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The individual and the State as agents responsible for the production of healthy societies: a thematic analysis from the perspective of health professionals in Catalonia (Spain)

La persona y el Estado como agentes de responsabilidad para la producción de sociedades saludables: análisis temático desde la perspectiva de profesionales de la salud en Cataluña (España)

Valeria Santoro Lamelas[1]

[1]*PhD in Psychology. Associate professor. Social Psychology Department, Universitat de Barcelona, Spain.*

ABSTRACT This article aims to analyze the meanings upon which health promotion intervention practices are based, and the consequences of these meanings in the identification of responsibilities in health. The passage of Catalonia's Public Health Law 18/2009 facilitated the development of the Demonstrative Project of the Public Health Agency, in the framework of which fieldwork for the Plan for Health Education and Promotion in Children and Adolescents in La Garrotxa (region of Catalonia) was carried out. In this way, 20 interviews with key informants were conducted. Through a thematic analysis, it was found that the State and the individual are identified as the primary agents responsible for the production of healthy societies. It was also evidenced that, in the articulation between the discourses referring to free and rational decision-making and those referring to the social, political and economic environment, different approaches towards responsibility are construed, with effects related to the potentiation (or lack thereof) of the State as a guarantor of the population's health in opposition to blaming of the individual.
KEY WORDS Public Health; Health Promotion; Decision Making; Social Responsibility; Health Knowledge, Attitudes, Practice; Spain.

RESUMEN El objetivo del artículo es analizar los sentidos a partir de los cuales se articulan las prácticas de intervención en promoción de la salud y sus consecuencias en la atribución de responsabilidades en salud. La aprobación de la Ley 18/2009 de Salud Pública de Cataluña propició la realización del Projecte demostratiu de l'Agència de Salut Pública de Catalunya el cual incluyó, durante 2009 y 2010, el Pla transversal d'educació i promoció de la salut en infants i joves en La Garrotxa (comarca de Cataluña), marco en el que se realizaron 20 entrevistas a informantes claves. Mediante un análisis temático, encontramos que se identifica al Estado y a la persona como los principales agentes responsables de la producción de sociedades saludables. Asimismo, evidenciamos que, a partir de diferentes articulaciones entre los discursos que refieren a la toma libre y racional de decisiones, y aquellos que refieren al entorno social, político y económico, se configuran diferentes enfoques sobre la responsabilidad, cuyos efectos se relacionan con la potenciación (o no) del Estado como garante de la salud poblacional en contraste con la culpabilización personal.
PALABRAS CLAVES Salud Pública; Promoción de la Salud; Toma de Decisiones; Responsabilidad Social; Conocimientos, Actitudes y Práctica en Salud; España.

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INTRODUCTION

In Catalonia (Autonomous Community of Spain), the current notions of public health are closely linked to the globalized discourse of affluent and aging societies. This is why public health issues are associated with the ideas of progress and globalization, and the focus of governmental health actions is mainly on the rise in life expectancy, the environment and personal habits.[1]

Within this framework, health promotion is gaining special strength as an area of public health aimed at improving people's living conditions and health, and at avoiding and/or lessening the impact of the negative effects of "progress". In order to achieve these objectives, health promotion suggest the importance of understanding health as a process that should be produced and reproduced every setting and moment of a person's life.[2] Thus, health actions should start to be taken not only in purely sanitary environments, but also in every sphere of an individual's life and in their relations with other people.[3]

This perspective of health is one of the possibility conditions for the development of "healthy societies", that is, a project of society where health is present in every relational context.[4,5] In other words, they are societies responsible for the development of governmental strategies that aim for the improvement of people's health through the promotion of healthy lifestyles and the adoption of policies that have an impact on the environment, which is understood as the material and social context that may improve or harm people's health.

This article proposed the development of a model of society based on the implementation of numerous knowledge technologies and interventions in public health, in which nothing escapes health policies, given that all the different spheres where individuals coexist and interact with each other may be intervened in order to improve people's health. Within this context, healthy societies show a specific type of biopower,[6,7] meaning a way to exert a power whose governmental principles are based on health and life, and health promotion is seen as a biopolitical strategy[8,9] generating knowledge, specialists and intervention practices over desirable, legitimate and efficacious models of life, health and relationships.[10]

After the passage of Public Health Act 18/2009,[11] a regulatory and institutional reform in public health was introduced in Catalonia as part of the development of healthy societies, which has promoted a new model of public health. This model focuses on the importance of the multiple elements affecting health and the need to merge governmental health agents into other governmental areas (such as education, city planning, sports, among others), and also encourages the participation of non-governmental institutions (such as NGOs, companies, consortia, and so on) in the development of interventions.

In Catalonia, Public Health Act 18/2009 gave rise to the creation of the Public Health Agency of Catalonia (ASPCAT) [*Agència de Salut Pública de Catalunya*]. To foster the development and territorial establishment of this institution, a number of pilot projects were launched during 2009-2010 to see if the new model would work. A large number of these projects were run in the health promotion area, due to their importance in the construction of healthy societies, in a territory with deep-rooted health protection and epidemiological surveillance practices.

In short, the research presented in this article is part of the Demonstrative Project of the Public Health Agency [*Projecte Demostratiu de l'Agència de Salut Pública de Catalunya*], which included the Plan for Health Education and Promotion in Children and Adolescents in La Garrotxa [*Pla transversal d'educació i promoció de la salut en infants i joves en La Garrotxa*] carried out during 2009-2010. This project sticks to a basic principle: the intervention of several entities and agents from the health promotion area in accordance with the governance model introduced by the Health Department. This model put emphasis on a coordinated work at the central, regional and territorial levels, and had the participation of territorial entities such as the

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local government, schools, and the Catalan Health and Social Care Consortium, among others. This project also proposed an interdisciplinary work between health and education agents. Notwithstanding the relations and the coordination between these entities in search of collaboration and complementarity in terms of actions, ideas and resources, each organization and department maintained its organizational autonomy.

On the basis of this framework, we conducted the research study that gave rise to the doctoral thesis "Public health as a problem of the government: analysis of the social issues related to public health under the governance model" [*La salud pública como problema de gobierno: análisis de los problemas sociales de salud pública bajo el modelo de gobernanza*], whose aim was to find out how public health is constituted as a technology used by governments on certain social problems. The article "Public health in the health-disease continuum: an analysis from a professional perspective" [*La salud pública en el continuo salud-enfermedad: un análisis desde la mirada profesional*] [12] and this article derived from that thesis. Both works address two different issues: how public health is built as an area of intervention within public health policies and who the subjects responsible for the creation of healthy societies are. Thus, although both articles share the same methodology and informants, they are different regarding the topics addressed (there is a divergence of references used, findings revealed, conclusions and discussion). On the one hand, in the article "Public health in the health-disease continuum: an analysis from a professional perspective", we identified the health-disease continuum as a key element used by health professionals to adopt and introduce several State policies and interventions in people's health, and we also discussed the implications of understanding health based on its multiple causes and the wellbeing of the population when designing public health policies. On the other hand, this study aims to analyze the meanings upon which health promotion intervention practices are based, and the consequences of these meanings in building subjects with health responsibilities. Thus, we delve into the process of making subjects and institutions responsible for the production of "healthy societies" and the consequences of adopting personal-based or community-based approaches.

METHODOLOGY

From a constructionist perspective, we understand that there is no reality alien (or external) to the global linguistic experience of the world,[13] as it is created through collective practices that always have both social and historical contexts.[14,15] Now, from our perspective, language does not merely have a referential function (that is, to describe or to express a situation), but it also has a performative and formative nature. This performative nature means that language is action-oriented,[16] while the formative nature of language refers to the creation of realities through speech. In other words, senses, priorities, interests, among other things, are produced as a consequence of a framework of preexisting social groups and structures that, in turn, we produce, reproduce and/or modify in the same linguistic practice.[17]

Our epistemological perspective required the selection of a methodology that would help analyze processes of sense production in an in-depth and specific way, considering the complexity and dynamism of social processes. This is why we suggested that a qualitative research should be carried out, as it allows rigorous, valid and reliable access to social interaction processes, production of senses, and the comparison and/or negotiation of arguments, placing special importance on the people involved in such processes and in the contexts where they are produced. We opted for this type of methodology firstly because it is oriented toward an open and flexible methodological design, thus promoting the production and integration of emerging and not stereotyped information about senses related to health

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promotion. Secondly, this type of methodology offers potentialities in the comprehension of these senses from a thorough, complex and situated analysis.[18,19]

In the task of getting access to and analyzing the process of construction of health promotion, we would like to highlight the relevance that language acquires throughout the entirety of this research, both to get access to the production of senses and to analyze discourses related to their production.

Informants and data collection technique

As noted above, the fieldwork of this research was conducted during the development of the Plan for Health Education and Promotion in Children and Adolescents in La Garrotxa [*Pla transversal d'educació i promoció de la salut en infants i joves en La Garrotxa*], one of the Demonstrative Projects of the Public Health Agency of Catalonia [*Projecte Demostratiu de l'Agència de Salut Pública de Catalunya*], which was aimed at serving as a starting point for the production of new health promotion strategies based on the coordination between the various health agents of the autonomous community and the local level according to the coordinated health-based action proposal contained in Catalonia's Public Health Act 18/2009.

We have conducted individual interviews for the collection of the data analyzed in this research. This technique is produced in the framework of a scheduled conversation that allows us to get access to more detailed information on events and situations in diverse contexts and moments. The communicative nature of this technique is also useful to grasp complex meanings mediated by the construction of events elaborated by the informants during the communicative act of recounting their experience.[20,21]

In short, we have conducted 20 interviews with key informants, whose selection was based on the identification of one of the groups acting as the driving force of the project, the self-proclaimed "operational team," which is composed of health agents from the central, regional and territorial levels. This operational team was in charge of running the course of the project, analyzing intervention proposals and reformulating them in order to ensure the implementation of the project. Therefore, we conducted interviews with all of the active members of the operational team, and with other agents who, although they were not formally part of the team, participated in a direct and active way.

The interviews were carried out in Catalan or in Spanish, depending on the informants' preferred language, and the excerpts from interviews in Catalan were translated for the presentation of the findings in this article. The interviews took place in the usual work environment of the informants (Barcelona, Girona and La Garrotxa), and were conducted as part of the demonstrative project, during the years 2009 and 2010, and after the end of the project, during the years 2011 and 2012, in order to reflect on and to delve into aspects previously addressed.

At the beginning, all the informants were told about the purpose of the interview, the data processing and the guarantee of anonymity to the participants. Each of them agreed to take part in the research study. In addition, the development of the project was institutionally endorsed by the Public Health Agency of Catalonia and the Universitat Autònoma de Barcelona. To this end, a scientific monitoring committee was set up to guarantee an adequate development of the research project by ensuring compliance with ethical principles and scientific rigor. The average duration of the interviews was one hour, with some interviews ranging from 45 minutes to an hour and a half.

The interview script contemplated issues relating to the foundations of health, the conceptualization of public health and each of its areas, the identification of the main problems in connection with public health, health responsibilities, the reasons for promoting health, the main elements of health promotion intervention, and the identification of intervening agents and the responsibilities on public health.

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The interview classification codes are the following:

- *Professional area of the interviewee*: general public health (PH), health promotion (Pm), health protection (Pt), epidemiological surveillance (S), CatSalut (Catalan public health insurance) (CS), education (E).
- *Level of decentralization of their work*: autonomic level (AL), regional level (RL), territorial level (TL).
- *Professional training*: biology (B), teaching (T), medicine (M), pharmacy (P), veterinary medicine (V), environmental science (E).

Analysis

A thematic analysis[22] was proposed in order to understand the meanings created by agents involved in public health programs through linguistic exchanges and the explanation of their positions on significant matters, and to clarify the effects caused by the creation of such meanings.

Once the transcription of the corpus was completed and through the repeated reading of the relevant material, we started to develop a preliminary approach to the codification of themes and subthemes – this is, the identification of meaningful segments in the text that are potentially relevant to the analysis.[23] We decided to prioritize the more descriptive dimension over the argumentative dimension. Then, we undertook the first categorization of data in order to maintain, on the one hand, the context provided by the global documentary corpus (the interviews) functioning as support for interpretation and, on the other hand, the set of statements related to the same theme, which allowed a specific and detailed analysis of each statement depending on its theme. During this process, we carried out the three following actions: (a) elaboration of conceptual maps of each theme and subtheme, also identifying their relation with other themes; (b) description of each theme or potential category by gathering the statements given explicitly by the informants, the interpretation of implicit connotations being limited to those comments added as external notes and thematic clusters; (c) verification of the link of each theme to the purposes of the study in order to get an increasing receptivity of meanings that were not contemplated in these purposes. For verification purposes, we identified themes in an eminently inductive way and established links between the themes and subthemes to the purposes of the study.

After obtaining the partial findings of the 3 actions mentioned above (elaboration of conceptual maps, description of each theme or potential category, and confirmation of the list of emerging themes and subthemes), we returned to the original text and began a new analytical phase whose aim was no longer the description of what people said, but the understanding of how the statements of a text worked in the construction of the objects they refer to, their relations and effects. This analytical phase consists in the following:

a. Explaining the positions of each professional interviewed regarding the definition of public health, and the common and divergent arguments arising from each of their positions and within them.
b. Searching for repeated connotations that appear in their statements to justify, describe, argue about, and so on, health promotion, and explaining the reasons of those repetitions, the meaning they acquired, the link with other discourses and their functions.
c. Identifying objects (health, habits, knowledge, among others) and subjects (individuals, the State) mentioned in the statements.
d. Enquiring about the effects of discourses, and analyzing the consequences of building subjects and objects in the assignment of health responsibilities and liberties.

During the analysis process, the variety of arguments helped us configure a complex image of health promotion, while also helping us identify regularities and links between them. Thus, the themes and subthemes turned into categories and subcategories and

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became interconnected, which resulted in a broader understanding of the phenomenon under investigation. This resulted in an argumentative system meant to understand how health promotion became an intervention strategy for the construction of hegemonically healthy subjects.

FINDINGS

The findings presented in this article help understand the logic behind health promotion interventions and the assignment of health responsibilities based on a specific understanding of the individual and their environment. To this effect, we organized the arguments that make up this category around four meaningful segments:

1. The shaping of the State and individuals as agents responsible for the production of healthy societies.
2. The design of interventions aimed at having an impact on personal decision-making.
3. The environment as a modulator of health practices.
4. The coexistence of opposing approaches on responsibility and their pragmatic and ethical effects.

The State and the individual: agents responsible for the production of healthy societies

Public health professionals identify the State and the individual as the main subjects that should take action on collective health. They contend that public institutions, which constitute a major part of the Welfare State, have an unavoidable responsibility toward the population when it comes to identifying needs and designing and implementing public health interventions. In this regard, while creating and transmitting knowledge (official discourses on health turned into truths), public institutions design and make interventions aimed at changing situations, living conditions and practices to produce a hegemonically healthy society.

> *I believe that institutions* [...] *are responsible for educating* [...] *You have to offer it to them. If people take it or not, that's another story. If they want it or not, it's another issue, right? So offering it, I think, is the responsibility of institutions rather than theirs, isn't it?* (CS/RL/M)

The interviewees highlight the leadership role of public health governmental institutions in leading and planning initiatives relating to population health. However, they state that health production is not only the responsibility of the Health Department, it also extends into daily life, where there are numerous public institutions with government-oriented purposes. As a result, they assume that health is not only the responsibility of specific departments, but that it goes beyond and spreads toward other institutional areas (education, city planning, environment, social services, among others).

> *Departments of Health, Housing, Labor, Education, Environmental Affairs, City Planning, among others, right? They're all elements related to the development of policies that'll have an impact on public health.* (PH/AL/M)

> *We've always said that the Health Department is the one in charge of policy planning.* (CS/RL/M)

Although many attribute an essential role in the detection of needs, the strategic planning and the design of health interventions to the State, in all of its institutional representations, professionals talk about social complexity and acknowledge the existence of interventions made by non-governmental entities and their impact on people's health. In other words, the emphasis on the multiplicity of elements that shape people's health derives from defending the need for each of the institutions immersed in the social fabric

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to commit themselves to ensure population health.

> *ONGs, institutions, and associations are added to the social fabric that's also concerned about health issues.* (PH/AL/M)

Based on the notion of individual freedom, health professionals grant the subjects the autonomy to take risks depending on the assessment they make of the pros and cons of their behavior. Professionals place in every inhabitant the ultimate responsibility for their own health care, as the inhabitant, they say, regardless of the existing determinants, is the one who decides to perform (or not) a practice, whether healthy or unhealthy.

> *You have the freedom, you should be able to choose, you should be autonomous, you should be responsible.* (Pt/TL/E)

They maintain that the *official* discourse on health promoted by the scientifically legitimized strata should be the one guiding an individual's health-related practices. However, they recognize that this *official* discourse would be added to the framework of knowledge and experiences that an individual possesses and on the basis of which they make decisions on health practices, which will later turn into habits if internalized in their daily life. Thus, the importance of increasing the power of the official discourse on health is suggested in order to guarantee "adequate" health-related practices and knowledge.

> *I mean, sooner or later, the individual will have... an option will present itself and the individual will have to decide, right?* [...] *then, what should be done is to reinforce these arguments so that the individual could have all the necessary knowledge for the moment when they have to decide.* (Pt/RL/P)

In this regard, public health professionals minimize State responsibility by highlighting the importance of preventing people from assuming a passive role regarding their health. They also promote the importance of making personal decisions about one's health care to prevent the ultimate responsibility from falling in State institutions.

> *In the first place, you have to take responsibility for your health. It's yours, right? And Catalonia's Public Health Act also says that, right? So the idea's to try to transmit the... the decisions you make about your health, right?* (PH/AL/M)

But, at the same time, health professionals state that the limits of freedom and autonomy become vague given that, in their opinion, an ever-moving tension is produced to impose limits involved in monitoring and looking after people's health as an attempt of the State to refrain from being excessively paternalistic or lax. They assert that many times the State applies corrective measures to social inequalities caused by its own political policies or by market interventions (actions targeted at health determinants, education campaigns on healthy habits to tackle a great number of discourses on consumption, esthetics, competitiveness, speed, and so on) that encourage practices contrary to those proposed to guarantee people's health.

> *So the idea is, of course, many people say "Wow! Too much social control," but where is my individual freedom? But I'm not sure if individual freedom without information is in fact freedom, because maybe you're conditioned by trends, by commercial elements, by whatever, right?* (PH/AL/M)

In short, it can be said that the public health professionals' discourse on health responsibility stems from the understanding of the State as the entity responsible for guaranteeing people's health, since it is the one that provides the necessary conditions and tools for every citizen to make the *correct* decisions. In this context, the rational subject is considered the intervention key, since the individual may (or may not) reproduce

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certain health-related practices. People are the ones who should decide, and these decisions are understood as resolutions adopted after a thinking subject distinguishes between what is good and what is bad and its consequences. By using this logic, the professionals that were interviewed talk about a certain degree of freedom in connection with the acts performed by each person whenever they choose their lifestyles.

The design of interventions aimed at influencing personal decision-making

Upon the understanding of personal practices as a model focused on the free and rational subject, capable of making their own decisions, and upon the assumption that the construction of healthy societies is based on the production of healthy subjects, health professionals highlight the importance of the State's role in spreading knowledge to guide people's health-related practices.

From this point of view, they state that, in order to guide these practices, it is necessary to design interventions aimed at influencing three action components: the production of *knowledge about what to do* to be healthy (knowing which practices are healthy and which ones are not), the production of *knowledge about how to do it* (having a good grasp of strategies to adopt healthy practices) and, finally, the production of the *intention to do it* (wishing to perform healthy practices).

> *You have to know what to do and how to do it, and you have to want to do it in an environment that helps you do it.* (Pm/AL/M)

As far as the first element is concerned, under the reasoning that public institutions are the ones who should produce truths about health and make them visible against false or biased information that may prevent people from adopting healthy habits, health professionals assert that the production of truths and the spreading of discourses on healthy and unhealthy practices are essential hinge points through which public health professionals articulate health promotion interventions.

> *The most efficient means should be used to make all people receive the information that's actually no information at all – it's disinformation that young people have instead. People should receive the real information.* (V/RL/M)

As regards the second element, health professionals assume that being healthy is a process that is "made" and, in "making" this process, daily practices are essential to guarantee the production of *healthy subjects* or, in other words, subjects who usually act following the health criteria proposed by relevant entities. In order to achieve this, they argue that it is not enough to know what the rules to be healthy are. Rather, people should be able to associate each of these rules with certain *instructions* that help them achieve their health-related goals. This is why health professionals consider this second element, the *how* element, another essential hinge point for health promotion. They understand that learning action guidelines is a tool that empowers people and provides skills for *making (themselves) healthy*. That is to say, for the production of healthy societies, people who make up these societies should know what the health-related goals are (to eat a balanced diet, to limit salt and saturated fat consumption, to do physical exercise, among other things) and, at the same time, they should know what the strategies to achieve them are (how to cook, how to limit the consumption of food with too much salt or saturated fat, how to incorporate exercise into our lives, and so on).

> *People should know that when we talk about healthy eating, we're not only talking about grilled food... Diet may be very varied and different... and a fried meal from time to time isn't bad either, if it's properly fried, with the right oil, at the right temperature, and all that.* (Pm/AL/M)

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Given the long tradition of spreading information about *what being healthy means*, public health professionals assume that the population has a great knowledge of the health criteria proposed. Nonetheless, they state that people do not know very well what the action guidelines aimed at achieving such health criteria are. Therefore, in the interviews they highlight the need to develop with greater vigor health promotion policies to provide people with strategic knowledge to act and achieve their health-related goals.

> *To many people, the problem often lies in the how... that is, how can I do exercise if I can't go to the gym three times a week? This is why our messages usually involve saying "No!" You have to exercise for half an hour and then it could be... so that... to get off the bus one stop earlier... to take more stairs, to do something* [...]. *That helps you know how.* (Pm/AL/M)

From the perspective of public health professionals, life becomes a set of instructions for dangerous practices (for example, using drugs or tobacco, occasional unprotected sex, among other things) and for people's lifestyles (what, how, when and how much to drink, eat, move, relate to each other, and so on).

> *The four basic axes for the promotion of people's health... How we relate to each other, how we eat and how we move* [...] *and well, what we consume.* (PH/AL/M)

However, although health professionals refer to certain behaviors as ideally forbidden (such as smoking or drug abuse), they tend to change the message from prohibition to moderation. During their interviews, they indeed state that promoting healthy habits involves certain tolerance relating to practices that can be regarded as unhealthy from a public health perspective. These professionals argue that this is not a binary approach (healthy/unhealthy) where all potentially dangerous practices are forbidden, but a continuum in which certain practices may be moderated until they turn into somewhat healthy practices.

> *I insist on this a lot, yet the other day I took a brochure* [...] *which was not from here, that said "brochure on how to live a healthy life: don't smoke, don't sunbathe..." and I said: "man, no! That's impossible... no!"* (Pm/AL/M)

In addition, as they understand that "being healthy" is materialized in the actions performed in various contexts, relationships and moments of people's lives, health professionals argue that practices that can be considered either healthy or unhealthy coexist in all individuals. For this reason, they emphasize the importance of promoting healthy behaviors and tolerating unhealthy behaviors considered as "exceptions" in order to obtain, as a result of both healthy and unhealthy practices, a life led in a much healthier way.

> [...] *No, nothing happens in one day, no, absolutely nothing happens in one day, but day after day... that's when things start to happen.* (Pt/TL/E)

Regarding the third element, health professionals state the need to intervene in order to generate the desire to be healthy, insofar as they argue that health practices go beyond knowledge itself. They understand that the fact of *harboring the intention*, which is a different way to express that there is a will to act, is mediated by the knowledge of which practices are healthy and how to assimilate them, as well as by the cost-benefit analysis of these practices. These professionals link the benefit obtained through health practices with a wide variety of elements: from physical aspects (such as the increase in aerobic capacity), material aspects (such as saving money), interpersonal aspects (such as social acknowledgement), to ideological aspects (such as drugs and their association with addictions, and addictions and their association with loss of freedom).

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> *To quit smoking is, perhaps, a liberation.* (PH/AL/M)

Moreover, health professionals state that the cost analysis is made on the basis of material limitations (efforts to gain access to certain spaces and products), temporal limitations (time availability and the need for a span of time required to perform an activity), or interpersonal limitations (they particularly emphasize peer pressure toward certain practices linked to the group an individual belongs to).

> *I mean, negative or positive messages, for example, saying no to drugs isn't the same as saying: "look... the thing is, if you use drugs you won't be able to do this, you won't be able to do that or doing this will be harder, learning new things will be harder."* (Pt/RL/Ph)

> *Therefore, what's in fashion in this little group is smoking. Then, the thing is to see it the other way round... what we know is that smoking is influenced by fashion.* (Pm/AL/M)

The environment as a modulator of health practices

As mentioned in the sections above, public health professionals attribute the final decision to the individual performing the action. Nevertheless, they also understand that the environment is also a cornerstone as far as decision-making is concerned. They hold that the environment limits or enables the development of certain practices depending on material conditions (for example, access to products, or environmental circumstances), as well as social, political, economic and ideological conditions (the latter being an area where health inequalities are specially dealt with).

As the environment is considered a modulating factor, which promotes or interferes with the making of personal decisions regarding health, public health professionals suggest during the interviews that health promotion interventions should not be based solely on personal education. Rather, they demand that the environment should be included as a target for intervention.

To this end, health professionals, who aim at training people to make health-related decisions, add a second complementary goal: working on the environment understood as a modulating factor that allows (or not) for the making of decisions and the performance of healthy practices.

> *The promotion's this: facilitation. And pay attention to Ottawa's definition, training individuals of the community because they are the ones responsible for their health. But we're in charge of facilitation, we have to make it easier... but they're the protagonists* [...] *society has to facilitate world health promotion.* (Pm/AL/M)

On the basis of a central idea in which the individual is considered the smallest unit of influence over people's health, health professionals add two major environmental levels of appeals, as influencing layers that cover and shape the individual: their immediate environment (relationship groups) and the determinants generating health inequality:

> *I believe that we have to spread a message, an intervention strategy through which I can look at a bigger picture, right? I give a piece of advice questioning the person about their habits, some people would pay attention to something related to the social or community environment and then, other people would pay attention to the determinants, to the origin of the causes.* (PH/AL/M)

Going back to the arguments about creating goodwill in connection with health-related issues, the importance of influencing people's immediate environment was emphasized during the interviews as a strategy to facilitate and encourage healthy practices, to

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increase access to those practices, or to informally punish unhealthy practices.

> *People know that smoking's bad* [...] *you may know it, but if all leaders smoke, then you will too* [...]. *So these environmental elements, this facilitating element that I was talking about earlier is what we must work on, so that people may want to work on it.* (Pm/AL/M)

Furthermore, health professionals add to the immediate environment a second layer that covers the individual: health determinants. They understand that both the community and social and economic circumstances generate material conditions that affect the possibilities of various groups to carry out healthy practices, depending on the position within the social group to which they belong. For this reason, health professionals, especially those having a greater tradition of working on social determinants of health, highlight the role of the State in reducing social inequalities in order to balance the scale and to reduce the gap that segregates people based on their access to health services due to social, economic and/or ideological conditions. This would result in the creation of environments that facilitate and promote the making of healthy decisions. Therefore, health professionals put emphasis on working on health inequalities.

> *So the individual is at the center, and their decision-making power should never be lost. And we have to help them have more decision-making power, but we have to ensure that their living conditions, their working conditions… all the structural determinants of their socioeconomic level* [...] *the crisis, the strikes, and so on. All this goes against health, and therefore, we have to help society become a health-generating one.* (Pm/AL/M)

Coexistence of opposing approaches on responsibility and their pragmatic and ethical effects

Considering the tension between the discourses about the individual as a free and independent subject who makes personal decisions, and the environment as an element with modulating and influencing effects, which produces specific scenarios that make certain healthy practices and the desire to be healthy possible, health professionals establish three approaches regarding the relationship between personal responsibility, and social and state responsibility. These three approaches are not unified into a single corpus of ideas about health, instead they coexist between the different professionals who take public health actions.

Regarding the first approach, those who have experience in interventions related to health promotion and social determinants highlight that the socioeconomic situation helps, to a greater extent, determine an individuals' health habits. Under this conceptualization, although the individual is not deprived of their ability to act (quite the contrary, the subject is able to make interventions, and their ability is considered a value to be fostered and taken into consideration in public health policies), unhealthy decision-making is not conceptualized as an unequivocal consequence of personal acts. Rather, it has to do with the social and systematic aspects which determine the decision-making process.

Thus, health professionals suggest that individuals are not to blame for what they do, given that their acts are determined by their social, political and economic circumstances, which condition their actions.

> *There're a lot of determinants* [...] *a whole series of things, so we'll never, never, never put the blame on the individual. We blame the victim from a social point of view, from a social health determinants point of view* [...] *their health conditions may be determined by*

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the place they live in, by their circumstances. (Pm/AL/M)

As far as the second approach is concerned, health professionals who occupy technical positions in the public health area (with less work experience in social determinants of health) highlight the importance of establishing minimal and inescapable state responsibilities. This conception stems from the idea of equal distribution of health. In other words, those who advocate this idea state that, considering the scarce healthcare resources, the State should provide basic services to the whole population. In addition, this approach is also based on ideological notions, given that the State's responsibility should be to ensure an individual's subsistence and to look after their health when it comes to certain fundamental issues, in contrast to services regarded as complementary (a kind of potential luxury that may only be enjoyed by those having resources and an interest in acquiring such services).

That is, it covers the costs to a certain level: you have to wait if you need to be operated on, but sooner or later you'll have it done. It covers the basic level, but if you want to go to a better doctor, with a better technique, then you have to pay for it. But at least the basic necessities will be covered. (Pt/RL/P)

Finally, regarding the linkage between personal responsibilities and social and state responsibilities, certain public health professionals focus their discourses on the individual and on their autonomy to make decisions, thus pushing social and structural elements into a second level of importance. In this sense, those who focus on personal responsibilities minimize, until almost hiding, social responsibility in the performance of certain practices and the development of diseases.

Individuals should understand that their health is their responsibility and not society's. Now, I may be blunt, but if you smoke for forty years, you are taking a risk. It's not fair [...] *that after having taken this risk, you say: "Man, now you're also mistreating me, because I was supposed to undergo a lung cancer surgery and you're delaying it for six months", "Sorry, I beg your pardon? You've been smoking for forty years, hmm? I haven't forced you to smoke, not at all!"* (Pt/TL/E)

This last approach, which separates personal choices from the context in which they were created, seeks to over-blame the individual for their own health situation. This act of over-blaming the individual resembles guilt, for it adds a moral burden to the personal decision, as the cause of an ailment or disease.

It's a matter of personal responsibility. I mean, during the last twenty years we ourselves got used to it and the administration has made us get used to thinking that every problem we have is a problem the administration should deal with [...]. *I believe that your personal responsibility is an inescapable responsibility,* [...] *the final decision is yours and therefore the final responsibility is yours.* (Pt/TL/E)

Yet, even in the cases of excessive personal responsibility, public health professionals highlight during the interviews another element affecting the action, apart from the environment and personal decisions: the biological burden. In this sense, the guilt is never completely ours because our body, understood as the biological structure that sustains our being, acts differently and independently from our intentions.

At the end of the day, it's all a matter of probabilities. [...] *it's the price we have to pay for being multicellular* [...] *but if you are a bit strict and have some discipline, you do exercise and are careful with your eating habits, and so on and so forth, you have fewer chances of falling ill.* (Pt/TL/E)

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DISCUSSION

This study proves the existence of two fundamental cornerstones for the understanding of health promotion as a biopolitical strategy in a neoliberal context[24,25]: the production of legitimized knowledge in discourses on scientific evidence as a key element for the administration of subjectivities in health matters, and the construction of people, who are seen as the minimal component that makes the construction of healthy societies[4,5] possible.

Regarding the first cornerstone, Castiel *et al*.[26] highlights the emergency of a new health morality sustained by the imperatives of the scientific evidence that, based on a self-care notion, creates realities and prescribes people's good and bad practices in connection with their own health. As explained previously, Catalonia's public health professionals who took part in this study consider the State as an entity that produces, manages and administers specialized knowledge on people's health. On the one hand, this approach ascribes to the State the responsibility for educating people in health matters and providing the necessary strategies to incorporate healthy habits. On the other hand, this approach causes state discourses and health interventions to acquire special legitimacy,[27] thus turning them into unquestionable truths that show the population what being healthy means and how to achieve it. In this sense, the action of teaching is associated with the desire of persuading those being taught so as to create certain predisposition to act in accordance with the official discourse on health.

As far as the second cornerstone is concerned, several authors who criticize the individualistic perspective of health processes[28,29,30] highlight that the strategies developed by neoliberal governments anatomize the comprehension of social practices based on the understanding of people as individuals with decision-making power over their own bodies. They are understood as rational subjects who freely choose their own destiny based on their skills, knowledge and interests. These strategies also direct the government's actions toward the reinforcement of the idea of producing subjects who are disciplined and experts in managing their health.[31] More precisely, the logic that understands the subject as a rational being who makes their decisions based on personal knowledge and desire is the main discourse on which the health promotion actions mentioned in this article are based on. Hence, Catalonia's health professionals emphasize the importance of producing and spreading knowledge about which practices make people healthy and how to accomplish them. Furthermore, they design strategies to direct personal intentions toward the desire to be healthy.

Now, according to the arguments presented by Castiel,[32] Dumas *et al*.[33] and Gurrieri *et al*.,[34] it is important to underline that the focus on the individual as a subject responsible for their own health is excessively simplistic because it leaves out the social structure and inequalities as health determinants, as well as leading to depoliticization of structural, material and historical conditions, which help develop social practices (healthy or not). In our case, this omission becomes particularly evident in health professionals' perspectives, which attributes to the State the minimal responsibility for ensuring certain basic healthcare services for the population, and places on the individual the responsibility for their actions in order to improve those "accessory" conditions. This omission also becomes visible in those statements that hide the role of social determinants and emphasize personal autonomy as one of health's essential elements. This results in a quasi guilt of the individual for their health condition, as shown in the presented research study.

Gurrieri *et al*.[24] warn that the discourse on the possibility to choose promised by the exercise of personal sovereignty as a result of the exercise of personal "freedom" and "independence," is, at the very least, questionable and unfair for those who do not have the resources and conditions to help them perform hegemonically healthy practices. These aspects result in social disparities in the construction of notions regarding personal health

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and in the availability of means to achieve health. The findings of Dumas *et al*.[33] are proof of these disparities, which confront the notions associated with the health care of the wealthier social classes and the notions associated with the economically vulnerable classes: whereas the former classes understand the body and health care as an end in itself, the latter classes understand the body and health as the means to meet urgent needs (feeding, work, family care, and so on). In this sense, notions of health care, understood as seeking personal improvement and self-realization[34,35,36] upon which health promotion interventions focused on the individual are legitimized, follow a logic that only takes into consideration the comprehension of health conditions of a portion of the population, precisely the most privileged one, and ignore the needs of a large portion of the population, given that the urgency to overcome poverty and precarious situations plays down health care as an end in itself.

In turn, Castiel[32] argues that the focus on the individual and the resulting invisibility and depoliticization of the structural aspects that make the practice of healthy habits and access (or not) to healthcare services possible, contributes to a growing social stratification, given that this approach serves to divide the population into those who are able to make decisions after considering several and various healthy options, and those who have a reduced access to these options. Therefore, not taking action on the structural situation results in the naturalization of health inequity based on making socially vulnerable groups accountable for their own condition.

On this basis, we suggest that there is a pressing need for the understanding of social practices to be incorporated as an exercise of power relations, which is always linked to the social structure that makes it possible,[37] so that we may change health discourses considering the impossibility to separate social, political and economic conditions from personal and collective health.

CONCLUSIONS

The aim of this article was to delve into the arguments presented by Catalonia's health professionals regarding the consideration and design of health promotion interventions and the impact they have on the attribution of health responsibilities. After considering these arguments, we have identified the individual and the State as the leading figures in the development of strategies for the construction of healthy societies.

We demonstrated that the idea of the individual as the central element toward which health promotion interventions are oriented derives from the understanding of the individual as a free and rational subject who, based on various fields of knowledge, experiences, criteria, situations, assesses the relevant costs and benefits, and incorporates (or not) certain healthcare practices.[38] As for the State, it is believed to be an entity in possession of health-related truths, and to be responsible for teaching people about these truths. For this reason, health professionals who took part in this study emphasize the role of the government institutions in providing health knowledge and criteria, enabling people to assess their habits and health condition to later use them in a somewhat coherent way and improve their own health.

In this sense, our conclusion is that health promotion policies and interventions provide several technologies of the self that are, according to Rose,[39] ways in which people are qualified to act on themselves (in relation to their bodies, thoughts, feelings and behaviors) by means of the development of knowledge, criteria, strategies, so on and so forth, in order to improve their health condition. In short, government actions on health promotion are aimed at generating knowledge and conditions that help people *freely* pursue health-related goals and, at the same time, be willing to use certain technologies of the self in order to reach these goals.

In the third place, we found out that the (material, political and social) environment

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is considered an external factor regarding health production, which influences the desire to perform hegemonically healthy practices and the material conditions that make such practices possible. Although the focus on the individual, understood as the agent making the final decision on their own health, is a remarkable element in the arguments presented by the health professionals interviewed, the importance the environment acquired is differing in terms of a determining factor in the decision-making process.

We have noticed that the constant arguments contrasting the idea of the environment as a framework of possibilities to be healthy and of the individual as an independent and rational subject have an impact on the attribution of health responsibilities. It was indeed evident during the interviews how health responsibility, in those cases where personal choice is minimized by social pressure and political, social, material and economic determinants, becomes a social matter, so the State, apart from informing and teaching people about healthy practices, should develop policies aimed at rectifying social inequality and provide tools to prevent and solve health issues. On the contrary, the stress on the ability to choose and personal freedom as the ultimate element of intervention constructs health not simply as an experience you had,[8] but as a process on which an individual can have an influence, by either improving or deteriorating their health condition, depending on the actions and conditions they have chosen. This conception may lead to an extreme accountability of the subject for their health practices and conditions: if you can chose to be healthy, poor health may be proof of the individual's lack of responsibility, reflexivity or willpower,[8] resulting in the relegation of social determinants which restrict the framework of possibilities on which decision-making is based.

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