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Health inequalities and place: A theoretical conception of neighbourhood

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Abstract

In the past 10 years, interest in studying the relationship between area of residence and health has grown. During this period empirical relations between place and health have been observed at a variety of spatial scales, from census tracts to administrative units in metropolitan areas to whole regions, and for a variety of health outcomes. Despite the richness of the data, there are relatively few publications offering theoretical explanations for these observations, and a sound conception of place itself is still lacking. Using place as a relational space linked to where people live, work and play, this paper conceptualises the nature of neighbourhoods as they contribute to the local production of health inequalities in everyday life. In reference to Giddens' structuration theory, we propose that neighbourhoods essentially involve the availability of, and access to, health-relevant resources in a geographically defined area. Taking inspiration from the work of Godbout on informal reciprocity, we further propose that such availability and access are regulated according to four different sets of rules: proximity, prices, rights, and informal reciprocity. Our theoretical framework suggests that these rules give rise to five domains, the physical, economic, institutional, local sociability, and community organisation domains which cut across neighbourhood environments through which residents may acquire resources that shape their lifecourse trajectory in health and social functioning.

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Introduction

Investigators in various countries have reported that area of residence is associated with health above and beyond individual level risk factors (Diez-Roux, Link, & Northridge, 2000; Jones & Duncan, 1995; Kaplan, 1996; Kawachi & Berkman, 2003; Macintyre, MacIver, & Sooman, 1993; Pickett & Pearl, 2001). Such associations have been observed for a variety of health outcomes including tobacco consumption (Duncan, Jones, & Moon, 1996, 1999) and smoking initiation (Frohlich, Potvin, Chabot, & Corin, 2002), adolescent risk behaviours (Ennet, Flewelling, Lindrooth, & Norton, 1997; Karnoven & Rimpala, 1996, 1997), general mortality (Yen & Kaplan, 1999), perceived

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health (Blaxter, 1990; Soobader & LeClere, 1999), and cardiovascular diseases risk factors (Diez-Roux et al., 2000; Sundquist, Malmstrom, & Johansson, 1999), thus suggesting that some neighbourhoods are healthier than others (Diez-Roux et al., 2001; Kaplan, Everson, & Lynch, 2000; Macintyre & Ellaway, 2000).

Attempts to understand the reasons for this spatial patterning of health have led to distinguishing compositional from contextual explanations (Macintyre et al., 1993; Shouls, Congdon, & Curtis, 1996). The compositional explanation attributes the geographical clustering of health outcomes to the shared characteristics of residents. Similar people (e.g., similar in terms of socioeconomic status, or educational level) tend to aggregate within geographical proximity, whether purposefully to share a common culture, or because they are driven to certain areas because of lack of personal resources, money and others (De Koninck & Pampalon, in press; Harvey, 1973). These shared characteristics explain in part the health and place association. The contextual explanation attributes spatial variations in health outcomes in part to characteristics of the environment proper (Macintyre & Ellaway, 2000). The contextual explanation states that there exist ecological attributes of spatially defined areas that affect whole groups. These contextual attributes pertain to various aspects of the environment, and they affect health over and above the contribution of aggregate individual characteristics (Macintyre, Ellaway, & Cummins, 2002).

This distinction between compositional and contextual effects has fuelled heated debates in the public health literature. Recent commentaries, however, have suggested that this framing of effects constitutes an oversimplification. Disentangling compositional and contextual effects cannot be done from a strictly empirical perspective (Macintyre & Ellaway, 2003). Indeed, people's distribution across areas of residence is neither random nor totally intentional. As a reflection of both chances and choices, residential decisions (or the absence thereof) are shaped by the correspondence between individuals' economic means and lifestyle preferences, and neighbourhood characteristics pertaining to the availability of resources and services, the quality of the physical and built environments such as housing, and other socially oriented criteria such as reputation, history or the presence of social connections (De Koninck & Pampalon, in press).

Conversely, neighbourhoods are not static, as their contextual and compositional characteristics change over time in a related, and sometimes almost synergistic manner (Soja, 2000). Galster (2001) identified four key neighbourhood users (and producers) whose decisions influence the flow of neighbourhood resources: households, businesses, property owners and local government. Through their consumption, service use, political processes and social connection patterns, these neighbourhood actors reproduce and transform their context, while the lifestyle and health of individuals are affected by the goods consumed, the services used, and the social relationships built. The collective lifestyle heuristic is an attempt to capture this dialectical relationship between individuals and places (Frohlich, Corin, & Potvin, 2001; Williams, 2003). It justifies "the need to link individual life histories with social factors" (Dunn, Frohlich, Ross, Curtis, & Sanmartin, 2005) such as those encompassed in the social entities of places (Curtis & Jones, 1998).

Our team has taken up the task of putting together a data infrastructure that will facilitate empirical studies of the evolution and associations between selected health outcomes, individual factors, and contextual characteristics of neighbourhoods. The first step in this endeavour was to elaborate a conceptual framework of neighbourhoods that would account for the local production of health. The main lens through which the framework, and this paper, views the neighbourhood association with health is through differences in the distribution of resources. We see this distribution as governed by four types of rules associated with five domains of social regulation. The spatial patterning of health inequalities is thus related to the variable configurations of those domains across neighbourhoods rather than simply the sheer number of resources available to residents within neighbourhoods. These configurations are in turn shaped by social interactions between neighbourhood users/producers and by patterns of geographic mobility through which people move away from, or into, areas according to their choices and to their personal economic and other resources.

This paper thus presents our conceptualisation of neighbourhood as a configuration of five domains through which residents acquire (or do not acquire) resources necessary for the production of health in every day life. A presentation of the specific mechanisms or pathways by which those resources

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