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KRZYSZTOF PUCHALSKI

Motywy działań ważnych dla zdrowia i ich społeczne zróżnicowanie

Social differences in motivation for health-related behaviours

Streszczenie

Wstęp. Poziom wykształcenia jest tą zmienną społeczną, która najsilniej na tle innych (obok wieku i zamożności) różnicuje stan zdrowia, zachowania zdrowotne oraz zdolność wykorzystania informacji dotyczących zdrowia.

Cel. Tekst analizuje motywy podejmowania dwóch typów zachowań – tych, które w świadomości społecznej uznawane są za sprzyjające zdrowiu oraz tych, które traktowane są jako zagrażające mu. Poszukuje zróżnicowania motywów tych zachowań w zależności od poziomu wykształcenia badanych.

Materiał i metody. Badanie przeprowadzono w 2002 r. techniką wywiadu kwestionariuszowego w celowo-losowej grupie 1134 pracowników 250 przedsiębiorstw (pow. 100 zatrudnionych) z terenu całego kraju.

Wyniki. Do działań ważnych dla zdrowia skłania badanych wiele różnorodnych motywów. Dla zachowań prozdrowotnych głównymi są: chęć zatroszczenia się o dobre zdrowie, utrzymania sprawności, wzmocnienia energii. Zachowania te częściej podejmowane są dla uniknięcia w przyszłości kontaktów ze źle ocenianą służbą zdrowia, niż z faktu choroby lub obawy o jej wystąpienie. Z kolei wśród przyczyn działań antyzdrowotnych badani akcentują różne aspekty przyzwyczajenia, czerpaną z nich przyjemność, towarzyszące im poczucie swobody i relaksu oraz niechęć do myślenia o szkodliwym wpływie takich zachowań na zdrowie. Poziom wykształcenia częściej i silniej różnicuje motywy podejmowania zachowań antyzdrowotnych, niż działań sprzyjających zdrowiu.

Wnioski. Edukacja zdrowotna w znacznie większym stopniu niż dotychczas powinna uwzględniać specyfikę swoich adresatów, związaną z ich poziomem wykształcenia. Szczególnej uwagi wymaga potrzeba dostosowania jej treści, metod oraz nadawców do specyfiki świadomości zdrowotnej (motywów działań związanych ze zdrowiem) grup najniżej wykształconych. W przypadku tych grup należy ponadto uwzględnić fakt ograniczonej skuteczności metod edukacyjnych na tle innych metod wpływu społecznego.

Słowa kluczowe: zachowania zdrowotne, świadomość zdrowotna, edukacja, promocja zdrowia.

Summary

Introduction. The level of education has a greater influence on health status, health behaviours, and an ability to use health-related information than other social variables.

Aim. The study looks at the motivation for two types of health-related behaviour (positive and negative) and its differentiation in respondents with different level of education.

Material and methods. The research was carried out in the year 2002 as a questionnaire-based interview on a random sample of 1134 workers of 250 companies with over 100 employees.

Results. There are many reasons why the respondents undertake particular health-related activities. In the case of healthy behaviours, the most popular are: the wish to take care of one's own good health, to maintain fitness, and enhance vitality. An occurring disease or fear of one is a less frequent reason for healthy behaviours than the wish to avoid future contacts with the health care system, which is evaluated negatively. Among the motives for unhealthy behaviours, the respondents emphasise different aspects of them being a habit, pleasure drawn from them, an accompanying sense of freedom and relaxation, and an aversion to thinking about a negative influence of such behaviours on health. The level of education is a more frequent and stronger differentiating factor in respect to the motivation for unhealthy behaviours than for healthy ones.

Conclusions. Health education to a much greater degree should take into account its recipients' specific character related to their level of education. Special attention should be given to the necessity of adjusting the content, methods and educators to the health awareness (motivation for health-related behaviours) in groups at the lowest educational level. In should be considered that in these groups educational methods may have a limited effectiveness in comparison to other social influence methods.

Key words: health-related behaviour, health awareness, education, health promotion.

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INTRODUCTION

An assumption that health behaviour and lifestyle have a strong impact on health status of a society is (however, not without doubt) well established in theoretical concepts, research results and policy documents. However, many practical issues related to the formation of health behaviour still remain unsettled. Among many others, those issues concern, e.g. the place of health promotion within the public health policy. Other important issues are preferred values, strategies and methods of influencing people, and the impact of popular practices supporting healthy lifestyle on social inequalities in health.

The research shows that taking care of one's own health (in the form of adequate nutrition, hygiene, physical activity, etc.) is correlated rather with a high educational level (and young age) than with financial status and other social characteristics of the person [1, 2]. The above mentioned connections prove that education has an important role in shaping healthy lifestyle. In this context, education can be considered from two points of view. The first is a general educational status and its correlates understood as variables concerning cultural capital. The second is health awareness – values, knowledge, beliefs, attitudes and skills concerning health issues. They are formed indirectly, in the socialization process, and directly through health education activities.

The developing health status of the society concerns all those groups who are better educated and higher in the social hierarchy [2]. These groups are in a privileged position due to the cultural capital linked to educational status, which has both direct and indirect - through health behaviour – impact on health. The cultural capital supports also competences indispensable to receive and use health-related information. However, when we consider equal opportunities in health, the key problem seems to be support methods for groups with lower educational status to enable them to use health education profitably and change their behavioural patterns.

The main problem concerning health education for adults is that the way information is presented does not sufficiently take into account thinking patterns of the target group [4]. The way the information is presented is usually closer to the values, assessment criteria and language of the author of information (usually coming from a privileged group). At the same time, it does not fit the way of communication that is usual in the groups with lower educational status. The "professional" authors usually try to use ex cathedra messages based on epidemiological research that are too sophisticated for the "lay" target group. Such messages also do not take into account the commonsensical thinking patterns. At the same time, "lay" people from the target group, especially those with a lower level of education, use they own logic, which is world apart from the rational thinking of medical sciences [5].

From this point of view, it is very important to explore the "lay" attitudes concerning health. The knowledge about different attitudes of people with various educational status is a key issue. It is a great support for health education that can eliminate health inequalities. Thorogood [5] underlines that this is one of the key problems of public health practice as knowledge about behavioural determinants of health (used in messages concerning health) is useful only when it is adopted by the target group and integrated into the "lay" common thinking. When messages are not accepted their impact on health behaviour is insufficient.

Aim. The paper aims to present the research as a basis for adjusting the content of educational messages for groups of different educational status. From that point of view, the motivation for health-related behaviour are presented. In the end, some conclusions concerning formulation of health messages for low-educated groups are presented.

The motivation concerns two types of behaviour: positive and negative health behaviours. The behaviours are identified according to three criteria: 1) they are – according to medical science – basic elements of lifestyle related to health, 2) they are considered by respondents as important for their health, and 3) they are common in a population under study.

METHOD

The study presented in this paper was undertaken by the team of the National Centre of Workplace Health Promotion from the Nofer Institute of Occupational Medicine in Łódź. The questionnaire interviews were carried on in 2002. The sample was random and consisted of 1134 employees of 250 large companies (over 100 employees) from all over Poland. The respondents were randomly chosen from two age groups: 45-55 years of age and 25-35 years (the study concerned specific characteristics of employees approaching the retirement age) [6]. The sample specification does not make it possible to draw conclusions concerning the whole population, even if we take into account only employed people. However, we can formulate hypotheses that can be verified in further studies.

RESULTS

Health-related activities

Care of one's own health, according to 2/3 of the respondents, means correct nutrition. A smaller group associate good care with physical activity, stress coping and avoiding psychoactive substances, particularly tobacco. A relevant group of the respondents (1/3) find participation in screening programmes a good way to take care of their health. Only one person in eight chooses following medical advice and taking vitamins or other substances as ways to improve health [6].

The respondents were also asked to list their own behaviours they perceived as the most dangerous to their health. Eighty eight per cent of the respondents point at least one such activity. Half of the respondents indicate not enough rest, and one in three not enough physical activity, just as many smoking, bad nutrition and neglecting signs of disease [7].

When it comes to health-enhancing behaviours, people with a university degree more frequently (twice more often than people with primary education) choose stress coping ($p=0.001$). In the same respect, the better educated respondents choose following doctor's advice three times

TABLE 1. Motives of healthy behaviour and the level of education

Motives	% of "yes" answers	number of respondents marking particular statement	level of education influence (χ^2 P. p. df = 3)
I wanted to take care in the best possible manner of the most precious thing in life, my health.	75	1108	$p < 0.0001$ $\chi^2 = 26.15$
It was important to me to be able to work longer and more effectively.	72	1099	$p < 0.05$ $\chi^2 = 9.77$
Though I felt good, I wanted to look better and be fitter.	67	1105	insignificant
I thought it important, in the context of the current bad situation in the health care system, to stay healthy.	66	1104	$p < 0.05$ $\chi^2 = 9.65$
I acknowledge that it was cheaper to take care of my health now then to pay for the treatment at a later stage of life.	66	1100	$p < 0.05$ $\chi^2 = 9.21$
I find this kind of activity a pleasure, I like to behave in such a manner.	58	1102	$p < 0.005$ $\chi^2 = 14.12$
I noticed that I looked worse, I got tired sooner, I got fatter, some things were not good for me.	57	1109	$p < 0.05$ $\chi^2 = 9.47$
It came naturally, I was born this way.	49	1100	$p < 0.05$ $\chi^2 = 10.42$
Doctors advised me this lifestyle and activity.	49	1105	insignificant
I was interested in health issues, I read a lot about them.	48	1107	$p < 0.0001$ $\chi^2 = 22.81$
I did it in the best interest of my family, spouse and kids.	48	1107	$p < 0.0001$ $\chi^2 = 17.38$
I decided to make a change when I was diagnosed with an illness, deterioration of health.	43	1117	insignificant
I was afraid that I might get seriously ill.	42	1115	insignificant
I was thought to act this way in my youth, at school, etc.	41	1104	$p < 0.05$ $\chi^2 = 9.54$
I wanted to try out something new and different.	28	1097	insignificant
My friends, relatives talked me into it.	24	1101	insignificant
I wanted to show others that I was capable of doing it.	24	1100	insignificant
The opportunity presented itself for activities enabling such behaviour were organized.	23	1104	insignificant
I wanted to follow a fashion for the healthy lifestyle.	22	1100	insignificant
My religion and beliefs demand such a behaviour of me.	19	1105	$p < 0.005$ $\chi^2 = 13.56$

less frequently (p=0.003). They also tend not to choose checking their health condition (p=0.003). On the other hand, those with university degree prefer physical activity (p=0.000) and healthy nutrition (p=0.001).

The education level has also an impact on negative health behaviour. The better education, the lower number of smokers were observed (from 63% to 21%, p=0.000). The same tendency was observed for excessive drinking (18% and 8%, p=0.000). Other health behaviours were not connected with the level of education.

Motivation for health-related behaviours

Motivation concerning the respondents' positive health behaviour are presented in Table 1. The number of issues seems to be important there.

The motivation for healthy behaviour that was most frequently mentioned (3/4 of the respondents) was indicating health as the most important value. The following reasons only specify the general meaning of the idea of health as a value (prolonged ability to work, vitality, good looks, no need to see a doctor).

More people would rather take care of their health than react to symptoms of the present or anticipated health problems. Thus, more people underline prophylactic care of health instead of reacting against illness. At the same time, more people take up positive health behaviour to enhance their energy and looks than to react against deterioration of these features.

The respondents seem to worry more about the contact with the health care system than with a disease itself. 42% of the respondents claim that the possibility to fall ill is a motive for positive health behaviour. At the same time, 66% claim that they behave in a positive way because they do not want to be clients of poorly organized and insufficient health care. Nearly the same number of the respondents think that positive health behaviour is less expensive than medical care.

TABLE 2. Motives for unhealthy behaviours and the level of education

Motives	% of "yes" answers	number of respondents admitting to misconduct and marking particular statement	level of education influence χ^2 P. p. df = 3
I got used to acting like this.	62	971	insignificant
Some of these behaviours are a real pleasure to me, I enjoy doing this.	56	973	$\chi^2 = 12.67$ p<0.01
I act like this cause I want to feel free, I do not want to limit myself.	54	975	$\chi^2 = 10.23$ p<0.05
This behaviour helps me to relax, cope with stress.	52	970	$\chi^2 = 9.33$ p<0.05
I rarely think whether my behaviour is harmful to health.	52	979	$\chi^2 = 23.03$ p<0.0001
There are things much more dangerous to my health than my behaviour.	47	976	$\chi^2 = 12.22$ p<0.01
I act just the same as other people in my country, who do not care about their health.	42	970	$\chi^2 = 35.47$ p<0.0001
All the limitations and directions concerning this kind of behaviour make me angry.	38	974	$\chi^2 = 24.08$ p<0.0001
It is more important to me to enjoy life now than to stay healthy when I am old.	31	973	$\chi^2 = 37.54$ p<0.0001
This kind of behaviour is a custom in my family.	26	967	$\chi^2 = 17.48$ p<0.001
It is a lie that this behaviour is dangerous.	18	966	$\chi^2 = 13.64$ p<0.005
I have such a strong health that nothing can harm it.	15	971	$\chi^2 = 8.88$ p<0.05
I follow the doctors who also behave in an unhealthy way.	15	971	$\chi^2 = 38.86$ p<0.0001
I do it influenced by my peers, co-workers.	11	969	$\chi^2 = 45.66$ p<0.0001
My health is so poor that nothing can harm it.	7	966	insignificant

Apart from the motives mentioned above, for many respondents an important factor is pleasure given by positive health behaviour (58%) and the tendency to behave in a positive way spontaneously (49%).

Almost the same number of the respondents claim that in their case positive health behaviour is influenced by rational knowledge about health and its determinants.

The respondents are reluctant to admit that their social context has an impact on their health behaviour (with the exception of the situation where the behaviour was learned in the family). Only a small number of the respondents claim that a direct social influence, other people, fashion or personal image creation can influence their health behaviour.

The motives for negative health behaviour are different. Those who declared that their behaviour has sometimes a negative impact on their health (88% of all the respondents) were asked for an explanation of such behaviour (Tab. 2). Among the most frequently given reasons, four groups prevail.

A great number of the respondents claim that their negative health behaviour is habitual. They also express an opinion that such behaviour is quite normal and should be considered as a normal behavioural pattern in the society. At the same time, like in the case of positive health behaviour, only a small number say that other people influence their unhealthy behaviour directly.

Secondly, negative health behaviour is a source of psychological well-being, pleasure and relaxation. It is also perceived as a method to cope with stress.

To the third group, negative health behaviour gives an opportunity to express independence and freedom of choice. It is also the way to show the distance to common norms and restrictions.

The last group suppress the awareness of a negative influence of their behaviour on health. They claim that other factors also influence health, and in comparison with them, health behaviour is not that important (yet, they are far from saying that it is not important at all).

Motivation and education

The level of education has the strongest influence on the motivation for health-related behaviour when compared with other demographic variables.

As far as healthy behaviour is concerned, we observe that the higher the level of education, the more the respondents tend to justify their activities describing the need to improve their fitness and looks, or the pleasure that is given by undertaking positive health behaviour. Contrariwise, religious motives become less important in this context.

Except the group with a university degree, the higher the level of education, the more the respondents tend to point other reasons for their healthy activities. Frequent motives are: an intention to take care of health as the most important value, to prolong the ability to work, to save money necessary for the treatment, and an interest in health issues.

When we discuss negative health behaviour, the differences in motivation between groups with different level of education are even greater (Tab. 2). Only the most popular reason ("I got used to acting like this") and the least popular one("My health is so poor that nothing can harm it") do not differentiate the groups. The respondents at a lower educational level often mention all the other motives. Thus, the less educated have more subjective justifications for negative health behaviour [11].

Now we are going to attempt a general characteristic of each educational group according to their leading motivation for health-related behaviour.

The people with primary education (twice as often as people with university education) use the motivation related

to religion. They also more often claim that their positive health behaviour was shaped during the early socialization process, or that this is a fully spontaneous process (the situation is similar for the people with secondary education). In this group, negative health behaviour is often justified as being socially influenced (by what the majority do, by doctors who are not health models, colleagues and families). People from that group relatively often express the opinion that it is better to take advantage of life now than to be healthy in old age. They also quite often claim that negative health behaviour can be a real pleasure. Generally, this way of thinking can be described as the conformist-hedonist motivation.

The respondents with vocational education underline elements of „false consciousness" (according to a well-known expression by Karl Marx). In comparison with the other groups, they more often claim that negative health behaviour is not dangerous to health. They think that other factors can be more dangerous. They seldom think about an impact of unhealthy behaviour on health and health messages make them angry. Hedonism in this group has more a rational character – negative behaviour is often described as a stress coping practice (but pleasure is not so much stressed). A similar situation concerns positive health behaviour. It is not taken up, comparing to other groups, because of pleasure. However, it is more often done for the sake of the respondents' families.

As far as negative health behaviour is concerned, the results for the group with secondary education is consistent with the results of the whole sample. Positive health behaviour in that group is justified by many reasons (above all, by considering health as the highest value, by the wish not to pay for medical care in the future, and by saying that positive health behaviour is a spontaneous process). The content of those motives can be summarized with Znaniecki's concept of "people with good manners". That group has the strongest motivation to implement positive health behaviour among all the groups described.

People with university education indicate pleasure as a motive for both positive and negative health behaviour (those with primary education use that motive only for negative behaviour). They seldom present „false consciousness" (typical for people with vocational education). They deny to be influenced by the social context. They also very seldom claim to be driven into health behaviour by religious motives or early habits. They are also not afraid of a possible future need to use insufficient medical care. The possibility to diminish their ability to work seems also not to be a big problem for them. On the other hand, they more often implement healthy behaviour when experiencing problems with fitness or looks. They key characteristic of that group is independence (from opinions and influence of others).

Education and health interest

Generally, thinking about one's own health behaviour is clearly connected with the level of education (p=0.000). The higher level of education, the more people think about their behaviour related to health. Only 15% of the people with university education declare that they never think about this issue (up to 43% of the people with primary education). Only 15% of the respondents with primary education think about their own health behaviour often or very often (36% of such people are in the group with university education).

The higher education, the more respondents take up positive health behaviour even when they feel that their health is good: from 16% of the people with primary education to 47% with university education. A contrary tendency is observed, when we look at people who declare that they never improve their health behaviour: from 33% of those with primary education to 9% with university education). The respondents with primary and vocational education twice more often that those with secondary and university education take up healthy practices only when they observe serious health problems (p=0.000).

CONCLUSIONS

Health education programmes for groups with lower education should be strongly supported by social-environmental intervention (including all the groups of potential social influence). Such an attitude is very important because this group does not show much reflection on health issues. For the same reason, it is important to create models of healthy behaviour and possibilities to implement them, as an alternative to models popular in these populations, to support people in coping with stress and drawing satisfaction from life.

Health messages should include also the elements of assertive communication that can help these people to defend against the pressure of negative models. In messages for this group not only the knowledge itself is important but also the correction of an actual attitude (with respect for individual opinions and choices). Also modern interactive educational methods, including active participation, are vital.

Educational activities for groups with lower education should be included in the work of medical staff (with particular sociotechnical background). This is important because these groups associate taking care of their health with medical care [1]. It is also vital that the medical staff themselves are role models (models being of great importance for those groups).

To sum up, it must be stated that the best way to improve health behaviour of groups with lower education is to give them an opportunity to raise their general educational level. Such a strategy is, according to Ostrowska, the best way to enhance a society's health [2]. Another way to do that is to improve public health policy (aimed at poverty, cultural and social marginalization, unemployment, dependency). Such activities are more important than even the best health education programmes, which are better for groups with university education that reflect health issues. These groups can later become role models that can influence the rest of the population through modelling process.

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