

Resisting 'reason'. A Comparative Anthropological Study of Social Differences and Resistance Toward Health Promotion and Illness Prevention In Denmark

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Abstract

Social differences in health and illness are well-documented in Denmark. However, very little is known about how health practices manifest in the everyday lives of different social classes. We propose acts of resistance and formation of health subjectivities as helpful concepts to develop our understanding of how dominant health discourses are appropriated by different social classes and transformed into different practices promoting health and preventing illness. Based on fieldwork in two different social classes, we bring forth how these practices both overtly and subtly challenge the normative power of the health promotion discourse. These diverse and ambiguous forms of everyday resistance illustrate how and when situated concerns move social actors to subjectively appropriate health promotion messages. Overall, these different forms of resistance elucidate how the standardized awareness and education campaigns may perpetuate the very inequalities they try to diminish.

Introduction

In Denmark, as in most of the western world, the fundamental pillars of biomedicine and health promotion dominate the way in which health, illness and the body is thought about and practiced (Lupton 1995, Rose and Novas 2005). In the 1970s, the new public health discourse began to influence the way in which health promotion and illness prevention was approached, turning focus towards lifestyle choices, such as smoking, alcohol and dietary intake, and active preservation of good health and prevention of illness as an individual responsibility (Briggs

2003:288, Lupton 1995:49-51). What has been referred to as the consumption of health (Lupton 1995, Shilling 2002, Rose 2007) started to dominate the ways that many people related with their health and bodies, which brought with it the active pursuit of the good and healthy lives¹. The power and domination of the new public health discourse has had significant implications for the organization of healthcare and for policy development in Denmark as well as in the rest of the world (Baum and Fisher 2014, Mattingly, Grøn and Meinert 2011). In the Danish context, the messages of new public health are expressed through various forms of behavioral health promotion and illness prevention. For instance, the Danish Health and Medicines Authority administers a number of annual interventions and information campaigns focusing on “lifestyle changes” and targeting the most widespread risk factors, such as alcohol habits, diet, physical activity and smoking.

Besides attempts to improve the overall health status in the Danish population through health promotion and illness prevention, a major policy focus has been to reduce the rising social inequalities in health (Ministeriet for Sundhed og Forebyggelse 2013, 2014). Initially, attention was directed towards social differences in the risk of getting a disease and in improving prognostic outcomes, but recently, social differences in the practice of health and illness have become an area of policy intervention through awareness and education campaigns addressing different population groups. These initiatives may be perceived as responses to the mounting problems of social inequality translating into inequality in health. Social inequality in health manifest not only in class differences in the risk of getting a disease, but also in the prognosis across almost all diseases. A high profile contribution to our understanding of these differences is the WHO appointed Commission on Social Determinants of Health, which focused both on the widening gaps *within* and *between* nations, and pointed out how structural determinants and conditions of daily life are detrimental for the social determinants of health, causing much of the inequality in health even within affluent welfare states (Marmot et al.

2008). In the global north, the Whitehall studies and the Black Report were among the first to draw attention to what has been termed the social gradient in health (Marmot et al. 1978, 1991, Townsend, Davidson and Whitehead 1988). Since then the intense scrutiny of the social gradient in health has amply demonstrated that the lifestyles of the higher social classes are the healthiest (Cockerham 2005:58, Marmot et al. 1978, 1991, Townsend, Davidson and Whitehead 1988, Williams 1995).

Within the social sciences a number of studies have also explored the social or cultural “effects” of the new public health discourse through the lens of bio-power and with reference to health subjectivities (Briggs 2003, Lupton 1995, Rose and Novas 2005). These studies illustrate how discourses of new public health and health promotion tend to impose notions of responsibility for maintaining good health requiring people to practice certain types of informed health behavior and utilize the health services ‘appropriately’, thereby implicitly reinforcing the expansion of health consumerism. Although bio-power studies have pointed out social differences in the way that these obligations are met, more recent studies focusing on different social groups and the practice of health promotion and illness prevention in less affluent settings demonstrate considerable social differences in modes of appropriation (Cockerham 2005, Dumas, Robitaille and Jette 2014, Seligman et al. 2014, Warin et al. 2015, Whyte 2002). For instance, it has been argued, with reference to the work of Pierre Bourdieu, that different social classes carry forth certain dispositions and preferences which guide their health related practices (Williams 1995). In similar vein, Dumas, Robitaille and Jette (2014) show how living in socially deprived situations and life circumstances makes people negotiate a hierarchy of priorities, based on their proximity to conditions of necessity, meaning that the participants in the study were concerned with living ‘day by day’ or ‘within the moment’, and influenced by a particular temporality. The authors argue that health promotion practices are often associated with the prevention of future and intangible health complications, whereas the

very present structural factors and short-term perspectives on the future influence orientations and dispositions towards illness prevention in disadvantaged settings. Similarly, in a study focusing on anti-obesity campaigns in a deprived community in Australia, Warin and colleagues suggest that the orientation of health promotion towards the future has limited relevance in lives shaped by the immediacy of poverty, contingency and survival (Warin et al. 2015).

This article departs in these findings, as we explore the particularities of how dominant health promotion discourses are appropriated by two different social classes in the Danish welfare state. Our aim is to elaborate on the ways in which health promotion and illness prevention, in a broad sense, is practiced, transformed or contested in everyday life, through a comparative analysis of detailed ethnographic material. By placing health and illness concerns in the context of everyday life, we explore how situated concerns move social actors differently (Whyte 2009:9) and how agency is played out through patterns of everyday forms of resistance (Abu-Lughod 1990, Ortner 2006, Scott 1985). Overall, this adds nuance to how subjective frames of reference and the dominating normative power of the health promotion and illness prevention discourse are played out in everyday health and illness practices.

Approaching everyday forms of resistance as expressions of health subjectivities

“Health related behavior is itself a routinized feature of everyday life. Something which is woven into its very fabric” (Williams 1995:583). Consequently, this paper draws on ethnographic fieldwork carried out by Merrild, with the aim of gaining insight into these everyday lives that shape health and illness practices in different social classes. Early on in the fieldwork period the persistence of varying forms of “non-compliance” with dominant health promotion recommendations became apparent, drawing our attention to what Scott (1985) has termed everyday forms of resistance. Scott exemplifies these forms of resistance as foot

dragging dissimulation, false compliance, pilfering, feigned ignorance, etc., i.e. forms of class struggles requiring little or no coordination or planning, but which rather take the form of individual self-help that avoids direct or symbolic confrontation with authority or elite norms (Scott 1985:29). In the analysis we present below, we explore health practices through the lens of resistance, which allows us to attend to the often neglected ambiguities and complexities that shape health subjectivities. Opening up the relationship between resistance and the power of the health promotion and illness prevention discourse creates a space where the subjectivity of experiences takes the center stage (Hoffmann 1999:674), and we examine how practices of everyday forms of resistance correlates with the formation of health subjectivities in different social classes (Whyte 2009).

In the following, we thus take resistance to be those everyday acts of modification or rejection of the health promotion paradigm that emanate from intentionality and the pursuit of projects (in the sense of subjective aspirations or goals) within the context of power and relations of social inequality, asymmetry and force (Ortner 2006:144-46). The concept of resistance is still surrounded by ambiguity and debate particularly regarding its intent and recognition. It has been argued that when resistance is depicted even in small scale acts of opposition, it loses some of its meaning and it becomes difficult to recognize what these acts aim to achieve (Keesing 1992). For instance when refusal and denial to carry out requested tasks or follow rules is termed resistance, it may be difficult to determine for whom and with what aim these practices are in fact acts of resistance. Nevertheless, it is usually agreed that acts of resistance are closely linked with the power and domination from where they emanate (e.g.Foucault 1983). However, rather than focusing on the significance of the small-scale subversive acts of rebellion in themselves, we wish to develop Abu-Lughod and Ortner's conceptual understanding of resistance as a *diagnostic of power*, which can lead us to interesting insights about the forms of power at which they are directed (Abu-Lughod 1990,

Ortner 2006). Thus, with reference to the work of Foucault (1983), Abu-Lughod and Ortner we illustrate how studying resistance can bring out structures of domination, differentiation and subordination, structures which are otherwise left unnoticed. Studying everyday modifications, rejections or neglect of the normative messages of the health promotion discourse (such as assuming responsibility of our own health and illness by eating healthy food, exercising, not smoking and seeking timely and appropriate healthcare), and how these acts are played out in particular situations in the micro-politics of people's lives, allows us to take a novel look at how contemporary health subjectivities are determined by both structural influences such as economic and social policies, as well as by specific everyday morals, practicalities and interactions that frame health practices in different social classes. While as Whyte reminds us, "by describing patterns of social interaction, morality, and meaning, they suggest the processes through which assumptions and consciousness about health assume significance" (Whyte 2009:13).

Methods and material

Danish society is often described as an egalitarian system characterized by an ideal of "imagined sameness", as introduced by the Norwegian anthropologist Marianne Gullestad (2001). However, social as well as public health research continually illustrates that society at large is marked by increasing inequalities (Baadsgaard and Brønnum-Hansen 2012, Diderichsen et al. 2011:12-18, Olsen et. al. 2012). In 2012-13 Merrild carried out 12 months of fieldwork among two different social classes in opposite ends of the social spectrum, living in two different suburban areas in the welfare state of Denmark. Using participant observation to study the everyday lives of the informants, the fieldwork aimed to develop a comparative understanding of how the socio-economic system is produced and reproduced in everyday

practices and to locate the different forms of life observed in relation to each other (Gullestad 1992:6, 26, Reay 1998:268).

Twelve key informants were selected through purposeful sampling (Bernard 2002); six came from what, in a descriptive sense, is termed the lower working class (LWC) and six from the higher middle class (HMC). The informants were recruited from social settings like activities in the community house in the LWC area, or the golf and tennis club in the HMC area, and were first introduced to the project by Merrild. After a few days Merrild contacted them by phone, and the first meeting was scheduled. The social classes were initially identified solely on the basis of ownership of property. Hence, HMC informants all owned a house situated in an attractive and high-status residential area, where the property value was generally set above 600 000 USD ², while the LWC informants all rented their apartments in a socially deprived housing association located in an area with high unemployment rates. Thus, the social inequalities between the informants from the two different social classes initially came across in their economic situation and in the uneven distribution of different (chronic) diseases. As in most socially deprived areas in Denmark, in the housing associations where the LWC key informants resided, the overall health status was poor, crime rates were high, eight in ten were outside the workforce and living on different forms of social welfare benefits (federal transfer payments). But as will become evident below social inequalities also manifest as social practices, such as communication (verbal as well as body language), interaction, and body maintenance and appearance. These practices, tastes and preferences may all be considered forms of classed based social and cultural capital which influenced and shaped dispositions and opportunities for different lifestyles (Bourdieu 1984, 1987).

The key informants, representative of two different social classes, were characterized as follows:

Lower working-class (LWC) informants:

- Primary or lower secondary school or short vocational training
- Renting their apartment in a low-income and socially deprived area
- Living on social welfare benefits (federal transfer benefits) for over the past year at the time of the study.

Higher middle-class (HMC) informants:

- Higher education and/or a financial position above average
- Owning their own property in an area where the housing prices are above 600 000 USD

All informants had a unique biography, but their life circumstances were similar and a determining factor for their social position and perhaps also their lifestyle. The informants were both men and women; some were single, some cohabiting, and some married. All informants have been anonymized and given fictive names, and any information which could potentially reveal the identity of the participating individuals has been omitted.

All key informants were followed regularly in their everyday lives during a period of 12 months. Merrild participated in a wide range of everyday activities, such as hanging out at home, grocery shopping, playing golf, leisure activities, social events in the housing association, doctor's appointments and job training. As many of the field visits took the form of social activities, relationships developed with family and friends belonging to the same social classes as the key informants, thereby extending the group of informants beyond the 12 key informants. Participation in the different life worlds took the form of repeated visits and personal engagement and underlined how; "ethnography of course means many things.

Minimally, however, it has always meant the attempt to understand another life using the self – as much as possible – as the instrument of knowing” (Ortner 2006:42). This relational character of the fieldwork meant that the social position of the fieldworker vis-à-vis the different social classes, was detrimental for both access to and participation in everyday life. In many ways the lives of the LWC were more open than those of the HMC, which attests to the significance of the power relations between the researcher and the researched for the ethnographic fieldwork and data production. Consequently, working with the LWC was more of a traditional ethnographic study of the subaltern, whereas working with the HMC bore the remissness of the well-known challenges of studying up.

After each field visit, extensive field notes were written. All 12 key informants were interviewed three times during the 12 months of fieldwork, and all interviews were recorded and transcribed verbatim. Both interview transcripts and field notes were subsequently coded by Merrild and analyzed thematically (Emerson, Fretz and Shaw 1995, Hammersley and Atkinson 1995). The analysis was carried out in dialectic interplay between reading and re-reading through the data and theory. The themes of bio-power and resistance were identified through this dialectic interplay, as they resonated with the empirical data and conversely the empirical data found expression through the analytical concepts.

Resisting health promotion in everyday life

“We are so happy to have stopped smoking”

The worn-out buildings and the different shades of gray surrounding the parking lots in the LWC neighborhood gives the impression of monotony. Inside the buildings, the staircases are made of raw concrete, and the doors to each apartment are anonymous, merely displaying a name sign and a button at the center of the door, supposedly a doorbell. Brian, a LWC key

informant, lives in a relatively large, tidy and bright apartment behind one of those doors together with his girlfriend Fanny and their 8-year-old daughter. He has no formal education, has had a number of different low skilled jobs, mostly in the manual sector, and he has also been temporarily self-employed. Most of his employments have been short-term, and many have ended abruptly for different, often dramatic, reasons. Brian is 49 years old and, like many of the other LWC informants, he does not have a single tooth in his mouth. He has been living on early retirement allowance for the last ten years. Like most of the LWC key informants, Brian is overweight and he is diagnosed with borderline, anxiety, diabetes and asthma and has also been treated for prostate cancer a few years ago. Although the first encounter with Brian and the other LWC key informants gave the impression that their health problems were of a physical character, it soon became clear that many of them also had a number of different psychiatric diagnoses, which they often presented as their main health concern.

As the following discussion, which took place one afternoon when Brian and Fanny were playing cards at the community house with Merrild and three of their friends, Carl, Janet and John, will demonstrate, health promotion and illness prevention messages were much debated issues in social situations.

There is a 'cancer doctor' who says that the number of lung cancers could be reduced by as much as 70% if everybody switched from normal cigarettes to e-cigarettes, Brian tells me triumphantly. Yes, and also the other illness..... what is it called.... COPD, adds Carl. Janet pulls out her I phone, and turns on a newsflash from one of the national broadcasting channels. A consultant doctor appears on the small screen and claims that if all smokers switched to e-cigarettes we would witness a significant drop in both lung cancer and COPD. Then a woman from the Danish Health and Medicines Authority takes over the screen and emphasizes that

the Danish Health and Medicines Authority definitely does not endorse the use of e-cigarettes. Janet looks at me triumphantly, and John and Brian assure me how happy they are to have stopped smoking. They have both regained the senses of taste and smell, and the four of them begin to discuss how amazing it is that so many in the neighborhood have switched to e-cigarettes in just six months. And nobody is exposed to passive smoking anymore, concludes Brian. Carl remarks that it seems as if Brian has spread a health-enhancing standard in the area. Everybody nods in appreciation..... (Field note extract).

The example illustrates how people practice their own form of health promotion and tap into the health promotion discourse in their own terms. As argued by Sherry Ortner (1989:12) in her elaboration of practice theory, such practices reflect and elucidate the structures in which they are embedded, in this case, the structure of the health promotion discourse of anti-smoking. By engaging with and accepting the premises of the health promotion discourse, we see how the practices of Brian and the other LWC smokers emerge from the health promotion discourse. They have adopted the message that smoking is bad for them and that it causes damage to their health, and they use the rhetoric of public health, such as quoting statistical illness incidence, drawing on expert opinions of doctors and using words such as ‘health enhancement’. Switching to e-cigarettes (electronic cigarettes) is considered equivalent to smoking cessation, even though the nicotine intake remains the same, which is something that they are perfectly aware of and eagerly discuss.

At first sight, smoking e-cigarettes is not an overt form of resistance to the health promotion discourse. Quite contrary, as demonstrated above, the LWC informants draw on public health reasoning, to evidence and support their actions and to substantiate the choices they make. Smoking e-cigarettes thus becomes a form of selective compliance with health

promotion messages of anti-smoking. However, when this selective health promotion practice is brought into contact with the established healthcare system, it transforms into an act of resistance. Suddenly the practice, which was previously considered a health enhancing activity, "retains oppositional authenticity and agency by drawing on aspects of the dominating culture" (Ortner 2006:62) – here the health promotion discourse of anti-smoking. This was demonstrated a few months later when Brian participated in a patient education program and pulled out his e-cigarette during class. When he told me about the incident, he was shocked and surprised by the virulent reaction by the nurse who was teaching.

She yelled at me, he explains, and told me that I'd better put that thing away immediately. She didn't even want to hear what I had to say about it - how it [smoking e-cigarettes] had helped me, how I have quit smoking more than 40 cigarettes a day. It made me really angry the way that she made a fool of me in front of the whole class. And all over her slides was written STOP SMOKING....

(Field note extract).

Brian and the other LWC smokers stop smoking because they believe that smoking is bad for them, but they quit smoking in a different sense than advocated by the health promotion and illness prevention discourse. When grounding their reasons for not smoking they tap into the health promotion discourse, leaving their practices as expressions of what Scott refers to as "hidden transcripts", namely those "practices which confirm, contradict or inflect what appears in the public transcript" (1990:4-5), in this instance the health promotion and illness prevention discourse. Viewing their practices as (perhaps non intended) as acts of resistance exemplifies the domination of the health promotion and illness prevention discourse. In the following we turn to explore health practices as they manifest in the HMC context, which will underline how

resisting the practices health and illness as defined by biomedicine and the health promotion discourse is not confined to LWC settings.

“We don’t have breast cancer in my family”

The neighborhood of the key HMC informants is an expensive upper-class suburban area. All of the informants live within walking distance to the sea, and all houses are large and spacious, each with a well-kept green garden. The physical surroundings and the ambiance is one of lightness, abundance and individuality, which is also the case of Jane’s house. Jane is a 67-year-old key informant. She is small and friendly-looking with short hair and a tanned face. She has previously worked in the credit union sector, but after her husband’s death 15 years ago she decided to end her working life, albeit she is still a member of several boards of directors. Since her husband’s death, Jane has lived alone in her large house, but she has an extensive social network, and several times a year she travels to exotic destinations such as Borneo and Peru. As all the other HMC informants, Jane leads an active life and plays golf and tennis several times a week, which is an important and socially informed part of her life. Her late husband was a GP, and many of her friends and neighbors work as medical specialists as do both of her children. She often consults with her children, especially her daughter, before making decisions regarding her health, but she does not univocally accept and embrace health promotion messages, a point made evident in the following interview extract, where Jane and Merrild are discussing the potential risk of getting cancer;

J: Since we have spoken last time, I have actually called and cancelled my breast screening appointment.

C: Did you..... why?

J: Because I decided that I would not get breast cancer.

C: Yes?

J: Plus that if I did get it, then I would not have anything done about it.

C: Ok. You have to explain that to me.

J: Yes..... Yes..... do you mean why I don't think that I will get it or why?

C: Yes both. And why you don't want to have anything done about.

J: Well, we don't have any kind of breast cancer in my family, right. And we have.... Well, I have breastfed my children a lot – both of them, right. And there is some old well-known study which shows that it works if you breastfeed your children. At least not that many of those who have breastfed a lot get breast cancer (Interview quote).

Although ascribing to and enacting the healthy lifestyle as directed by the health promotion and illness prevention discourse, Jane resists dominant views on what counts as 'appropriate and informed utilization of the health services'. She refers to her age of 67 years when explaining her decision and to her previous experience with her husband's deterrent death from cancer as a reason for not wanting to go through any form of diagnostics or treatment therapy herself. *"I don't want to get sick and spend all that time sitting up there [at the hospital...] I have been through that once already"* (interview quote). And, if she does get cancer, her children will surely look after her, she reasons.

Although the informants in both classes actively engage in health promotion and illness prevention and legitimate their everyday health practices with references to dominant discourses, some of these lives allow their prescriptions more than others. By juxtaposing the cases of everyday forms of resistance with the established regimes of proper health practices, we get a glimpse of the complexity and subjective ambivalence of resistance (Ortner 2006). Simultaneously, these forms of resistance illustrate the diversity inherent in the category that we know as “the active and informed subject”. Moreover, analyzing resistance demonstrates how power relations take many forms, have many aspects and interweave (Abu-Lughod 1990:48). The health promotion and illness prevention discourse is powerfully present in the lives of all informants – irrespective of social class. By looking into the way that everyday health practices take the form of resistance towards the health promotion and illness prevention messages, the power of the discourse is brought out. This elucidates how the dominating definition of what it means to stop smoking takes on a narrow and normative form and refuses alternative smoking cessation methods, perhaps even methods with harm reductive potential. Likewise, when breast cancer screening is rejected on the basis of subjective experience and personal relations, the standardization of health promotion and illness prevention is questioned and the subjectivity of health practices is exemplified. Thus, approaching resistance as diagnostic of power illustrates how people experience and ‘live’ this power in different ways.

In the remaining part of the article, we focus on just those competing concerns and the differences in maintaining health and dealing with illness, respectively, which is further elucidated through the everyday acts of resistance.

Maintaining health or dealing with illness – exploring situated concerns

Herbal solutions - “But of course they don’t like that”

One of the main findings of this study, was the ways in which the LWC informants defied the passive role which the health promotion discourse often assign to people from lower social classes, where knowledge and education is often promoted as the solution to health disparities (Baum and Fisher 2014:214-16). Everyday forms of resistance, such as switching to e-cigarettes as a way to stop smoking, or using herbal drinks as a form of medicine, as we shall see in the following case, are practices deeply intertwined with and expressive of health subjectivities and situated concerns of individuals (Whyte 2002).

The significance of dealing with illness as an intrinsic part of life is exemplified in the case of Ingrid, a 70-year-old LWC informant. She has lived alone in her small apartment in the housing association since she divorced her husband almost 30 years ago. She has worked as an office clerk her whole life, but has been living of retirement benefits for the last five years. She rarely sees her two adult children; a situation which is causing her a lot of concern. Ingrid has a large social network and is very outgoing. She often goes to the community house to participate in different social activities such as meetings, communal eating and general socializing. The community house has several functions. First and foremost it provides a place to hang out, but the facilities also accommodate different social events, and the place is always full of people engaged in discussion, arguments, fun and laughter. Particularities of illness issues, especially the deteriorating health of people living in the neighborhood, are vigorously discussed, and advice and suggestions are offered in abundance. Often people would compare blood sugar levels, discuss their medical consultations and share information and personal experiences with both new diagnoses and the progress and status of “old” problems. Dealing with illness and different forms of suffering is considered part of everyday life, and health-related issues are discussed in social situations in a matter-of-fact way using concrete examples, perhaps because all the key informants and many of their friends and family suffer from various forms of chronic diseases.

During the fieldwork period, Ingrid commutes back and forth between her GP, the hospital and an eye specialist for a number of different conditions, and she worries a lot about her deteriorating health. Most health services in Denmark are available free of charge as they are financed through taxation, with equity serving as the overarching principle (Krasnik 1996). Accordingly, most of the Danish population has free and, in principle, equal access to primary healthcare clinics, who serve as the gatekeepers to more specialized treatment in hospitals or specialist clinics. Thus, Ingrid schedules appointments with her GP as she finds necessary while she needs not worry about the financial burden. One of the reasons for her regular visits to her GP is monitoring of her low hemoglobin levels in preparation for an operation. She is a proactive patient, and, like most of the other key informants, she seeks information about her many symptoms and illnesses on the internet and discusses her health with a number of people in her social network. During one of her health-related discussions with a friend, an herbal mixture was suggested, which she now drinks to improve her low hemoglobin level. She has already witnessed a rise, and she has told the doctors at the hospital that she will continue with her herbs until her hemoglobin reaches the desired level. *“But of course they don’t like that”*, she explains while laughing. She does not know why, but they gave her a prescription for something and told her to take that drug instead. During one of her regular monitoring visits to her GP, the low hemoglobin level and the herbal mixture were discussed.

Ingrid tells the GP that she has drinking the mixture and, while laughing and glancing over at Merrild sitting in the corner of the office, adds that she has drunk it even though she knows that it is not popular. The GP seems evasive, but finally looks firmly at Ingrid and tells her that if the mixture was to have any effect she would have to drink an enormous amount. They didn’t like it at the hospital either, Ingrid smiles, which makes the GP promptly ask if they gave her something else

instead. They gave her a prescription. And how many milligrams are you taking, the GP wants to know. Ingrid does not know, she has to take the prescription morning and evening....

The GP tests Ingrid's blood, and it appears that her hemoglobin level has risen again. Well that is good, says the GP, and Ingrid bursts out, Ohh, then it [the herbal mixture] must have worked. The GP ignores her comment and suggests that they make a plan for increasing her low hemoglobin to the desired level, and they agree that Ingrid should return in two weeks to have another test. And when you have made my hemoglobin level rise, I will return to the hospital for the surgery, Ingrid concludes. The GP nods and adds reassuringly that Ingrid should not worry, 'we will get it up before that time, no problem' (Field note extract).

When Merrild and Ingrid leave the GP, Ingrid continues to talk about the herbs and how the health sciences do not acknowledge its effect, and how she tried to get the GP to explain why the herb has had the effect on her hemoglobin level that her blood count just showed. Whether or not the herbal mixture had any effect is not the issue. Rather, is the way in which Ingrid's knowledge and experience with the herbs are disregarded and considered inferior to the biomedical perspective, which insists on a prescription drug. Initially, Ingrid resists and insists on the effects of her herbal intake, but eventually she responds "appropriately" to the situation and takes on the role of the compliant patient, who lets the GP *raise her low hemoglobin*. Nevertheless, after the consultation, she expresses her frustrations, and in the months after she continues to take her herbs alongside her prescribed drugs as a way of retaining some form of agency in the battle for her weakening health.

The case of Ingrid demonstrates how the acting subject at the same time resists and supports the existing system of power (Abu-Lughod 1990:47) through contesting, but at the

same time subsuming to the dominant health promotion discourse. Her practices clearly emerge from the structural context of the dominance of bio-power, as it is played out in the clinical setting, but at the same time demonstrate the potential resistance of health practices. Although Ingrid complies with her doctors' advice of taking the prescription drug, she maintains the significance of her own remedy and insists on her right to agency by continuing with the use, pursuing her project of dealing with her illness within the relations of asymmetry and force (Ortner 2006). Drinking a herbal mixture may seem a minor and insignificant act of agency, but it illustrates how people practice their own form of health promotion and modify the dominance of bio-power which insists on following medical regimes and being compliant. Ingrid's health and illness practices demonstrate the diversities and differences in modes of appropriation of health promotion and illness prevention, and how these different appropriations are shaped by the values and convictions – the subjectivities – of different social lives. The various forms of resistance are shaped by different social contexts and follow different logics as will be illustrated in the following case.

Dietary changes

Esther is a sociologist by training and has a long and wide-ranging career behind her. She is a square-built woman in her sixties, who lives in a large house together with her retired husband. As their financial situation allowed it, she chose to terminate her working life a few years ago and retire with her husband. Esther takes an interest in organic food, she is outspoken and very engaged in her young grandchild and involves herself actively in the local community where she is a well-known figure. Like the other HMC informants, she exercises, eats healthy, keeps fit and tries to avoid getting overweight. Maintaining a slim figure in the HMC is partly described as a health concern but just as importantly as a matter of appearance. Expression

such as “not letting oneself go” or “letting it get too far” are often used and demonstrate how the HMC informants are “involved in observing, imposing, and enforcing the regulations of public health, particularly through the techniques of self-surveillance and bodily control encouraged by the imperatives of health promotion” (Lupton 1995:76). The enactment of the health promotion messages, such as exercising and eating healthy, are unquestionable and a way of life for Esther and the other HMC informants. None of the HMC informants were overweight, and none of them had any lifestyle or psychiatric diseases. The importance of being able to lead an active and healthy life was exemplified in various instances, where the HMC informants made claims on their bodies and functionalities. As one of the other key informants said,

”we reach a certain age and if we exercise, well, we are not supposed to have pains in the knee, then we can get a new knee, right? And a new hip and so on..... We don’t just put up with it as they did in the old days”. (Interview quote)

Only one of the HMC informants smoked, which largely reflects the socioeconomic distribution of smoking among this group in Denmark. He explains,

*“I smoke between zero and five cigarettes a day, and I will control it **myself**, and decide myself whether I will smoke or not. But I don’t smoke in front of my wife as she finds it stupid that I smoke, and she can’t help commenting on it”* (Interview quote).

So he smokes on the stairways in the basement, and he does not smoke when he is with people who do not smoke so that he does not have to justify his seemingly inappropriate practice; a practice that falls outside the contemporary notion of the civilized body, which is subject to conscious and rational control (Lupton 1995:70). However, at home in his own house, he

allows himself the pleasure of smoking a cigarette because, as he says, “*health also has something to do with happiness*”. Like the LWC smokers, he is perfectly aware of the health hazards of smoking. But he has been living with myxoedema for many years, and he relies on studies which have shown that smoking has a beneficial effect on his chronic illness. So he has found a balance and concludes that smoking is good for one thing and bad for another.

Returning to Esther, who during some months has been concerned with irregularities in her cholesterol level and some unexplained elevated liver counts. Earlier in the morning on the day of the visit referred here, she has been called in for an ultrasound of her liver. She is usually fairly calm and formal, but today she is rather shaken up by the urgency of the situation, which Merrild discusses with her in detail,

She has always been concerned about that liver, but does not know why – ever since she had the scan that she paid for herself at the private clinic. They told her that it was a fat liver, nothing else. Now she worries that it is the cholesterol medicine that she has been taking, which she has suspected all along. But she has all kinds of things going around in her head. Could it be the medicine or all those dietary changes that she has been making?..... She has been checking a lot on the internet, she says, and continues to reason and search for possible explanations and scenarios that could explain her high liver counts..... And if it turns out to be the medicine, which she has never liked anyway..... But you are not taking the medicine, CHM ask her. No, and I haven't done so for a long time, she answers. Does the doctor know, CHM continues. No, she has not told him Because if I can achieve the results through changing my diet myself, I would much rather do that, she says firmly. (Field note extract)

Esther, like Jane and the other HMC informants, does all “the right things”: she eats healthy, she exercises, and she acts on bodily sensations to the extent that she has her liver examined at her own cost. She deals with and puts a lot of effort into her health, and nobody in the family understands that she is suddenly at risk of being seriously ill. Nevertheless, she does not take the prescribed drugs which she firmly believes does her more harm than good. She reasons according to the health promotion discourse. Yet, at the same time, she acts on subjective sensations and trusts her own judgment above that of the GP. By *achieving the results through changing her diet*, she draws on advice from specialized dieticians, while also enacting her health subjectivity and selectively choosing from health promotion and biomedically informed knowledge.

Once again, it is exemplified how the health promotion discourses frame health practices, but standardization is resisted and the health subjectivities are played out in the pursuit of the project; hereof maintaining good health. The contrasting concerns of dealing with illness are brought home by the following statement from Brian, who often unloaded his distress of encounters with the health care system when socializing with his friends.

It is not allowed to be fat anymore, Brian almost shouts, but it is allowed, he continues, they cannot decide that. It was the same when he went to see his own GP, he explains; she said it as well. She said that he had to lose weight. If he did not, there would be all the secondary complications to his illness. But he told her that he could not lose weight because eating was the only joy in his life. And then she just said, “then it is your own fault”. Everybody has such a bleak perspective on things, he moans, also the GPs, they are so pessimistic. If I die tomorrow or if I turn 55, either way I won’t feel the difference (Field note extract)

Brian's statements may be seen as expressions of anger, frustration, and direct opposition towards the health promotion discourse. But they also exemplify how certain values and lifestyles are overridden and devalued and bring forth issues of power, domination, right or wrong health status, moral responsibility, and self-determination. The structural impediments of Brian's life, in the form of economic constraints, exclusion from the workforce and marginalization due to his psychiatric illnesses, positions him at the margin of society, and his health and illness practices further underline this exclusion. He is dealing with multiple illnesses in his everyday life, and resists the moral obligations of staying health, while at the same time, expresses an alternative health subjectivity which diverges from the one prescribed by the health promotion and illness prevention discourse. But in doing so he feels disarmed by the hegemonic power of new public health, where each individual is responsible for his own health, subject to moral judgments, and where compliance with medical advice is positively valued (Lupton 1995:71).

Conclusion

We have explored social inequality in health through the lens of resistance and demonstrated how, at the same time as resisting the health promotion and illness prevention discourse, the informants from both social classes also embrace, accept, and actively employ its messages and principles in both complex and ambiguous ways.

Although all informants were interested in improving their well-being, a central concern in the HMC, was maintaining their good health, as illustrated by the cases of the key informants Ingrid and Jane. In the LWC, exemplified in the case of Brian and Esther, dealing with general hardship and the presence of multiple and chronic illness and social concerns shaped their mode of and approach to health promotion. We argue, that in order to understand the dynamics of social inequality in health, it is vital to recognize how people from different social classes

actively engage with health promotion and illness prevention in their own and distinct ways, rather than passively receive and accept the messages of health and illness education campaigns. Furthermore, the different forms of resistance also underline the significance of the overall sense of well-being as opposed to the presence of multiple illnesses when health promotion is appropriated to the actualities of people's lives. These findings, dealing with illness or maintaining good health correspond with many other studies which have illustrated how the significance and meaning of health, illness, and the body are different in diverse social groups (e.g. Blaxter Patterson and Bethel 1982, Cockerham 2005, Dumas, Robitaille and Jette 2014, Williams 1995). Hence we add to the growing evidence that contest to how the overall structural determinants and political economy influence and constrain how people from lower social classes live their lives, and how life circumstances and life contingencies shape the dispositions and opportunities for engaging in health practices (Dumas, Robitaille and Jette 2014: 140).

Moreover, comparatively contrasting health practices that challenge the imageries drawn up by the health promotion discourse and approaching resistance as a diagnostic of power, as suggested by Abu-Lughod (1990) and Ortner (2006), has brought out the moral imperatives of maintaining good health which requires people to practice certain types of informed health behavior and use the health services "appropriately". We demonstrated how people from different social classes use biomedical language and symbolism when substantiating their health practices, which highlights the omnipresence of the bio-medically founded health promotion discourse. However, in the process of practicing health promotion in everyday life, the messages are appropriated subjectively, and the boundaries of the discourse are challenged accordingly. This supports Ortner's views on how people pursue their own intentions and projects, albeit closely related with ideas of power and structures of dominance (here of the health promotion and illness prevention discourse) and inequality (Ortner 2006:145). The cases

presented above, all exemplify ways in which people from different social classes resist the standardization of health promotion and illness prevention. But what is more, they illuminate structures of domination, differentiation and subordination and reflect how some patterns of resistance are more subjected to exclusion and marginalization than others

Along with other writers on resistance (Abu-Lughod 1990, Keesing 1992, Ortner 2006, Scott 1985, 1990), we point out how the different forms of resistance are closely intertwined with and, in fact, emanate from the power at which they are directed; in this case, the health care system and the health promotion discourse. We argue with Ortner that representations, discourses, and language all serve as elements of the hegemonic processes that sustain systematic inequalities (Ortner 2006:19). The ubiquitous position and authority of health promotion and illness prevention discourse may fail to acknowledge how people from different social classes actively engage in health enhancement and illness prevention in their own and distinct ways, by applying, transforming, and trying to convert the messages to the conditions under which they live. These transformative practices are at risk of being stigmatized and deemed ‘wrong’ which illuminates how the health promotion and illness prevention discourse contributes towards establishing normalities, and in the process creates categories of deviants – of those who do not conform to the standards of ‘normality’ and assume responsibility of maintaining health and preventing illness. If the ways in which the different contexts constraints or enables health and illness practices are not acknowledged as expressions of health subjectivities, the public health awareness and education campaigns may bear the risk of even perpetuating the very inequalities they try to diminish, as the wealth of meanings, experiences, and embedded nature of bodily practices are ignored (Andersen and Risør 2014:4). As argued by Baum and Fisher, the institutionalization of individualism, biomedicine, and behavioral views of health and illness helps “to maintain a form of social silence around

the alternative views of health that challenge the normality of everyday social, economic and cultural inequalities” (2014:218). What is more, it overrides how the lives of disadvantaged populations are structured and conditioned by the wider social and political organization of society, and their marginalization is perpetuated by the social support of the dominant ways of practicing (in this case) health and illness (Bourdieu 1997).

On a practical level, our analysis has pointed out how everyday concerns and subjectivities matter so much that they produce resistance, although with different life goals and intentions. Failing to recognize and acknowledge the health practices that are actively carried out in different social classes, may lead to misinterpretations of these practices as lack of understanding rather than subjective attempts to improve health and deal with illness.

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¹ We have addressed the move towards health consumerism elsewhere (see Merrild et al. 2015)

² An average one-family house (depending on geographical location) costs around 300 000 USD