you could die young, well excuse me*

*please but I'm sure you were brought up eating full fat milk and butter, lard, bread.'* *'Of course we did.'* *'Bread and dripping.'* *'Puddings.'* *'Yeah, she's 85 you know and my grandfather is 96 and other people who look after themselves very well, drop dead.'* (Group 3). Whilst another commented that *'yeah, keep active very important, my grandma and my aunty they're so active. My grandma is aged 84....at the same time my, my grandma's sister in laws who's never active you know and she died long under age and she had problems.'* (Group 7)

This tension between risk information and personal experiences was frequently explained in terms of fate as a natural lottery, but at other times participants focused on what were seen as uncontrollable environmental factors such as pollution and genetic inheritance as predestination *'I know the skinniest of people that have died early', '9 times out of 10 that could be come down to a medical condition' 'My kids have MacDonald's my kids have biscuits in the fridge'* (group 1). In this way, information which as frequently seen as generalised and simplistic was challenged by notions of individual difference, as *"what's good for one is not so good for another"* (Group 3).

In summary then, whilst there is evidence that participants recognised health advice, when it comes to acting upon it, other factors such as age and socio-economic status seem to play a part. Lower income and younger groups presented far more instances of confusing message content and conflicting sources of information when accounting for their behaviours. They were also more likely to focus on the immediate benefits rather than long term costs of risk behaviour to adopt a fatalistic view of potential health consequences. However, whilst talking about health, participants not only focused on the dynamic nature of a number of intra personal processes, they also inevitably discussed how health is understood and negotiated in the context of social relationships. As the discussion developed it became clear that inter personal processes associated with peers and family relationships provided role opportunities that either nurtured or undermined health.

## **3.2 Social relationships and health**

### **3.2.1 Peer relationships**

Peer relations were seen as key in promoting social and psychological health and this was apparent when participants discussed the social support provided by friends when dealing with stress, *"we don't take time to relax because we're all running around like little ants all over the place, and I think if we took time to relax and talk about it"* (Group 5). Social ties and belonging were important facilitators to health and are discussed further in relation to community below (see section 3.3.3). However, the majority of discussion focussed on the importance of peer relations in determining normative perceptions and behaviours, something that was highlighted in nearly all groups. This was particularly the case when discussing young people's alcohol, tobacco and dietary behaviour. Older participants reflected on the behaviour of their own children and young people themselves talked in detail about the importance of peers. For both groups, influences were seen to exert themselves primarily through the modelling of appropriate group behaviour, *'usually*

*you see your parents as the role model or the tutors as the role model, as the first time you know and later in your life it's the people as your role models, you know.'* (Group 7) and the need to develop a separate social identity *'to rebel against society. If society like tells you not to do something and you're like a teenager you do the complete opposite so the actual advertising like saying don't do it, they're gonna actually do it.'* (Group 5) and similarly in relation to smoking *"I'll hold me hand up 'cos I was like 'I wanna be grown up now' (Group 11).* In some cases it was also recognised that there were sanctions for failure to follow peer group behaviour, *your're fighting an uphill struggle from peer pressure...lets take that as an example burgers and that's the staple diet if you deviate from that its sort of we can't do it and of course if they are seen to be eating something different then they are frowned upon'* (Group 6)

Here behaviours were not undertaken for their health benefits but for the rewards associated with group membership, partly derived from resisting official advice. This is best illustrated by one young participants response to tobacco health warnings, *'I've got those warnings written on my wall, I printed them off the computer and stuck them on the wall' 'you can buy fake ones now off the internet and stick round your fag packets' 'they're amazing.'* (Group 4). Older participants also discussed how norms influenced their own behaviours, but here talk focussed on conforming to rather than resisting healthy norms. Higher socio-economic groups in particular tended to see smoking declining as it was seen to be far less socially acceptable than in the past.

Gender also appeared as a key influence on normative processes, particularly in relation to seeking medical advice and binge drinking. Both male and female participants of all ages presented similar everyday experiences of men's reluctance to seek medical or emotional help. This was thought to be an expression of masculine identity and their need to *'deal with it and get over it.'* (Group 4). This meant that *'a lot of men don't really want to go the doctor and discuss like, you know, health issues, where as like women are more forward.'* (general agreement) *'The other way is...they just want to be like machos and you know they can't be seen as weak really.'* (Group 7). In the same way gender norms were seen to be responsible for increases in the number of young women binge drinking. This was seen to be now socially acceptable and an expression of independence *"You do see more drunk women about than there is men' 'yeah' ... 'oh yeah I know but I don't know, doesn't bother me though' 'you only live once."* (Group 8). It is important to note however, that such norms were not discussed in isolation from broader cultural developments which facilitated their development. The expression of normative identity through health threatening behaviours was frequently linked to increased opportunities for consumption and individual choice in society, *"they shouldn't make drink that cheap. But you know I really enjoy it, that sort of things, that's what my life is all about.'*(Group 8) (see section 3.3.1).

### **3.2.2 Family relationships**

Another key context widely identified for its influences on roles and responsibilities for health was the family. This was an area discussed in great depth in all of the groups as it was seen as the main context where participants felt a role obligation to take responsibility for their own and others' health. The mixture of participants from lone parent to extended family backgrounds and with dependent children, those with previous child caring responsibilities and those never experiencing parenthood, provided a range of

views on the subject. Good family relationships were seen as an end as well as a means for achieving health. A popular top tip was 'make time for your family' and this importance of family bonds appeared in many of the groups discussions,

*Participant 1 - 'You need time to know your family...don't lose that bond and then you can educate...eat in the family'*

*Participant 2 - 'Yes that's one of the hardest things to do' (agreement)*

*Participant 1 - 'If you nurture that within your own family which we've all had it'll lead onto the next generation and then we've got that continuity of wellbeing and health, cos I think we've lost it in the past 20 odd years.' (Group 5).*

Discussion also highlighted a common expectation that family roles could positively influence health behaviours. Many parents discussed their experiences of trying to provide positive role models within the home, *"if you've got young children you don't drink but then your children or grandchildren see what you're doing if they're seeing parents taking active exercise, eating fresh fruit and vegetables and not drinking and not smoking as opposed to not doing all of that how do you influence the next generation coming on board"* (Group 6). In particular they tried not to smoke in front of children to set an example and to reduce the dangers of passive smoking. Parents were also seen as having a moral obligation to educate their children and to provide family structures that promoted health. Here discussion initially centred on a perceived general decline in parental skills especially in relation to diet, with agreement that,

*Participant 1 - " a lot of people just don't know how to prepare it they haven't got a clue you know they haven't and it's not just people who you were saying on low incomes who are eating poorly there's a lot of people on quite high incomes like processed foods and who need who need ready made meals*

*Participant 2 -" that's the trouble we were brought up weren't we, mother father in the household and they give us food that was a meal cooked and you had to sit and have another" (Group 5)*

Because of this, it was felt that children *"have never been in contact with having to prepare their own food or anything,"* (Group 8). This breakdown in the transfer of knowledge and skills was also highlighted in relation to exercise, poor budgeting skills, basic hygiene and dental health. The groups went on to suggest that this lack of education within the family was due to a decline in parenting responsibilities, with children being left to *'fend for themselves'* (Group 3). For example,

*Participant 1- "The parents don't seem to be bothered.*

*Participant 2 - There's an attitude, 'Oh let them go and do it all, let the Nanny State rule,' but it starts at the home, education on everything from social behaviour, to diet, to reading and writing" (Group 11).*

However such views were challenged by those with greatest experience of parenting. Across all groups they highlighted changes to family structures due to increased demands as the reason they were unable to fulfil parental roles and responsibilities. Numerous personal examples were given of the decline of *'the good old days of family life'*. These were most vividly described in relation to how families no longer ate together. When asked to reflect on why this may be, nearly all groups focussed on how increased work demands had fragmented family life and reduced opportunities for family based activities.

This process was compounded by the increased use of television and video games by young people (see section 3.3.2). The relationship between competing parental responsibilities, shifting family structures and the role of television is perhaps best illustrated by the following contribution:

*"It's lifestyle changes. In the home now ... it used to be we always sat around the table every evening for your meal, I was working, my wife wasn't working, we'd wait for the children to come home from school, the meal would be prepared and we'd all sit down the table, even Saturdays we'd sit around the table and give us time to talk and discuss things. In the early part of their life we didn't have a TV so there was no sitting and eating while the TV was on with everyone boggling at the TV, or computer.(..) I know it's not harmful but they're not getting talked to, they're not getting spoken to so it seems that the families don't act as a family anymore." (Group 11,).*

Women in particular highlighted the tension between shifting gender role expectations and competing demands from inside and outside the home as *"lots of women go to work now so they haven't got the time well that's right so you go back to lifestyle therefore 2 people working" (Group 6)*. This impacted on the time they were able to invest in fulfilling responsibilities they felt towards themselves and in particular their children,

*"It's true at the end of the day if you're working (...) if you're working you coming home from school you're working 5 o'clock you're doing evenings you are doing quickest thing, doesn't matter, Fish shop" (Group 1)*

*"I think it's the cost of living where both parents have got to out to work and then when the children come home for convenience they're too tired to cook and they've both done a day's work. So the wife might say to the husband 'I'm not doing it because I've been in work all day.' Or.... The, husband might say vice versa to the wife and then is it just left to the children to just get a convenience meal, so it's a cost of living and the lifestyle." (group 11)*

In summary then, the majority of participants recognised the effect of peer relations on health, or in most cases poor health. They also highlighted the family as a primary sphere for nurturing and maintaining health and in doing so acknowledged the primacy of family based roles and responsibilities for health. The difficulties in undertaking these roles and meeting responsibilities in the light of competing roles were also more than apparent. What was significant however is the way that participants explained these difficulties within a dynamic context of social and economic change.

### **3.3 Social and economic change and health**

#### **3.3.1 Marketing, consumerism and choice**

The majority of groups suggested that increased health risk was a natural result of marketing which promoted and incentivised unhealthy lifestyles. This was particularly the case for diet and alcohol where talk reflected an awareness of marketing approaches such as branding and segmentation which encouraged a lack of responsibility for health,

*"all the clubs and pubs are promoting drinking and they have got this on and that on and so on and I don't know if, it's probably died down a bit but it will still be there but at the*

*moment they are really targeting the freshers, giving out leaflets in town, this party is on, that party is on. So in a way, it is not the alcohol that they are promoting but it's that sort of lifestyle" (Group 8).*

Parents especially were critical of businesses that targeted children and young people in marketing campaigns as it was felt they were more vulnerable to such techniques and required protection.

*Participant1 - Toys, giveaways, the whole thing that attracts children to saying they want a burger and they get a little toy.*

*Facilitator – So free gifts with meals influence choices?*

*Participant1– Yes, free gifts with the fast foods.*

*Participant2 – Yes, if you get a happy meal you get a toy and your meal and they have to try to collect the whole set and they want to go back." (Group 11).*

This protection was seen to include restricting marketing but also in one group, the availability of unhealthy products, *"This junk food is easily accessible, advertised on TV and located in the main streets of towns and cities" (Group 10).* Influential role models were also seen to lack social responsibility and needed to play more of a part in promoting health rather than selling products for financial gain,

*Participant1 'And role models for younger children, you know like David Beckham, sports stars and footballers those sort of role models. If they came out against things like smoking and endorsed healthy attitudes and lifestyles, because kids are influenced by them, more than their parents sometimes, certainly more than us.'*

*Participant 2-'But then you've got Gary Linekar with crisps! If he's going to do that he needs to balance it out with something healthy doesn't he?' (Group 9).*

Parents, particularly from lower socio-economic groups highlighted the negative effect of having to deal with the increased expectations of children. They seemed to undertake more social comparison when making judgements about self and appeared to feel more pressure to provide status symbols for their children to facilitate peer acceptance. At the same time they recognised that they had more limited resources to do so,

*Participant 1 -"parents are always working to buy these materialistic things"*

*Participant 2 "I find, like you just said, the more you have, the more you want and from that, that makes you depressed and instead of counting your blessings with what you've got, they're always trying to keep up with Jones." (Group 3).*

This meant that it was *"difficult for parents in this day and age when children want something. All the things that their friends are having and they have to decide whether the child has it or not" (Group 10).* Perceptions of consumer pressures therefore had a negative effect on parents, creating feelings of stress and feelings of social inadequacy and undermined parental roles for health. It was also felt that children's well being could be adversely effected by such processes. The majority of groups felt that increased pressures to consume had led to children becoming independent consumers at an increasingly early age. In this way they had been encouraged to think of themselves as autonomous individuals with a right to choose. Something that was contrasted strongly with participant's past experience, *" I'm not being nasty but I'm not as old as you and we didn't have a choice" (Group 1)*

Inevitably these choices were influenced by the peer processes outlined above and were often achieved by drawing on their own financial resources. A case of *“he’ll go down the chip shop with his own money”* (Group 1) regardless of parental wishes. There were several comments suggesting the difficulties this causes for parents, *“because even if you try to say something to your child because it’s laying on the bed eating food all day long and not getting exercise, all you get back is a load of abuse and at the end of the day what can you do about it?”* (Group 11,) and young people, many of whom thought that *“children don’t even listen to their parents any more”* (Group 4).

### **3.3.2 Technological change**

Discussion across all groups also focussed on how historical developments in technology either facilitated or constrained roles and responsibilities for health. Older participants especially provided vivid examples which compared and contrasted current and historical experiences. In the main these related to detrimental changes in food production and the growth of sedentary lifestyles. Participants highlighted a tension in their views on how technology had impacted on their health. On the one hand there was an acknowledgement, in the main from older participants from less affluent areas, that technological change had impacted on employment patterns and was associated with the local decline of heavy industry. These changes had in turn contributed to reductions in chronic illness. Interestingly however, it was felt that people were less healthy than in the past. This was largely to do with food production and preparation. In the past it was felt that people had a closer relationship to and understanding of where food came from and were intrinsically involved in its production and preparation.

Technological change in the main was seen to have taken food production away from the individual and the local area. Although in one higher income group the effect of changes in local planning were also discussed, *“as far as I can see in the last 20 or 30 years uh public housing anyway and even private housing for sales produces uh very small gardens and maximum density of housing per acre uh the amount of cultivation of vegetables and things like that um has declined that’s my impression over the years people no longer cultivate their produce children don’t see things growing and they don’t know what they are they only see them on a shop or a supermarket shelf ...* (Group 6). Despite a slight variation in perceived causes, what was clear was the relationship to food production at times was seen as more important than or to compensate for what was consumed,

*Participant 1- “yeah everything was fried there was always fried breakfast bacon eggs can always remember it as a kid”*

*Participant 2- “but it was also sort of home produced”*

*All - “yes”*

*Participant 1- “still had the fat but it didn’t have the additives see did it”* (Group 5,).

This contrasted sharply with participants’ discussion of modern processed foods, where great suspicion was expressed in relation to safety and quality. This is perhaps best summed up by the following exchange,

*Participant 1- “Processed foods are the bigger problem – not ‘sweet foods’ – “but I don’t think that’s the major problem this not eating the odd ice cream or the odd chocolate it’s the problem is the heavily processed foods I think they’re eating and I think that a lot of people don’t realise that these what muck actually goes into these heavily processed foods”*

*Participant 2- “the thing is uh like chicken all that they inject it in the factory with water to bump up the weight but um so you not actually buying like a (...) 1lb of chicken whatever”*

*Participant 3- “and with a lot of the fresh meat to make them grow up they feed them antibiotics and all that as a growth stimulant but you like eating that so you have the antibiotics in your system so when you actually do get ill they don’t work” (group 5)*

A decline in the consumption of home or locally produced food, and the related rise in processed foods, with seen to have major implications for the habits of future generations. This led a number of the parents to express a strong desire for children to participate in the growing and cultivation of fresh food produce,

*Participant 1- “Like you said now Lynne those children they can’t have seen their mother clean a potato can they”*

*Participant 2- “No the only time they’ve time they’ve ever seen chips is in”*

*Participant 1- “The chip van”*

*Participant 2- “The chippy “*

*Participant 3- “where does food come from it’s out the freezer and the microwave”  
- Mmhmm (general agreement)*

*Participant 3- “They don’t even think about where it’s come from” (Group 1).*

A number of other references to technological advances were made during group discussions, all of which were seen to contribute to a more sedentary lifestyle. Parents in particular, highlighted the problems of their children watching too much television and the growth of gaming and computer culture, both of which led to less physical activity. Some participants suggested that this was due to the lack of a parental presence in the house due to the demands highlighted earlier, whilst others expressed worries about the safety of local environments for children to play in (see section 3.3.3) Discussion also included changes in the work place, which was now seen to be more desk bound and less physically demanding, the home and particularly the increased and habitual use of cars even for short journeys,

*‘ We were away for the weekend and we asked the girl at the hotel if there was anywhere we could walk to for a bar meal. ‘Oh yes’, she said, ‘There’s a little place about a mile and a half down the road.’ She said ‘I don’t think it’s very far’, but other people were saying ‘Fancy telling people about that when it’s a heck of a long way to walk’, and it wasn’t more than a mile and a half. It was quarter of an hour max I suppose. Every household has cars now, they thought that a quarter of an hour walk was quite a long walk” (Group 9).*

### **3.3.3 Changes to community**

Discussion of social change frequently led to a discussion of participants’ experiences in their local communities, focussing on both social and physical aspects (see section 3.4.1). These discussions took place predominantly but not exclusively within lower income groups and suggested that incentives for individual action can come from both feelings of moral obligation and perceptions of mutual benefit. Groups highlighted the mutual health benefits derived from friends and the local community from simply ‘*being there*’, providing support, or by working together for the benefit of the community. Discussion suggested a moral obligation on the part of participants, but also recognition of the personal benefits of reciprocity. In some cases discussion reflected the nature of the groups sampled with a

number engaged in community activities, *'it's like me I like doing volunteer work most of these things is going round to old people's place maybe sticking a door...so you go in there and you like find they just want to talk to you.'* (Group 5). A number of younger participants highlighted the effectiveness and personal benefits of participating in a youth forum, *'we've actually got like people's opinions across like the town and everything now we're not getting blamed for vandalism...'* (Group 2). The potential of individuals in community campaigns and networks was also highlighted in a woman's account of her work for a drugs support group which she set up to work in partnership with schools; *'so anyway I've put in for funding to do a parents' pack and I've applied now to get funds for every school in Merthyr...for just a basic drug awareness pack for parents.'* (Group 1). Other community networks related to support groups for those with specific diseases, self help groups, hobby and leisure interest groups and rotary organisations.

Although the benefits of community networks were highlighted, there was feeling that community relationships had declined, with older participants and those from ethnic minority groups in particular highlighting negative changes. Parents were most concerned with a decline in community trust and safety. This impacted on their children, who were seen to be *" largely confined to the home area now especially middle class families uh and even the social group what I would call the working class social groupings have been influenced by child abuse and um rampaging newspaper editorials about dangers to children on the streets "* (Group 6). It also meant that facilities like the local swimming pool and park were not used by children, *'The park is a dangerous place now it's not like it used to be.'* (Group 1). Younger participants however talked in depth about how such fears and a lack of belonging led to feelings of marginalisation and being stereotyped as 'trouble makers' in their local areas. This not only impacted on feelings of self worth and belonging but led to practical difficulties in accessing local spaces, *"Another big factor as well is the leisure centres they call em public leisure centres but they don't let the public in em"* (Group 2) .

The feeling that social values had changed was also apparent when participants discussed their work communities in both affluent and less affluent groups. There was general agreement that employees were primarily seen in instrumental terms, with employers paying little attention to social responsibility. There were no examples of work organisations taking responsibility for the health of others. Rather individuals relied on the law to protect their health and utilised regulation and its enforcement, with a new 'litigation culture' emerging. One group in particular illustrates the view that employers are driven by primarily by profit and outputs,

*Participant 1- "You know they're only interested in production they don't care if you're stressed going home from work I don't know an employer who has been anyway"*

*Participant 2- "To stop you getting stressed it's going to cost them money and they're not willing to fork out any money they're going to get as much money out of you as what they can. If you go off sick so a lot of places don't pay sick wages now so you gotta claim of the social so they don't care they just go OK next one in".(group 5).*

Such values were also seen to have been adopted by public sector employers, who were now no longer seen to be traditionally caring but driven by outputs *"I did 12 years in industry and then got out of industry and got into what they call the caring industry cos I work in a hospital and when I started it was a caring industry no talk about productivity I'd left that behind in the factory and now they start talking about productivity and that in the*

*hospital you've got no chance. Its just beds in beds out. Its empty beds that's all they want, get em in get em out (Group 5).* For some participants in more affluent groups this lack of social responsibility was tied up with the natural way of things, *"There's always from time immemorial been that some will be at the front and some will be at the rear..."* *"life is competitive isn't it"* (Group 6)

In summary, whilst discussing the underlying reasons for the increased demands on social relationships for health, the majority of groups highlighted an increase in the sophisticated marketing for unhealthy products and a breakdown in trust in food production. It was also apparent that the majority of participants viewed their work communities and many their local communities as instrumentally driven and lacking in socially responsible values that supported and encouraged individual belonging and mutual responsibility. Those from less affluent backgrounds experienced these most keenly. Such participants also discussed a number of structural barriers to fulfilling roles and responsibilities for health in qualitatively different ways to more affluent participants, and it is to these that we now turn.

### **3.4. Structural determinants of health**

#### **3.4.1 Local physical environments**

As well as the social aspects of their communities outlined above, participants also discussed the physicality of place and its influence on health. In groups from more affluent backgrounds, and to an extent from more rural locations, the discussion turned to the favourable aspects of the physical environment and how this was closely linked to a sense of community and well being. In nearly all examples participants engaged in downward social comparisons, comparing and contrasting their locale with what were seen as less favourable areas such as inner cities, where *"people get injured and stabbed and killed and whatever"* (Group 6), whilst at the same time playing down the influence of environment on health in such areas, *I don't know if I'm being naïve but with living in poor housing...I don't think nowadays people live in housing that bad* (Group 8 ). Young people in one group described how their local area was a *'nice place to live'* with *"fresh air"* and how this would encourage them to move back into the area. In another group, participants commented on how the positive aspects of the physical environment encouraged them to move into or stay in the area,

*Participant 1 – "I moved down here I chose to move down here 4 years ago you chose to move here you chose move here why because green and pleasant land space peace uh less stress culture you name it"*.

*Participant 2 – "it's another headline there isn't it happy people make for healthy people surely happier living in a more pleasant environment aren't you as we are down here so that's the big factor too I think"* (Group 6).

However, not all participants drew on positive experiences, with some in more rural groups arguing that this *'idyllic'* area was far from stress free, with declining economic conditions and services *"the impact on rural communities has been quite devastating...there have been arguments about the influx of um new residents to areas as to having an impact but one of the big impacts has undoubtedly been economic factors which have affected the farming industry and continuing to do so and that's something we*

*all have to cope with here because we're surrounded by farms small farms that have gone bust and farmers have been found hanging in barns I mean it really has been quite a serious situation (Group 6).*

Those from lower socio-economic groups were more likely to focus on physical aspects of the environmental that represented direct threats to health such as pollution from factories and in one case their close proximity to a nuclear power station. The majority of the time however, discussion centred on physical aspects of more private spaces with many examples of poor housing experienced by themselves, friends or families, with one participant stating *I've also got to live in damp low quality housing or to be homeless. (Group 11)* and another that they *"had a pipe in my back garden every time they flushed upstairs it was going all over my back garden.* This led another group member to observe *"like she said she had that problem {pipe in back garden that overflowed every time the toilet flushed} with her house you could be as healthy as you want but with that in your back garden you can still catch disease from it so it ain't just about what you eat is it its about everything really .*

### **3.4.2 Local services and facilities**

Less affluent participants also more readily discussed the provision of community resources, with those from more affluent backgrounds failing to highlight service provision in any real depth. Participants referred to the way in which they were constrained by limited and inflexible community facilities which did not respond to community needs. For example, in one group participants discussed the inflexible opening hours of the local leisure centre concluding that *"our leisure facilities are absolutely terrible, shocking (Group 2).* These sentiments were echoed in another group where there was criticism of the opening hours in the local swimming pool. *"There's a swimming pool and I would say it's only used three hours a day maximum properly through the week and then it's closed on bank holidays. Seaside resort, Bank Holiday, swimming pool's closed and you're like 'Oh well?'" (Group 1).* Ethnic minority participants also highlighted inadequate leisure services due to a lack of cultural sensitivity and women only classes

Considerable discussion also focused on community health services, with less affluent groups making unfavourable comparisons with more prosperous neighbouring communities. For example comparisons were drawn between the level of health services available in a local village compared with a neighbouring town,

*Participant 1 "you've got to be healthy here. because we haven't got a doctor after 5.00 (agreement and laughter), you cannot be ill..."*

*Participant 2 "And you can't see the doctor he has to phone you first..."*

*Participant 1 "The only place you can be unhealthy is Brecon as they've got doctors in Brecon (laughter)" (Group 2).*

These comparisons were particularly acute when considering what were seen as localised health problems such as drug misuse and teenage pregnancy, where services were not thought to be adequately tailored for young people, *'my sister's friend was pregnant when she was 16 she went to buy a pregnancy test from the clinic and they wouldn't sell it to her they said no 15 she was and they said she wasn't old enough but I don't know if they've changed that now but at the end of the day where else is she supposed to go she went to the clinic like (...) its closed most of the time' (Group 2).*

Similar experiences were highlighted by ethnic minority participants who discussed inadequate provision for patients where English was not their first language.

### **3.4.3 Individual responsibility and structural determinants**

In the majority of groups there was considerable discussion of how structural factors might influence health. As participants discussed the roles and responsibilities of the individual in responding to such structural constraints, further light was shed on how such responsibilities in oneself and others are rationalised and justified. Whilst some participants in higher income groups were able to reflect on potential links between structure and health, in general the importance of these was subsumed by moral judgements concerning choice and agency. These judgements were reflected in the discussion of less affluent participants who referenced them when discussing their responses to health advice and, in a similar way to younger participants, the construction of a separate social identity.

For more affluent participants, when considering the situation of others discussion quickly focussed on individual responsibilities and the concept of equal capacities. This may reflect a general tendency to ascribe internal deficiencies when explaining socially unacceptable behaviours in others (Ross, 1977) but did seem rooted in their own experiences of personal agency. Groups were likely to highlight internal deficiencies such as a lack of understanding or valuing health for poor health behaviours in those perceived to be less well off,

Participant 1- *"I think you can alter you're behaviour because it's not necessarily a monetary issue...it doesn't cost you to give up smoking or to go for a run around the park.., Just cos you're poor doesn't mean you can't...you can still run etc....you can do that you know"*

Participant 2- *" A social thing, people find themselves in low cost housing... are there because they didn't take an active interest in their education...they're quite happy... 'Just generally lazy people' 'there's a higher percentage on council estate who are less motivated in life and quite happy to sit on government handouts' (Group 8).*

When alternative perspectives were raised these were quickly challenged by other participants in the groups

Participant 1 –*"I am lucky enough I've got a choice because I can afford to have the choice but I can take you to houses council estates here in Carmarthen where the parents have no choice because of financial reasons'*

Participant 2-*" No I'm going to disagree with you strongly there parents have a choice of what they provide they go to the shopping with whatever amount of money they have at their disposal and they choose what's on the shelf in Tescos or any other (Group 6).*

Alternatively education was presented as a resource that could be used to address inequities, through individual betterment as, *'all education is important however low down the scale you may be isn't it you can always improve yourself by education'* (Group 6). Failure to do so was presented as a failure of individual character, a perspective that contrasted with a less affluent group who highlighted a lack of pupil motivation within the context of poorly resourced schools which were filled with *'an air of depression'* and referred to as *'dumps'* (Group 3).

Although a significant minority within less affluent groups also highlighted the ability to make choices and exert agency, *“at the end of the day everybody has got the choice to say no you know you can’t be forced into smoking if you don’t want to.”* (Group 2), the majority were more likely to highlight external factors that acted as barriers to enacting responsibilities, particularly cost and availability, where there was considerable consensus,

*Participant 1- ‘Wherever you take em to you gotta have money’*

*Participant 2- ‘You go to Asdas or Tescos and it’s (fresh fruit and veg) extortionate’ ‘Same with healthy eating food you buy, they tell you to eat healthy eating junk is a lot cheaper’*

*Participant 1- You can get a packet of biscuits a snack for the kids 20 odd pence 30 odd pence something healthy, healthy bars grain you get one bar for 50 pence.*

*Participant2 - ‘sometimes the healthy option costs more than the options easier to buy and get fat.’*

*Participant 3- ‘fruit and veg is quite expensive though’*

*Participant 1- ‘I know but how much is an apple about 19p innit something like that (..) but when you think about how much you get on benefits and stuff you think about your weekly amount of money to go shopping you can’t buy all that in one go it’ll be too big and all be gone off’ (Group 1)*

Subsequently, discussions highlighted an awareness of and typical responses to the sorts of moral judgements highlighted., *‘they got their posh cars they got their posh eating they got money and then they turns round and says people on social are getting too much.’* (Group 1) and *‘that’s another thing people they don’t want me to smoke in public places and its like you gotta go on at me about smoking and I say well I’ll stop smoking when you stop driving your car (..) when you start riding your bike to work I’ll give up smoking...’*(Group 2). In many cases discussion moved on to highlight mistrust and suspicion of government, *‘I gotta be honest I think the government make their mind up on things when they feel like when it comes into what they’re getting paid to work on for this month when something really big happens it’s all against that then and buggger everything else.’ ‘The government are quick to tell you what not to do, they’re not so quick to sort it out.’* (Group 1) who were often seen to be motivated by instrumentality rather than social responsibility, *‘it has to make you ask the question, why are they so worried and the thing that keeps on coming back to me, is why is the Government worried about the nations health. You think you don’t give a damn about me or Jan, not, but you’re worried about the budget, they don’t care about us as individuals.’* (Group 3).

The use of language frequently reflected an ‘us and them’ mentality and in and out group processes, with feelings of marginalisation and a lack of mutual trust and responsibility between socio-economic groups and the state and the individual apparent. This is perhaps best summed up by a participant at the end of one exchange *‘Ah well that’s the way we are up here we do things wrong’* (Group 1). Some participants went on to discuss their refusal to take responsibility for health in positive terms and as a response to stigmatisation. Discussion highlighted resistances to health advice as a way of maintaining agency, *‘But who decides what quality of live is, you know, that is a very subjective, sort of, argument, isn’t it, you know, who determines what somebody’s quality of life is.’ ‘It’s only yourself who can know that.’ ‘I don’t want to walk miles, yeah, but I don’t walk the miles, so I never walk that mile, do you know what I mean but my quality is doing the things but, that I want to do.’* (Group 3). In this way negative social judgements

of groups and behaviours were used to develop positive social identities and increased feelings of control .

### **3.5 Organisational roles and responsibilities for health**

As participants explored issues of individual responsibility talk naturally turned to their views and experiences of how statutory and non statutory bodies either complemented or conflicted with their own roles and responsibilities. The following section focuses on discussion concerning the types of roles and responsibilities for health that are assigned, to which organisations and bodies and why. Health improvement roles and responsibilities were discussed in relation to a range of organisations including local statutory organisations (Local Authorities and Health and Education Services) non statutory bodies (employers and the media) and central government. The responsibilities of local level statutory bodies included addressing the structural determinants of health, facilitating healthy behaviours and supporting the development of a sense of community. Such responsibilities were largely seen to be determined by value judgements concerning statutory responsibilities, moral assessments about choice and agency, as well as issues of resources and effectiveness. There was general agreement about school roles but variation by socio-economic status in relation to local government and health. These local level organisations, along with community and voluntary groups represented important arenas where less affluent individuals felt able to develop meaningful roles and address mutual responsibilities for health. For non statutory bodies there was consensus that profit imperatives frequently impacted on population health and discouraged shared responsibility for health. It was here, addressing unhealthy marketing, food production and working conditions, together with ensuring clear and consistent health information that the role of government was seen as crucial. This role was again determined by a mix of social values and perceived issues of resources, authority and effect

#### **3.5.1 Local Authorities**

Amongst lower income groups in particular, discussion focused on the need for Local Authorities to invest in local facilities that protected and promoted health and highlighted a responsibility for the maintenance of neighbourhoods and communities. Authorities were therefore seen to have responsibility for addressing the social determinants of health and to provide a framework of individuals to take responsibility for their health. There was little prolonged discussion as to why this might be, as these activities were seen as statutory responsibilities and Authorities had the power and resources to effect changes that went beyond that of the individual. Less affluent participants, suggested an additional moral obligation on the part of Authorities to protect the more vulnerable members of the community such as the elderly, younger people and children. When asked about examples of activities that impacted on health, these participants drew on their own experiences with community based activities, focussing on facilitators of exercise and a healthy diet but linking these to broader psychosocial benefits. The use of community dieticians, Healthy Living Centres and food co-ops were all described positively by lower income participants in terms of their impact on the physical and social health of local communities. For example. co-ops were seen to provide cheaper, healthier food, as well as serving positive social and economic functions in the local areas *'a good thing that has happened in a deprived local area recently is a food coop. Every Thursday you can get coffee and tea in a local centre and it's £2 for fruit and £2 for vegetables. This*

*supports local farmers. I think it's a good thing because it brings people together.'* (Group 11)

Discussion highlighted some concern as to the reach of such initiatives, a case of the "usual suspects" participating, but it was felt that over time, messages and health practices were filtering through the communities so that now, *'There's a lot of people especially down in the Gurnos who perhaps wouldn't be buying that amount of veg and they are, they have changed their eating habits'* (Group 7). Activities held in conjunction with the Healthy Living Centre were also seen to serve the dual purpose of strengthening social ties as well as facilitating healthier lifestyles. The view that initiatives needed time to facilitate uptake and reach deepened participants' arguments for a moral basis to local government roles and responsibilities. They were seen to have an obligation to maintain their responsibilities to those in need once they were undertaken. A number of less affluent participants, *".. if there's enough groups doing it the message will get through slowly cos you know" 'it's a long term thing innit'*. It was considered that the governmental sponsors of initiatives placed unrealistic expectations on the local communities to sustain schemes and were over reliant on volunteering. In some ways this was considered to do more harm than good by raising expectations and then abandoning the good work that was being done.

### **3.5.2 Health service**

When discussing the roles and responsibilities of the health service, the focus was almost exclusively on the NHS as a treatment rather than a prevention service. Across many of the groups there was recognition that health services had a key role to play in addressing unhealthy stereotypes and roles in society. As public services it was felt that they had an obligation to address unhealthy practices. Health services were seen as reflecting rather than responding to unhealthy masculine roles. *'If a woman went to the clinic and said something I think the people there would treat it more sensibly cos it's a woman but if a man went there they'd just tell him like women do get treated different and men don't get treated half the time'*. This was partly felt to be because *'there has been the well woman clinic, and possibly because of childbirth women are more likely to be receiving more medical input than men, I think there ought to be targeting of issues relating to well men'* (Group 6). This led to a number of suggestions as to how services could be targeted more effectively to address mortality rates in men. These suggestions came from both male and female participants and included men targeted from a younger age to reduce embarrassment; *'women always get check ups smears whatever men never get asked to...(...) boys from a very young age should be shown when they get tests and stuff (...) to show that they're not embarrassed to cos I think that's a lot of the problem with Chlamydia infection boys won't go to the doctors'* (Group2).

It was also implied that health service approaches reflect and perpetuate age stereotypes associated with younger and older groups. In an older participants group it was explained; *'Dan and I are probably the oldest here now uh when we got the doctors with a problem which is concerning us what do we get what do you expect at your age...'* (Group 6). Inadequate services catering for the health problems of younger people were also described in one of the young people's groups:

*'but I don't think there's any centres around here is it for drug addicts or kids'. There was also perceived discrimination in screening services: 'Well those breast vans that come around and young people us girls are not allowed there till they're about 40 which is wrong my mother can just go over and be tested random like and we can't "if they really wanted to prevent it then they'd do tests on everyone' 'usually breast cancer in young people is more dangerous and more severe like everyone should be treated the same' (Group 2)*

Further areas of discussion found socio-economic background emerging as a key area. Less affluent participants and those from ethnic minority groups emphasised their concerns and experiences regarding shortcomings in treatment and services as previously discussed. They expressed far more health needs and a greater reliance on the national health service to address those needs. Opening times, locally available services, youth friendly and multilingual services all emerged as issues. A greater reliance meant that participants expressed a fear that what were seen as mutually understood and agreed roles and responsibilities for health were being abandoned due to competing financial pressures. Although for some there was a recognition of the financial implications of NHS responsibilities, they were expressed in terms of mistrust for "this target culture" and a loss of socially responsible values, where it was argued that you "do so many blood pressures a week, you get so much money and now, you know, what is she concerned about, is she concerned about putting up her bank balance or is she really concerned about my blood pressure." (Group 3)

The idea that health services should have an increased role in prevention was not widely discussed within the groups, when it was it was more likely to be amongst more affluent participants. Here there was agreement that there was a need to reorient health services to address the underlying causes as this would result in a more effective discharging of existing responsibilities regarding treatment. A prime example is provided by a discussion on what was seen as an unhealthy tendency for GPs to over prescribe drugs for symptoms rather than try to offer alternative treatments of cause such as counselling, 'I think that doctors are too ready to give drugs for depression and not giving the time for someone to talk about their problems. Often they get five minutes and that's it' (Group 12). There was recognition however, that ultimate responsibility for this lay with central government who were seen to determine the discharging of roles and responsibilities through budget provision. More affluent participants also highlighted a reorientation in responsibilities which reflected not only issues of efficiency and effectiveness but the morality of choice and agency previously highlighted. Here it was felt that individuals should be held accountable for the outcomes of health choices,

*Participant 1 – "it's interesting that the NHS increasingly now are asking questions about people's health aren't they and the way they are or are not looking after themselves which again should influence the waiting lists so one would treat those with **real problems** (emphasised) rather than those who people who smoke 50 a day'*

*Participant 2 – "what about the people with problems who exacerbate ....*

*Participant 1 – "yes exactly, we all pay for your national health service but **you're** not getting it" (Group 6).*

### **3.5.3 Education services**

The education system was discussed in the majority of groups as participants considered deficiencies, needs and examples of good practice. Younger groups drew on their own experiences of schooling, whilst parents and older groups reflected on the experiences of their children or grand children, as well as recent media coverage. In addition a number of participants reflected on their professional roles as teachers.. This provided far more discussion as to the nature, extent, rationale and means of discharging roles and responsibilities than any other sector. There also seemed to be a strong consensus across groups that schools have a critical role to play in terms of education, provision and the wider school environment. There was broad agreement as to the reasons why schools had such a prominent part to play. These reflected an accepted social value, a sense of the obligation that schools have to pupils, which itself represented the obligation that society has to its younger more vulnerable members. This was reinforced by the idea that children were not responsible for the consequences of their actions in the same way that adults are. In addition, and significantly, issues of perceived effectiveness, meant school initiatives were seen as a means of addressing parental concerns over less controllable changes to family structures and social context, whilst children were also seen as a cost effective target group that could be more readily influenced early in their lives.

#### ***Lifestyle education***

Nearly all groups highlighted a critical role for schools in education for a healthy lifestyle. Parents tended to compare their own experiences against current approaches which were seen to be inadequate. Many younger participants were also critical of curriculum approaches to health. Older participants focussed on the benefits of a skills based approach that included role play and practice, with some arguing for the return of home economics. This approach was seen to be effective in a range of important life skills such as cooking and managing a budget, *“When I used to do cookery in school you had to take all the veg and prepare it all and you’d do it properly and I still cook that way now, it’s very rare I use frozen or tinned foods.”*, this was contrasted with a current example by another discussant, *“There was one incidence where they told my granddaughter to take a pot noodle. She was told to take in pot noodle!”* (Group 10).

It was thought that schools should not only teach children how to cook food, but should also teach children about food production, the nutritional content and the financial cost of various foods, *‘They should explain everything to you explain why, what calories do and stuff like that coz they don’t really do that’* (Group 4). A general detachment from nature was seen to be a common problem in a number of groups. For example, one participant who is involved with a gardening project with local schools explained how a lot of the children were unaware of where different fruits came from and described how growing fruit and vegetables could help build this kind of awareness, to *“Improve education and knowing what to do with and what where everything comes from.”* (Group 5)

Younger participants focussed on the inadequacy of education for sexual health and drug misuse and the need for trusted and expert sources,

Participant 1 - *‘it was like, they (the teachers) weren’t given any instructions on that and*

*that doesn't help because it was just everyone switches off and it's an awful lesson.'*  
Participant 2 - *'I don't remember talking about, all I remember is them telling drugs are bad, and sex education, and I think that was about it really.'* (Group 8)'

The use of external experts was thought to be one way forward, as they were thought to be , *"someone who actually knows a bit more about it."* (Group 8), but also to be able to address sensitive issues more easily and would be trusted with confidential information. *'It was just some people were too ashamed to admit about sex and that and the teachers just will not teach it' 'Cos its your teacher innit how are you supposed to tell you teacher stuff like that' 'They don't keep it confidential'* (Group 2). In one group, this need for external experts and high quality lessons was considered important not only for educating pupils, but addressing the much discussed absence of parental skills *'I think you have to educate the generation that you're targeting and then you have to try and reach them because you got them in school everyday, ten weeks at a time, whatever and hopefully they will take the message forward because the children will help to educate the parents, there is nothing more successful than a child asking its mother constantly to give up smoking.'* (Group 3)

### ***Environments and policies***

Participants recognised a need to support curriculum teaching by creating environments that facilitated healthy behaviours. Half of the groups discussed physical activity, here discussion identified concerns with a perceived reduction in levels of exercise in schools due to pressures on the curriculum, *'if anything goes in a week, it would be your PE slot'*, meaning not only that children are getting less exercise but also that that this would affect their attitudes to exercise. However a need for healthier food provision was recognised in nearly every group and discussed in terms of problems and potential for improvement. One of the main issues with school dinners was with unhealthy processed food; *'But if you've been watching Jamie Oliver's School Dinners it also looks as if some schools are equally to blame in some respects because they've been falling into the trap of giving people processed food because it's cheaper. '... (Group 5). These were seen to have consequence beyond the school gate, "So I put them on dinners and one of them came home one day and when I asked them what they had for lunch he said 'windows,' which are waffles, and my younger boy said 'I've had a dog bone chicken drumstick.'* Then they started saying they didn't like this and they didn't like that and it actually spoilt their eating habits ' (Group 6 ) and similarly, *'The garbage they have been giving children in schools. Those chicken nuggets. It is garbage and nothing else. They are going to school to get an education and to learn, and if they learn that this is the stuff to eat then it's not a good education'* (Group 12).

These concerns were compared and contrasted with the perceived benefits of schools discharging their responsibility to protect the health of their children. These roles and responsibilities were not only justified by moral consideration but issues of cost and educational effectiveness *"I think one thing that will guarantee the child healthier meals really would be if pressure was put on the schools and on the government to provide a healthy meal for all the school children and if necessary free because the eventual cost that would be saved in 20 years time because the children would be so much healthier but people need to start spending money now as an investment in the future.'* (Group 5). The behavioural implications of improving dinners were also identified. *' a by-product of*

*that which astounded Jamie Oliver and astounded us as well but wasn't really a big surprise was the teachers came back and said the actual discipline in the classroom was now improved dramatically because the kids are eating proper sensible balanced food (Group 6)*

Possible practical ways forward for improving school food provision were also highlighted. Several participants described how vending machines were being withdrawn from local schools and healthy tuck shops, fruit bowl and salad bars introduced. These were seen to be effective in the long term, *'So it did work in the end, it was getting a lot better because the option was there, people were like oh, well we'll try it and obviously it got better.'* (Group 8). The introduction of water machines in schools was also mentioned as a positive development as were Breakfast Clubs, particularly as they addressed cost as well as issues of availability, *'At the moment they pay for breakfast club. If it were free maybe more of the right sort of people who need to use the breakfast club would have access to it. Rather than at the moment it's only those who can afford it and who are more enlightened use it whereas they're not really the ones who necessarily we need to get in to the breakfast club.'* .... *'If the mums and families felt that these children were going to have their breakfast free then it might give them the motivation to get the children out, to get them to school whereas they maybe haven't got that at the moment because they can't afford it anyway.'* (Group 9).

Two of the groups (Group 1 and 12) went onto talk quite explicitly about 'whole school' approaches to health promotion, for example *'I'd like for someone like Jamie Oliver to come in and suggest what to do and for the children to be involved. It's no good just putting it in front of the child. Ask them what do they like and what would they like to try and have a huge session of trying different things and you could incorporate that into any lesson. Quite willingly we'd do a whole school thing on this, it's just everybody working together.'*.... (Group 1). Participants highlighted the need for consistency between school policies and the need for new or better enforced healthy eating, anti-smoking, anti-drugs and bullying policies that confront the influence of peer pressures

Despite these positive suggestions however, a minority of participants highlighted a tension between the role of the school, individual choice and parental roles and responsibilities. Ultimate responsibility for the health of pupils was seen to lie with parents and with the pupils themselves. These often presented limits to what school level action could achieve, as one teacher put it *"people who don't like pasta go up town and go to MacDonalds"* (Group 5). Legal, financial and organisational frameworks were also seen to act as barriers to schools' ability to discharge their roles. Local Authorities were seen to be responsible for the staff and financial resources that enabled schools to fulfil their responsibilities. Nearly half the groups discussed budgetary or staffing constraints that were seen to be the responsibility of local government. For example *'to be fair to the cooks there I mean if there's only one of them or two of them there and they don't come in a couple of hours early they're not going to have time to clean the veg are they'* (Group 5). and in relation to the revenue raised for vending machines, *'It's the LEA as well, not just the schools. They provide chocolate machines don't they in school? Especially in the secondary schools, which is probably the very time they should be targeting kids'*. (Group 9). Whilst central government was largely seen to constrain rather than facilitate school health improvement roles. Government pressures to prioritise core subjects at the expense of other health related subjects such PE, PSE and home economics and auditing were seen as over intrusive, *'So there's still no room for teachers to innovate and*

*to think for themselves what does this community need at this particular time and because we've been obsessed with standards and standardising standards' (Group 3) . This was compounded by what was seen as the general litigiousness of contemporary society which deterred the potential activities of schools*

#### **3.5.4 Shared responsibility for health**

There appeared to be strong consensus that schools had a responsibility to protect and promote the health of pupils via education, policies and provision. The reasoning behind this was both moral, given their relationship of care with children, and practical, given the likely effectiveness of actions and the efficiency of dealing with groups. Discussion on other local statutory agencies highlighted more variation, with lower income groups engaging in more debate about the need to provide adequate local services that provided support for more vulnerable members of the community and addressed the barriers to physical and psychosocial health. It should be noted however, that discussion also focussed on the relationship between organisations and between individuals and organisations. A number of participants in discussing such issues raised the issue of shared responsibility for health.

Discussion concerning shared responsibility focussed in the main on local level statutory agencies and took place amongst less affluent participants. There was general agreement that statutory bodies like schools, local authorities and health services needed to work together to ensure consistency of messages and policies,

*Participant 1 - "Attention to detail needs to be done sort of systematically through schools through health centres anybody who's got sort of working for the government no matter how loosely they should be ensuring that the message there's a consistent message then going through that this is how you should be eating you know proper um home cooked food"*

*Participant 2 - 'it's long term it's not just you can't have just one group doing it it's got to be consistent and it's got to go perhaps through the schools through the health centres through any community work you know anybody working with people from the community it's just got to be that consistent message through all the workers' (Group 5)*

In terms of facilitating shared responsibility between individuals and organisations, voluntary and community groups were presented as key facilitators. These allowed individuals to come together to develop shared values and objectives, pool resources and to clarify and support mutual roles and responsibilities for health. For example, in an older people's group the joined up working of social services, the health services and local epilepsy pressure groups was seen to be important to the effectiveness of the services provided. Interestingly, those from more affluent backgrounds engaged in little discussion on shared responsibility for health and made few references to organisations or frameworks that facilitates mutually agreed roles and responsibilities for health.

#### **3.5.5 Non statutory organisations**

There was little expectation amongst participants that non statutory organisations would take responsibility for others' health or that shared responsibility could be developed

without effective regulation. The nature and purpose of these organisations meant that their responsibilities were to generate profits, sometimes at the expense of the health of the individual or society in general. In the case of employers, several of the groups discussed the health impact of poor and stressful working conditions, but most saw corporate responsibility as desirable but unrealistic as business was seen to be motivated by instrumentality and profit,

Participant 1 - *'My boss wouldn't give a shit (...) that's all he cares about is the shop's clean and the money is getting paid'*

Participant 2 - *'All they care about is you doing the work so they can have money innit'* (Group 2).

Although a small minority of participants tentatively suggested that this might be due to a lack of awareness of the benefits of taking health improving action, such as reduced sickness absence, *'It's just awareness you don't have to tell people what to do, it's like with exercise you could just explain if you do this every day it's good for you...people need to know that would happen and then they'd do it...hopefully'* (Group 8), this view was not supported. Employer responsibility for health was primarily seen to manifest itself in relation to health and safety legislation and this was seen to be motivated by fear of litigation and a subsequent loss of profit not any higher moral desire to comply, *'it's not for safety, it's so you can't sue anyone'* (Group 8). In the same way, schemes like 'Investors in People' were discussed not in terms of health benefits but instrumentally, as a way companies could generate additional profits through PR exercises.

A similar perspective was offered on the role of the media and advertising. Nearly all groups agreed on the negative impact of advertising on health behaviours, particularly for children. In addition, general media coverage of issues meant that participants dealt with confusing and contradictory information and built up perceptions of unhealthy normative behaviours. There was recognition that the media can have a powerful effect on health behaviours, particularly through the use of well-chosen role models to promote health with children; *'I can remember at the junior school when my children were there somebody, I think he was a footballer from Swansea, came to give a talk about healthy eating and it really did make a big impression and eldest one gave up meat and all sorts, no chips and it lasted for a good 3 months and he finally weakened but it was very powerful and it wasn't coming from me it came from him. 'I don't want to eat these things anymore because I won't have a healthy heart', I think that was the campaign and it did work'* (Group 9). Discussion of media good practice highlighted the potential role for public service broadcasting and influential role models who encouraged and facilitated responsibility for health in individuals and organisations. Three quite different groups (Groups 4, 6, 11,) identified a *'Jamie Oliver effect'* (Group 4) in relation to a recent television series focussing on school dinners. This was thought to provide a model for future broadcasting to promote health, *"First and foremost I'd like to say that that Jamie Oliver programme, that series that was on a few months ago was an eye opener, we have discussed healthy eating in the park. It must've altered, it certainly opened the government's eyes, it opened the majority of the populations' eyes, you know 9 out of 10 children who have school dinner are eating turkey twizzles. (Group 11).* However, broadcasting in the public interest was seen to be the exception rather than the rule. There was little agreement that the media and advertisers would take account or assess the negative consequences of their actions. This was because participants generally doubted the extent to which profit driven companies would act in the public interest

without regulation and for this they turned in their discussion to the roles and responsibilities of central government.

### **3.5.6 Central government**

Discussion of private sector responsibilities in groups naturally led to the role of government in everyday life, focussing on whether governments should inform and facilitate health behaviour change through awareness raising and information or regulate environments that impact on health. Again, socio-economic position was associated with the relative roles and level of responsibility assigned to government and individuals.

More affluent participants were more likely to support the improved provision of health information that encouraged and enabled individuals to make decisions about their health. The focus of discussion was on the improved clarity and targeting of health promotion campaigns. For example one group called for clearer information on drink driving, *“But I wasn't sure, as in, certain drinks, how many units are in a drink and stuff, I know sometimes they write it down and you get it like if you buy drinks in cans and stuff, but they don't always make that clear in pubs and clubs.”* (Group 8) . Whilst another argued for targeted content that addressed health related attitudes and norms *“basically there are some people who smoke and they do try and cut down a lot because they know it's bad for them. And there are some people who just think smoking is really cool and in it still, they don't do it because they like it, they do it because they want to be cool, and it's like, some people have that attitude, not many but that's a small group and you have got to try and show them that it's not cool and then maybe they will realise that their health is, well maybe they will think that maybe I should do something about it'...(Group 8)* . However, there was some concern expressed as to whether this information was reaching those most in need,

*‘That's the thing with this health thing right, people that don't know about it don't know about it for a reason right, they don't actually go looking for it. The people that know about it are the people that actually look for it if that makes sense’ ‘which means they're not bothered or they are bothered....If you're not bothered to start with you're not gonna really bother. (Group 4)*

Less affluent participants tended to be more critical of the effectiveness of governmental roles in this area. They were more likely for example to query the effectiveness of Health Challenge Wales in relation to themselves and express mistrust. Talking about Health Challenge Wales one participant commented; *“I have no idea what the challenge is really. I presume they want us all to be better but I don't know what they mean by better or who decides what better is.”* (Group 3) . These groups were more likely to highlight activities that focussed on the resources and structures in local areas that were highlighted above,

Participant 1 - *“Well all the points (of HCW) are valid (group-yeah) but they've been having the same points for years though and what's been done about it. ”*  
(group agreement)

Participant 2 – *“Yeh that's nothing new ”*

Participant 1 – *“There's nothing new”*  
(...general agreement noises)

Participant 1 – *“It’s just it is a very expensive sort of publicity thing really, they’re only saying what everybody knows”*

Participant 12– *“The problem we’ve got is they’re not putting the money into the workers on the ground, in the villages and in the communities in order to get these things going (.....)”*

Participant 1 – *“ Look at the cost...”*

Participant 2 – *“How many workers would that have paid to help the communities to develop health ? ”*

*(group agreement)*

Participant 3 – *“Yeh everybody knows it’s better for you to be healthy than unhealthy you don’t have to have a major campaign to tell anybody that but every body knows its much wiser to be healthy”*

*(group agreement)*

Participant 4 – *“We all know what we’re doing wrong”*

Participant 1 – *“Yeh we all know we need to change our diets to be healthy”*

Participant 4 – *“And people who smoke know they shouldn’t smoke don’t they (yeah-agreement)”*

*(Group 2)*

Less affluent participants were more supportive of a role for government in regulating business in order to improve health, this covered the working conditions for employees, but also business activities and outputs that impacted on the wider population. This was most apparent when discussing the health effects of tobacco,

*Participant 1 – “The thing is if they want to stop so much why do they let the companies continue to make em and sell em”*

*Participant 2 - “ Yeah I think the thing is they get money from em”*

*Participant 3 – “every packet they sell the government get money from it”*

*Participant 4 – “Yeah they get a quid off it from it”*

*Participant 1 “cos they make so much money off it don’t they I mean and they sponsor pretty much everything don’t they sponsor football all the sports stuff like that” (Group 2)*

Government was also seen to have a role and responsibility to directly address the material and social conditions of vulnerable groups. This was seen to be determined by a moral imperative but also issues of efficiency and effectiveness,. As has been highlighted, this could be achieved by providing adequate resources and a supportive policy framework for local government, health and education services, but also by creating an economic environment that facilitated health. This covered reducing financial barriers to healthy behaviours ,

*Participant 1 - ‘the government could you know cut the costs on things’*

*Participant2 - ‘Especially on the healthy stuff’*

*Group agreement,*

and reducing unemployment levels, where it was felt that *“If you have work you then have self confidence don’t you? If you don’t have work you may feel that you are not fulfilling your potential”*. (Group 1). The exception was the regulation of smoking in public places. Here there was a great variety of views expressed, with little consensus achieved. A number of participants questioned the efficacy of such a ban, *“There should always be places which are allocated non smoking areas. But if you like say you’re not allowed to*

*smoke in 'ere people are going to go elsewhere or you gonna have them standing on the doorstep puffing away so you've got fight your way through."* (Group 2) , but they were challenged by a number of participants who smoked who saw it as a way of cutting down, *'I think you smoke less if you can't smoke in public places.'* (Group 1). Whilst there was broad agreement concerning the responsibilities of government regulating organisations, this was less apparent in the relationship between government and the individual's behaviour. There was a feeling of unease associated with a ban and a sense of loss of autonomy amongst smokers, with talk of *"taking somebody's rights away"* (Group 2). However, these were frequently challenged by others in the group who highlighted the competing right of others to be protected from health risk,

*Participant 1 - "The thing is you might say it's against your human rights if you stop smoking in public places. The thing is its against someone else's human rights if somebody's smoking in there"*

*Participant 2 – "Going back to the pub, you need to consider the creatures working there. We can go in and out for a pint and they are there perhaps for eight hours or more"* (Group 2).

Participants from higher socio-economic groups were more likely to raise concerns over secondary non health consequences that would arise from government involvement in business, leading to additional bureaucracy and loss of profits. One participant argued at length for a more regulatory role for government,

*"There is a lot of uh individual responsibility choices on this list but the I don't think we should underestimate the impact of government planning and government decisions in health improvement take the 1961 clean air act before 1961 um everybody was belching out black smoke all over the place... and similarly with smoking the government's policy on smoking has undoubtedly had an impact on smoking at one time when I joined rotary 20 years ago this club there were probably 50% people who smoked I don't think there are any now so, so what government can do in the macro planning of health control I think is quite considerable and um that goes into planning and socio –economic policy and so on individuals can't have any couldn't have any control about black smoke for instance but collectively you know the government did do something about it"* (Group 6).

However, there was little agreement, with participants also critical of government intervention in terms of their basic social values, *"you start to tell industry what it can and can't do then you're moving towards nationalised firms."* (Group 8). The exception to this was the regulation of individuals smoking in public places. Affluent participants expressed support, but not consensus for regulation in this area. Many of them expressed a desire to protect their own health and those who worked in pubs and clubs. Even here there was a lack of consensus of whether bans should cover places that did not serve food, highlighting similar concerns about and tensions between the rights and responsibilities of the individual and government.

## 4. Conclusion

### 4.1 Implications and recommendations

Using focus groups to examine roles and responsibilities for health with the general public has highlighted the often complex processes in which responsibility is understood, assigned and enacted. Drawing on pre-existing groups has traditionally been seen to facilitate access to “networks in which people might normally discuss (or evade) the sorts of issues of interest” (Kitzinger and Barbour, 1999, 8-9). This allowed participants to reflect, not only themselves as individuals, but as members of friendship groups, families and communities when considering roles and responsibilities for health. Their discussion highlighted a number of common perspectives but significant and consistent differences in who was seen to be responsible for health, whether or not responsibility was acted upon and what these roles and responsibilities entailed in terms of the nature and extent of actions and the groups acted upon. In the main these differences were associated with socio-economic background, with some additional variation by age. These differences seemed to be associated with the different threats to health experienced by these groups, attributions of responsibility and agency, variable experiences of social and economic change and different social values associated with individualism and the role of the state.

Turning first to perceptions of individual responsibility, the majority of participants highlighted that knowledge and awareness did not necessarily lead to an acceptance or enacting of responsibility. This required additional motivation, which was found in older participants and those with immediate threats to their health status. Individual responsibility was also more readily accepted by more affluent participants. This seemed to be associated with their selection and interpretation of information and existing perceptions of costs and benefits, efficacy and outcome expectancies. There was a common view that health advice often needed to be more consistent, to be clearer and to come from trusted sources across all groups, but more affluent participants seemed to associate more immediate benefits and less costs with behaviour change, to value their health more, to have greater feelings of autonomy and behavioural control and to be less fatalistic about the future. At one level this highlights the importance of research based targeted health promotion campaigns. This would facilitate campaigns that utilised appropriate channels, sources and content for messages. For young people and those who are less affluent there appears a need to focus on immediate non health benefits of and the skills needed to undertake change.

However these differences in perceptions were associated with variation in the experience of structural disadvantage and social and economic change. This highlights the need to draw on organisational roles and responsibilities to address the variable social and physical conditions that impact on health of different groups in society. Affluent participants were able to draw on feelings of autonomy and resources to enact individual responsibility more readily. They were also attributed agency and choice when discussing others' health risk behaviour. On both sides, moral judgements were seen to be being made in relation to enacting roles and responsibilities. For some less affluent respondents, this led to resistance to and mistrust of health promotion advice. Feelings of marginalisation and stigma are unlikely to lead to collective social responsibility. Arguably

there is a need to further understand the relationship between perceived social position, social comparison judgements, moral frameworks and attributional processes to inform appropriate policy approaches.

Aspects of community, both physical and social, appeared to impact on participants in qualitatively different ways. Less affluent participants experienced more direct insults to health, relied more on statutory services to protect their health, and expressed higher levels of dissatisfaction with service provision. Although some more affluent participants acknowledged these, their impact was played down by the majority. Less affluent respondents expressed a greater dependence on local statutory services and saw more of a role and responsibility for them in protecting population health. Statutory services by their very nature were seen to have a moral obligation to protect the vulnerable in society, but they were also perceived to be the most effective bodies to do this. Overall there seemed a strong desire to maintain what were presented as mutually agreed roles and responsibilities between the individual and the state. Overall discussion focussed on the role of statutory bodies in the treatment rather than the prevention of health problems, something that was also found amongst more affluent discussants. When prevention was discussed, effectiveness was seen to be determined by gradual normative changes and reliant on long term investment. Structural barriers that need to be addressed within local communities were housing, safety, leisure services, targeted health services, the provision of fresh locally produced food and an examination of how work and leisure patterns encourage sedentary lifestyles. The latter for example will require an assessment of how activity can be developed in day to day activities and for less affluent participants how leisure and community facilities can be encourage inclusivity and feelings of safety.

Lower socio-economic participants also expressed unease with what was seen as rise in individualism at the expense of collective community values. These feelings were associated with a perceived increase in instrumentality, profit motivation and consumerism. They highlighted more examples of the use of extended social networks, and voluntary and community groups when enacting their own responsibilities for health. It has been argued that perceptions of collectivity are developed and expressed through such social networks (Davidson et al, 2005). The relationship between perceptions of place, issues of social capital, but also wider economic and political processes could usefully be examined to understand how they facilitate or inhibit responsibility for self and others.

Although these consistent differences were highlighted across and within groups, it is important not to overlook the areas of consensus for participants. The latter showed particular responsibilities and roles for organisations throughout society. The majority of groups perceived media coverage of health issues to perpetuate damaging normative perceptions, especially the young. When highlighting examples of positive public service broadcasting, participants argued for a more socially responsible media sector and the increased use of influential role models for health. Further research is needed to explore the production influences on the media, to explore the efficacy of awareness raising with key stakeholders in the sector and to assess the health impact of media coverage.

There was also agreement over the negative effect of advertising for unhealthy products, again especially in the young. Participants were supportive of restrictions on the advertising of unhealthy products for children. They saw this as the government's role and

responsibility in terms of a moral obligation and issues of effectiveness. This need to address advertising and marketing aimed at the young was a more general one; lower SES participants in particular highlighted the pressures to consume as impacting on financial resources and psycho-social health. Such processes compounded wider structural inequalities and there is a need to further understand how consumerism may be used as a form of social acceptance and status through upward social comparison undertaken by the least well off. Restricting such advertising may be controversial; an alternative approach may be the development and evaluation of targeted initiatives for children that facilitate an understanding of and skills in reading the social marketing techniques used by advertisers

The general view, regardless of background, of the young requiring support and protection seemed to be associated with their developmental level and position in society. Responsibility was assigned to families, schools and statutory bodies to protect the health of children as a moral obligation. In some cases issues of efficiency and effectiveness were important secondary considerations as it was seen to be possible to influence large numbers, relatively easily at an early stage in their lives. This was particularly the case when participants discussed the roles and responsibilities of schools. Although there was an acknowledgement that ultimate responsibility lay with parents and central government provided the policy and resource framework, the school was seen as an important body that could support and educate about health. Significantly many participants highlighted the importance of provision and whole school environments to facilitate health, this was seen to be particularly important in relation to diet where most concern was expressed. Here pupils could be educated about nutrition, food cost, engage in growing food and have healthy food provided throughout the day. Studies of the effectiveness of whole school approaches and the relationship between curriculum and policy could therefore be usefully conducted.

All groups discussed in great detail the role of social relationships in shaping roles and responsibilities for health. Relationships with family and friends carried with them perceived moral obligations and established mutually agreed roles and responsibilities. These social ties and feelings of bonding and belonging were powerful influences on individuals. Peers therefore acted as important sources of support for both health protecting and health threatening behaviours. These relationships are increasingly being seen as foci for health improvement initiatives especially amongst adolescence. Our understanding of process, its application to a range of health areas and its functioning in different age groups over time however is limited and requires further exploration. There seems to be a particular need to understand how these norms are reinforced and diffused at the societal level, for example in relation to the acceptability of gendered health behaviour. This may require research that examines multiple social, economic and cultural factors. The family represented one of the key areas where meaningful reciprocal roles and responsibilities for health were accepted. The difficulty here appeared to be barriers to enactment. There is a need to further understand and then to develop initiatives that address and support a number of family processes that facilitate health. These included how families deal with competing demands, changes in traditional gender roles, the development of parenting skills, the maintenance and development of social bonds, work- home life balance policies and child care services.

Views on the role of central government were less clear. Many participants, but especially those less affluent, highlighted the limits of health promotion campaigns, although at the

same time they made suggestions regarding message channels, sources and content. There was a lack of consensus across groups as to the extent that government should regulate organisations, although the majority supported regulation to protect children, in other areas less affluent participants tending towards a more interventionist role. There was a common view across all groups that private employers had largely failed to take adequate responsibility for the health of their employees. This was seen to be quite natural as they were driven by profit not health goals and viewed staff in instrumental terms. Regulation was seen as the main tool to establish and enforce roles for health, although more affluent participants were more likely to highlight unease around secondary consequences regarding such regulation. Research is therefore needed to examine how regulation can be used effectively and efficiently for all parties concerned, but it is also important to understand what may foster feelings of social responsibility amongst employers. More affluent respondents seemed to suggest that less regulation and more economic growth would lead to increased autonomy and health choice for the individual.

The regulation of individual behaviour was more problematic for participants, with prolonged discussion weighing up the rights of the individual versus the rights of the group. At this level, participants found it harder to articulate the sense of obligation, recognition of mutual benefits and reciprocity that was associated with family and friends and in some cases local communities. These difficulties may well be associated with broader social, economic and cultural changes that impacted on social relationships. These appear to have raised questions not just for government, but individuals about their own roles and responsibilities and their relationship with the organisations and institutions around them.

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## **6. Appendices**

## Appendix 1: Consent form and participant information

ID Number:

### Consent Form

Research into roles and responsibilities for improving health

- I am willing to take part in the focus group for this research and for the focus group to be tape recorded.
- I understand that no-one will have access to the tape beyond the research team.
- I understand that any personal statements made by participants in the focus group will be confidential. All comments will be anonymised in any reports or papers that are produced as a result of the research.
- I understand that taking part in the research is voluntary and that I may withdraw at any time.
- I understand that this research is being funded by the Welsh Assembly Government. The data from this research will be used for three things:
  1. Report to the Welsh Assembly Government
  2. Academic research papers
  3. PhD work being conducted by one member of the research team.

Name of Respondent:.....

Signature of Respondent: .....

Date: .....

Name of Researcher:.....

Signature of Researcher: .....

We may decide to follow up participants at a later date, to see if views and ideas have changed. If you would not mind being contacted again, at a later date, please provide contact details below. Providing your contact details does not commit you to further participation in this research.

Contact address: .....

.....

Telephone number: .....

ID Number:

**About you**

The following questions are about you. This information will be used by the research team for describing the characteristics of focus group participants. This will be stored separately to the consent forms and this information will not be disclosed to anyone else.

1. Which of the following age groups do you belong to?

16 to 24 years	
25 to 34 years	
35 to 44 years	
45 to 54 years	
55 to 64 years	
65+	

2. Are you:

Male		Female	
------	--	--------	--

3. Are you:

Married or living with a partner	
Single	
Divorced or separated	
Widowed	

4. At the moment, which one of the following descriptions comes closest to how you would describe yourself? Please tick more than one if necessary.

Retired	
No paid work because disabled, invalid or permanently sick	
Caring for the home	
Carer	
Unemployed	
Employed or self employed	
Other (please specify)	

5. Do you have any of the following?

Children aged 16 and under	
Grandchildren aged 16 and under	

6. Would you mind telling us what your total household income is? By that we mean the total amount you (and your husband/wife/partner/others living in your household) normally take home after deductions like tax, but including any state benefits, pensions, regular interest on savings and so on?

Less than £5,000	
£5,000 to £10,000	
£10,000 to £14,999	
£15,000 to £19,999	
£20,000 to £29,999	
£30,000 to £39,999	
£40,000 or more	

7. Please provide the first four digits of your postcode. This will allow us to identify the sort of area you live in. This will not (and cannot) be used to identify individuals.

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**Address slip – to receive a summary of research findings**

The researchers will provide a summary of the findings from this study. If you would like to receive a summary, please make sure you include your contact details on the provided address slip. This does not mean that you will be contacted for follow up research.

Name.....

Contact address: .....

.....

## Appendix 2: Focus Group Schedule

### Focus group schedule

**Introduction and consent forms (15 mins)**

**Participants to introduce themselves (5 mins)**

**Headlines discussion (30 mins)**

- General Q: Do any of these spark any interest amongst people? Any they can relate to? Any they strongly agree or disagree with?
- **Key questions:**

**What health issues are most important to you?**

**Do you think you have a role in improving health for:**

- yourself                      - your children                      - rest of family friends/neighbours?

**What can you do to improve health? What are you doing?**

- yourself                      - your children                      - rest of family friends/neighbours?

**What helps /prevents you looking after your own and others' health?**

**Who else do they think has a role in improving health and what are they? Prompt**

Also ask have you heard of **Health Challenge Wales?** What is it? How do you think it can address the health issues we've just talked about?

**Focussing task with top tips for health (30 mins)**

- Present each participant with list of top 20 tips for staying healthy.
- Ask participants to work as individuals to rank their top 3 from this list of 20. Can make up their own tips.
- Explain that we'll then come back as a group and try and come up with a group 'top 3'.
- Key questions:
  - Why is this a good tip?
  - Do others agree/disagree – why?
  - Can others be persuaded?
  - Who has responsibility for putting this 'tip' into practice?
  - What about the tips that people did not rank in top 3?
  - Try and establish level of consensus and disagreement in the group.
  - Overall, what is more important?

**Summary and ending questions (10 mins)**

### Appendix 3: Headlines for discussion

<p><b>Mirror poll finds majority support for smoke free public places</b></p> <ul style="list-style-type: none"> <li>• Does this surprise you?</li> <li>• Do you feel that smoking should be banned in public places?</li> </ul>	<p><b>Poor get more depressed</b></p> <ul style="list-style-type: none"> <li>• Would you agree/disagree?</li> <li>• Other things leading to depression?</li> <li>• Other health problems related to being poor/rich?</li> <li>• Who is to blame for this health problem?</li> <li>• What should be done/by who?</li> </ul>
<p><b>Being fat ‘lessens risk of early death</b></p> <ul style="list-style-type: none"> <li>• Use this to investigate acceptance/resistance of health promotion messages</li> <li>• Does this match up with what you already know?</li> </ul>	<p><b>Where you live has a big effect on when you die</b></p> <ul style="list-style-type: none"> <li>• What do they mean by this headline?</li> <li>• What things about where you live might lead to early death?</li> <li>• Who is to blame?</li> <li>• What should be done?</li> </ul>
<p><b>Parents could do more to halt childhood obesity</b></p> <ul style="list-style-type: none"> <li>• Who is to blame for this?</li> <li>• Is it parents or someone else?</li> <li>• Who is responsible for taking action?</li> <li>• What are the limits to the action?</li> <li>• What do you think schools/parents/others should do?</li> </ul>	<p><b>People have to take charge of their own health, by losing weight, watching their diet, and not smoking. Otherwise, the demands on the NHS will become so great that it will be very hard for us to sustain it. It will die of overuse</b></p> <ul style="list-style-type: none"> <li>• Useful as this conflates obesity and smoking – allowing participants to choose the focus.</li> </ul>
<p><b>Men missing out on health care cash</b></p> <ul style="list-style-type: none"> <li>• Do you think men are less likely to access health services?</li> <li>• Why is this?</li> <li>• Who take more responsibility for their health – men or women?</li> <li>• Can anything be done to encourage men to look after their health?</li> </ul>	<p><b>Happy People Make for Healthy People</b></p> <ul style="list-style-type: none"> <li>• Turns focus to well-being, not just health.</li> <li>• Do they agree with this?</li> <li>• What helps make happy people?</li> <li>• Who is responsible for making people happy?</li> <li>• Is it just individuals or others?</li> </ul>
<p><b>‘Laddish ideal’ helps drive men to suicide as more women turn to drink</b></p> <ul style="list-style-type: none"> <li>• Do men have a laddish attitude?</li> <li>• Why might they turn to suicide?</li> <li>• What causes women to drink?</li> </ul>	<p><b>Health improvement policies need to be ‘gender-specific’</b></p> <ul style="list-style-type: none"> <li>• Do men and women face different health issues?</li> <li>• Why is that?</li> <li>• Do they have a role in improving each other’s health?</li> </ul>

## Appendix 4: Ratings for top tips for health

### Ratings for individual participant's top tips for health

Top tips for health	How many ranked (1,2, 3 or just highlighted) - % (n=95)
1. Follow a balanced diet with plenty of fruit and vegetables	68%
2. Keep physically active	59%
3. Don't smoke. If you can, stop. If you can't, cut down	50%
4. Manage stress by, for example, talking things through and making time to relax	31%
5. If you drink alcohol, do so in moderation	14%
6. Use education as an opportunity to improve your socio-economic position	11%
7. Take up cancer screening opportunities	11%
8. Don't live in damp, low quality housing or be homeless	7%
9. Practise safer sex	6%
10. Cover up in the sun, and protect children from sunburn	5%
11. Don't be poor. If you are poor, try not to be poor for too long	4%
12. Be able to afford to pay for social activities and annual holidays	3%
13. Be safe on the roads: follow the Highway Code	2%
14. Claim all benefits to which you are entitled	1%
15. Don't work in a stressful low-paid manual job	1%
16. Don't be disabled or have a disabled child	1%
17. Be able to afford to own a car	1%
18. Don't be a lone parent	0%
19. Don't live in a deprived area. If you do, move	0%
20. Learn the First Aid ABC – airways, breathing and circulation	0%
Other tips listed:	
<ul style="list-style-type: none"> <li>• Make time for your family (x4 participants)</li> <li>• Spending quality time with family</li> <li>• Follow some sort of moral/religious code</li> <li>• Prioritise</li> <li>• Don't come to my house you can have passive smoking</li> <li>• Enjoy life. Take one day at a time</li> <li>• Live for today, tomorrow may never come</li> <li>• Be happy with what you've got and not fret over what you haven't!!!</li> <li>• Join an active club</li> <li>• More time playing with children outdoors</li> <li>• Live every day as if it were your last - one day you'll be right</li> <li>• Eat 5 fruit and veg per day</li> </ul>	
NB – across 12 groups 95 (out of 101) participants completed the top tips exercise	