spectra 100

Lifestyle and health

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Lifestyle has an influence on health – but what influences lifestyle?

Determinants of health. A healthy lifestyle could prevent many chronic diseases. But lifestyle – like health in general – varies considerably throughout our society. The boundaries between healthy and unhealthy often parallel those of social distinctions. One of the main tasks of health promotion and disease prevention is to enable health equality. This calls primarily for structural measures – because these also influence lifestyle.

Smoking, alcohol consumption, an unbalanced diet and lack of exercise are crucial health factors associated with a number of non-communicable diseases such as cancer or cardiovascular disease. According to estimates by the WHO (World Health Organization), up to 80 percent of cases of coronary heart disease, 90 percent of type-2 diabetes cases and a third of all cancer cases could be prevented if people engaged in more physical activity, followed a healthier diet and quit smoking.

The worse-off are in poorer health

Health is the greatest good – and, like all goods, it is unevenly distributed in society. The question as to whether or not we stay healthy has long since been determined by factors that go beyond biological or genetic determinants or individual health-risk behaviour.

Health inequalities are an omnipresent, universal phenomenon. In social terms, life expectancy and premature mortality are unequally distributed in all countries for which relevant data are available. This effect is found independently of the indicator of social inequality used, whether it be educational, occupational or income status. The more unfavourable the socio-economic status, the higher the mortality rate and the lower the life expectancy.

Which factors do mostly shape a healthy lifestyle?

In which direction does the relation between the effects of socio-economic and health inequalities progress? According to a meta-analysis commissioned by the Federal Office of Public Health (FOPH), it is primarily socio-economic status that impacts on health, rather than vice versa. Low socio-economic status is associated both directly and indirectly with a greater health risk.

What's the cause: behaviour or circumstances?

In this context, "directly" means that individuals with a low level of education or low occupational status share a culture that promotes patterns of behaviour harmful to health. This approach is also referred to as the cultural-behavioural approach. It includes cigarette smoking, alcohol consumption, an unhealthy diet and physical inactivity. Such patterns of behaviour are closely associated with physiological and biomedical parameters such as high blood pressure or high cholesterol levels, which are risk factors of many chronic diseases.

It is assumed that 30 to 50 percent of health disparities can be attributed directly to health-risk behaviour. This approach therefore does not suffice on its own to explain health inequality. The materialist/structural approach is considered to be an effective explanatory model. It argues that the health of people at the lower end of the status hierarchy is influenced indirectly. Not only do they have less in the way of financial resources, they also tend to live and work in environments that are more harmful to health compared with people further up the social scale.

More recent research has increasingly broadened efforts to find an explanation and has added new approaches. Of the latter, the psychosocial approach is the most highly developed. This more psychological approach was taken up because of growing doubts as to whether behavioural and material factors were sufficient to explain the social gradients of health. This hypothesis was supported by research findings confirming that clear health disparities also exist in groups in which health risks such as unfavourable living and working conditions tend to be unlikely, for instance in public-sector employees. As a result, psychological and psychosocial factors have increasingly been added to material factors to explain health inequalities. These include, for instance, critical life events, chronic everyday pressures such as stress (e.g. lack of participation in decision-making, insufficient scope for action), social support and social networks, self-confidence and coping resources. Numerous studies have shown that uneven distribution applies not only to psychosocial pressures, but also to the resources for coping with them. This means that people of low socio-economic status are doubly affected. Generally speaking, psychosocial pressures and resources are attributed a level of importance comparable to that of material factors in efforts to explain health inequality.

Prevention: focus on structural conditions

Behavioural, material and psychosocial factors are therefore responsible for a large part of the inequalities in health. Where must preventive action be taken in order to achieve the maximum effect? Studies indicate that the independent effect of health-risk behaviour and of psychosocial factors is less than that suggested in the separate analyses. Conversely, this means that health inequalities are due primarily to material factors because the latter have a much stronger effect than health-risk behaviour and psychosocial factors.

In other words, measures that target health-risk behaviour are helpful in improving health overall. But they will not be successful enough to reduce health-related inequalities of opportunity because material living conditions and psychosocial factors play a greater role than health-risk behaviour in explaining socio-economic health distinctions. Health-risk behaviour is more a consequence of material/structural living conditions and psychosocial pressures. This means that behavioural prevention primarily addresses the consequences rather than the causes.

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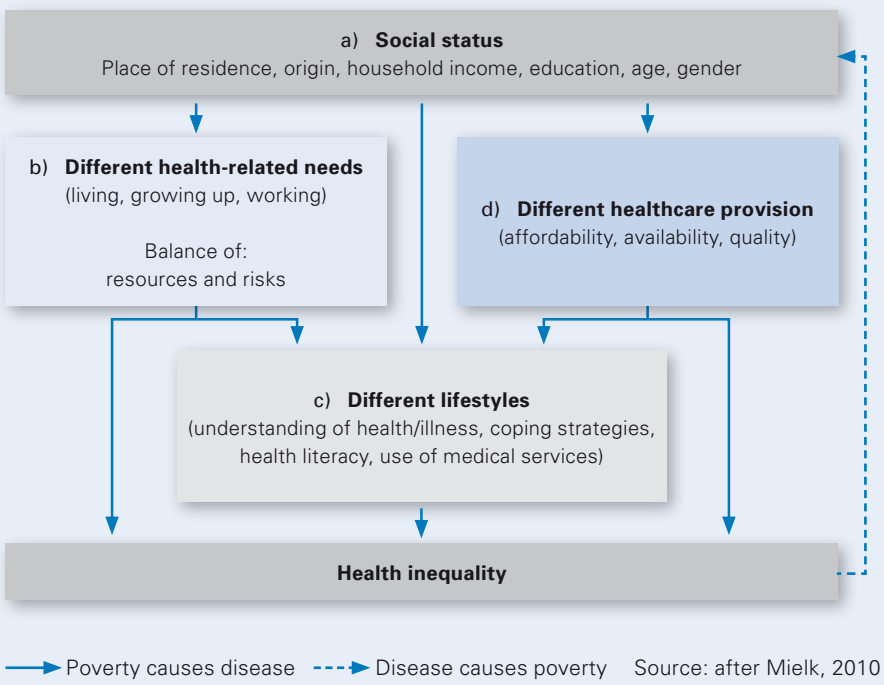
A healthy lifestyle is rarely due to free choice alone. The following model shows the chains of effects between social status and health status (extended arrows):



– Social status (a) shapes lifestyle (c) and has a direct effect on health status.

– Health risks and pressures accumulate over the years, depending on the life situation: the earlier an individual is exposed to a health risk (e.g. a disturbance of psychological development in childhood), the longer the effect on subsequent development (b). While men tend to suffer from health risks associated with their work (e.g. in the building trade), health pressures in women are due primarily to social risks (e.g. as single parents).

– Finally, healthcare provision (d) and health literacy (c) also play a role.

“spectra” is like a restaurant menu – it has something for everyone.

Six questions for Professor Thomas Zeltner. As Director of Switzerland's Federal Office of Public Health (FOPH) from 1991 to 2009, Thomas Zeltner helped shape the Swiss healthcare system and international health policy for many years. Today, he is President of the Science et Cité Foundation, which promotes dialogue between the sciences and the people of Switzerland, and he is a professor at the University of Berne and Harvard University as well as an advisor to numerous organisations and governments.

Spectra was being published throughout almost your entire term of office as FOPH Director. What comes to mind when you think of this "newsletter for Prevention and Health Promotion"?

Firstly, spectra has enabled us to express our views clearly and concisely on controversial topics and helped us position ourselves. Secondly, it has enabled us to raise awareness of topics that would otherwise have been somewhat overshadowed by other issues. It gave us a chance to say: "Look at this, it's important" – hence the title "spectra", which covers the entire range of colours and possibilities.

The mass media are very quick to respond when something sensational or topical occurs, but they tend to narrow it down to succinct details. The job of spectra is more to provide sound background information. Does it come up to scratch in this respect?

Yes, in fact very much so. Spectra has a good and highly distinctive profile. It combines the task you've just referred to with a high level of reader-friendliness. Spectra is a bit like a restaurant menu – it has something for everyone. It uses a wide range of formats, making it a pleasure to read. But you don't have to read it from beginning to end – it can be laid aside for a while. It's a classic magazine format. This sets it apart from the daily media, which are similarly structured, and from scientific journals, which also provide background information but, as reading material, are almost too dry. I think the combination is very successful.

Do you think that we're reaching our target public and that spectra is being read and heeded?

I for one read it and I've heard from others that they enjoy reading it. In my opinion, the key target group would be people whose work is concerned with the concept of "health in all policies", i.e. who are active in other areas of society and politics. They need to be constantly reminded of how important their activities are for health. The topics that spectra addresses make it clear that lifestyles and living conditions play a much more crucial role than curative approaches. It's like with children of the clergy – they don't need to have the Bible explained to them. Likewise, there isn't such an urgent need for health professionals to read spectra.

In the mid-1990s, AIDS and drug abuse were the burning topics, high up on the list of people's concerns. This is no longer the case today. Looking back after all this time, what have been the major problems of the last twenty years?

The major crises you mention were followed by others such as pandemics and new infections. They brought with them the realisation that health issues, economic problems and prosperity were very closely interconnected. The defining experience in my term of office was SARS and the sudden realisation of how vulnerable the world was. SARS brought the great Basel World international clock, watch and jewellery fair almost to the verge of ruin. Then there were the conflicts between the interests of health and business in relation to efforts to reduce smoking. All this engendered the really big topics centred on chronic, non-communicable diseases and their prevention.

The 100th issue of spectra is focusing on lifestyle. Which changes in lifestyle have most obviously had an impact on health in the last few decades?

You're probably expecting me to mention diet, physical activity and overweight. These really are important – and also unresolved – topics. They are important for us because we in the public health sector still don't know how to tackle them to sustainable effect. But there is a second topic that is coming increasingly to the fore. It's about demographics, about staying healthy into advanced old age. Because of Switzerland's demographic development, this topic deserves much more attention. Hence, social health does too – and therefore not just mental health. Measures to prevent social isolation are among the most important in terms of keeping people healthy. Isolation is an inhumane way of life. It's becoming increasingly obvious that steps to avoid isolation later in life need to be taken at as early an age as 50. I also completely underestimated the problem. For a start, we have to be able to walk, get out of the house and cultivate contact with other people, and we have to be able to hear and understand others. I regard this as one of the really big issues of both the present time and the future.

Are you someone who will always enjoy the feel of paper in your hand or do you also like to read things on a tablet computer?

Those who know me are aware of my liking for lying in the bathtub and reading. A tablet's not really suitable for that sort of thing. I like to have a paper in my hands and the option of putting it down somewhere and picking it up again later. However, I would say that spectra has to be available online and on tablets. After all, today's reading habits have changed; we also want to be able to read on the move. My wish for spectra is that, in addition to one-way communication, it will succeed in evolving into more dialogue-based forms. I'm quite sure it will achieve this by the time its 200th issue comes around.

At first hand

Large numbers of Italians have migrated to Switzerland in the last hundred years. Most of them have earned their living the hard way, doing physically challenging work on building sites, in hotels or big factories. Their children have gone to school here and have therefore been able to take up other occupations. They are no longer trained as bricklayers and waiters, but became bank employees, businesspeople and lawyers. Many of them have taken Swiss nationality, studied at our universities and hold political office. They have integrated into society, and it is hard to imagine it without them.

The University of Zurich's Institute of Social and Preventive Medicine has investigated the life expectancy of these migrants and also that of their children. At first sight, the findings are startling: on average, the first generation of migrants lived longer than their Swiss contemporaries, even though they not only worked harder than the Swiss, but also tended to smoke more and take less exercise. The second finding is even more surprising: on average, the "secondos" generation – their children – die earlier than people who have spent their whole lives in Switzerland.

The solution to this apparent puzzle is "lifestyle". First-generation Italian migrants behaved just as they had done "at home". They cooked with olive oil (rather than butter), ate a lot of fish and vegetables and drank red wine in moderation. A further positive factor in addition to their diet was the important role played by their families. Anyone who fell ill received medicine from their GP and care and attention from all their relatives. In this configuration, any illness – whether mental or somatic – did not go undetected for long. These close ties have been severed in the second generation of migrants. The "secondos" take their bearings from the more individualistic lifestyle of their new homeland. This includes altering their dietary habits. Like most of us, they now eat increasing amounts of ready-made products – and suffer the well-known harmful effects on health.

What can we learn from this? Healthy living is not just a question of income, nor does it mean a life of self-denial – after all, Italy is positively synonymous with la dolce vita. Healthy enjoyment is what is needed!

Pascal Strupler
Director of the Federal Office of Public Health

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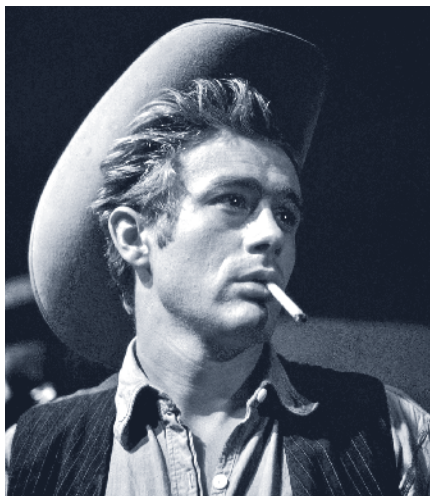
From freedom symbol to commonplace addictive substance

Smoking and society. Smoking was still regarded as absolutely normal just a few decades ago. In fact, it was not only accepted, it was positively celebrated, as a "torch of freedom". Nowadays, the wind of freedom is blowing from another direction: for anyone who wants to feel free and enjoy life, smoking is out.

The global advance of tobacco consumption began with the industrial production of cigarettes in the mid-19th century. With the sudden availability everywhere of tobacco in a ready-to-smoke form, the number of smokers soared dramatically. Until the 1920s, however, hardly anybody smoked in restaurants. This changed when the tobacco industry started promoting smoking as a kind of substitute for dessert – a strategy that was particularly successful in enticing figure-conscious women to light up. During World War Two, cigarettes lost the glamour they had acquired in the early 20th century. Instead, they were elevated into a symbol of comfort and relief from the miseries of war. After 1945, all of Europe was smoking. Among women, the trend was underpinned by emancipation because smoking seemed to represent everything that the women's lib movement was demanding: independence, self-determination and a foray into a male domain.

This nebulous view of smoking was created by the claims of a powerful tobacco-advertising machine. For decades it promised smokers the freedom and the coolness of a Marlene Dietrich or a James Dean.



James Dean und Marlene Dietrich: Icons for supposed freedom and coolness.

From glorification to clear-sightedness

The 1960s saw the first doubts and warnings about smoking when the findings of medical research on the subject were published. This marked the start of a far-reaching social change. The positive image of cigarettes began to crumble. Marlboro Man was unmasked as a nicotine junkie. Smokers were no longer regarded as individualists but as the victims of marketing.

A learning process for society

Society has undergone an impressive change and learning process in the last two decades. Triggered by tobacco control efforts, this re-think has resulted in a far-reaching paradigm shift. Even if advocates of smoking still try to associate it with "freedom", there is a growing realisation that true freedom means "free from smoking".
More than three quarters of all European countries have now introduced bans on smoking or imposed restrictions on tobacco advertising. In Switzerland, too, the majority of the population approve restrictions on smoking. Even smokers are in favour of them. According to the Addiction Monitoring in Switzerland, in 2011, 71% of smokers in Switzerland favoured a general ban on smoking in restaurants, bars and cafés.

9000 deaths a year

And there is no way this truth can be glossed over: the cigarette is "the only consumer product which, when consumed as indicated, kills". Historian Robert Proctor expressed it even more forcefully in an interview in the Tagesanzeiger, a Zurich daily newspaper: "If cigarettes were invented today, they would certainly be illegal." In Switzerland, over 9,000 people die each year as a result of smoking. In addition, smoking generates social costs of over ten billion francs a year.

Non-smokers enjoy life

Given such figures, there is something almost cynical about critics who dismiss tobacco control as pleasure-hating, health-obsessed hysteria. The new trend towards non-smoking and the tobacco prevention campaigns are not an expression of a modern-day puritanism that regards any form of enjoyment as harmful to health or, at the very least, suspect. People who quit smoking are neither victims of a paternalistic society nor sudden disdainers of the pleasurable. On the contrary, giving up smoking means gaining both new enjoyment, and new quality of life. Once the withdrawal symptoms are over, most ex-smokers report an increase in energy, more intense sensory reactions and a new feeling of freedom. They are no longer slaves to their addiction.

The culture of smoking is not yet dead

Though the culture of smoking in present-day industrialised countries may seem to be at the dying-embers stage, it is far from dead. In 2011, 24.8 percent of people living in Switzerland smoked. The last ten years have seen a slight downward trend. But Switzerland is certainly not a smoke-free society, nor is that the aim of the National Tobacco Programme. Its target is to reduce the proportion of the overall population that smokes from the current 24.8 to 23 percent by the end of 2016. That target is still a long way off, even though not smoking has become the social norm.

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Employee fitness is also an economic factor

Physical activity in the workplace. On average, employees spend 60% of their day in the workplace, many of them doing sedentary work. As a result, over 50% of the working population do not get enough exercise, their performance declines and they are more likely to fall ill. Employers can counter this trend by introducing physical activity programmes at work.

The human body is made for physical activity. But in the present-day service-based economies of highly developed countries, office-type work is growing exponentially. It seldom requires physical activity, and poor posture often develops over time. But manual labour also frequently has damaging effects on health. Jobs that involve carrying heavy loads often result in musculoskeletal problems, particularly of the back. Strengthening and relaxation of the body is therefore important in all sectors of the economy and benefits not only the workforce, but their employers as well. Fit and active employees are more resistant to a hectic pace of work and stress, they are better at handling pressure, have fewer health problems and are absent less frequently.

A healthy workforce = more profits

Corporate health promotion is often limited to isolated measures such as providing healthy food choices in the canteen or incentives to give up smoking. Nowadays, however there is a need for wider-reaching programmes that include physical activity. Studies show that such "multicomponent programmes" significantly improve health, reduce absenteeism and ultimately generate economic benefits. The business consultancy Boston Consulting Group estimates that the productivity gains yielded by a simple corporate health-promotion programme could enable a European company to achieve health-cost savings or additional profits of up to 400 US dollars per employee per year.

Intervening at four levels

But what does a corporate physical-activity programme need in order to be successful? What makes it more acceptable to employees and more likely to be used by them? Studies indicate that interventions at four different levels are required:
– personal level
– interpersonal level
– organisational level
– environmental level

To be successful, such programmes have to enjoy the backing of top management and be integrated into the corporate guidelines. They should also be part of a comprehensive health management programme.

Swiss-based projects

As far back as 1986, the Ottawa Charter designated the workplace as an important setting for prevention activities. In addition, Swiss government minister Alain Berset has explicitly included the workplace as a setting for prevention in the federal "Health 2020" strategy. At the beginning of 2013, the Federal Office of Public Health (FOPH) cooperated with the Swiss Foundation for Health Promotion and Suva (Swiss Accident Insurance Fund) in launching a joint project to promote, among other goals, physical activity at the workplace. The aim is to harness existing knowledge and available resources to help interested companies devise and implement suitable tools and methods for promoting the health of their employees at the workplace.

The pilot project is already in the realisation phase: at its Orbe (Canton of Vaud) site, Nestlé has developed various approaches that are designed to improve physical wellbeing in the workplace and prevent musculoskeletal disorders.

Links: www.actionsante.ch
www.aeps-ch.org

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