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7. PLACE

Katherine L. Frohlich, Julie Vallée, Sally Macintyre and Anne Ellaway

Place refers to a socially significant or socially constructed location in geographical space.

While place has arguably received most attention within disciplines such as geography, both geographers and sociologists have explored the relevance of place in our understanding of health variation and inequality. Place constitutes, as well as contains, social relations and physical resources (Cummins et al., 2007). While there is no single definition within medical geography, geographers have tended to define place as being a socio-cultural location, with space being a natural and physical construct relating to geometric location. According to Gesler, 'place is studied with an eye to its meanings for people; space is analyzed in terms of its quantifiable attributes and patterns' or, in other words, place is 'a space filled with people acting out their lives' (quoted in Kearns and Joseph, 1993: 712). In the recent past, there has been a tendency to focus nearly exclusively on place of residence in much of place and health research. We will expand this focus to include more contemporary and relational notions of place, shifting the emphasis to nodes in networks, rather than discrete and autonomous bounded spatial units. Relational theories posit that places are produced and maintained by the activities of 'actors', proximate or distal to a particular place, who operate individually or in concert across a wide range of geographical scales (Conradson, 2005; Cummins et al., 2007). After elucidating the historical background of the idea of place and health, and pointing out the concerns of disciplines such as epidemiology and geography, we highlight the current relevance of the concept of 'place' in medical sociology with reference to some recent research.

An early text on the influence of place on health was *Airs, Waters, Places* in the Hippocratic Corpus from the fifth century BC. The three elements in the title refer to features of climate and topography, believed to influence the prevalence and types of disease found in different places. In Britain, social regularities in death rates were first studied systematically in the 17th century by John Graunt, whose 'Natural and political observations upon the Bills of Mortality' was published in 1662. Graunt was interested not only in the direct effects of the

environment on physical health, but also in its effects on mental health and human behaviour. During the early 19th century, contagionist and anti-contagionist explanations of disease causes opposed one another, while variations of miasma theory still predominated. According to that theory, geographic health disparities were due to topographical factors such as differences in altitude and climate. A pioneer in the sociology and geography of health, the French doctor Louis-René Villermé (1782–1863) adhered to anti-contagionist explanations of disease causation and demonstrated the association between poverty and mortality by studying the variations of mortality rates across the city of Paris. Villermé famously demonstrated that death rates in 12 arrondissements varied by population density and income. The impact of industrialization in the 19th century generated a considerable amount of interest in the social and geographical patterning of disease in the UK, Germany and the USA. In Britain, for example, William Farr examined the social patterns of mortality by comparing the death rates of different localities. He drew up life tables for ‘healthy districts’ which could be compared and served as a basis for inferring that much premature mortality was due to environmental conditions and therefore preventable. Friedrich Engels’ work on the conditions of the working class in England was undertaken in the spirit of scientific discovery, social justice and reform, as was Rudolf Virchow’s work on typhus in Upper Silesia during this same period.

Since this time, the respective influence of people and place on health is often called into question. An increased emphasis on the role of individualism in studying the relationship between people and health emerged after the second half of the 20th century. This followed on the heels of the epidemiological transition (the replacement of infectious diseases by chronic diseases due to improved hygiene, healthcare and disease prevention), and the consecutive focus on chronic diseases and individual lifestyle choices (particularly the ‘big four’ of smoking, drinking, diet and exercise). Emphasis on people also expanded in the political realm: priority groups, such as the poor, migrants, and others, defined as ‘high risk’ subpopulations, also became the target of national health policies around this time. This increased focus on people, however, detracted attention away from a more structural and collective understanding of the conditions that shape health outcomes. Concomitantly, place, particularly in the form of local areas, neighbourhoods and Healthy Cities, gained importance, for example in the Ottawa Charter for Health Promotion (WHO, 1986). In this context, the creation of ‘supportive environments’ (referring to settings where people live, learn, work and play) was identified as one of the five key action areas of health promotion.

This focus on local areas resulted from two rationales: places merit exploration because they either concentrate people affected by health problems (e.g. spatial segregation) or because they are themselves involved in the production of health problems (e.g. neighbourhood effects). These two rationales echo two former competing hypotheses about

the relative importance of 'breeder' and 'drift' communities. The 'drift' hypothesis suggests that ill individuals gravitate towards specific areas while the 'breeder' hypothesis suggests that such areas generate illness in their residents. These two rationales also echo the introduction of multilevel (i.e. mixed effect regression) models into health and place research in the 1990s. This methodological formalism led to a significant amount of empirical research seeking to separate out the effects of neighbourhood contexts from the background characteristics of residents – otherwise known as context vs. composition.

A compositional explanation for area differences in health involves analysing the role of individual characteristics of residents in a particular area (e.g. the collective age, sex or socio-economic status of people living in a neighbourhood). A contextual explanation of area differences in health, on the other hand, involves analysing the role of the characteristics of an area (such as access to amenities and facilities to support a healthy life), over and above those of the individual residents (Bernard et al., 2007; Diez-Roux, 2001; Macintyre and Ellaway, 2003; Riva et al., 2007). Place effects, however, often continued to be treated as a black box of people-place interactions. The frequent use of ecological indices to measure material advantage or disadvantage in residential areas (famously through deprivation indices based on postal or census geography) is a case in point. In research using these ecological indices, it remains unclear if they are used as proxies for neighbourhood social structures shaping health status and behaviours, or as proxies for individual social profiles. The latter case involves the ecological fallacy – the inference of individual-level relationships from associations observed at the aggregate level. A number of influential sociological papers in the 1950s (e.g. Robinson, 1950) warned that the ecological fallacy could lead to entirely incorrect inferences being made because ecological and individual correlations between the same variables can differ markedly, even in different directions.

Competing interests between individual and place explanations of health lead to a false dualism about the respective importance of context and composition (and of breeder and drift hypotheses), thus failing to recognize that they may mutually reinforce each other. In his book *The Truly Disadvantaged*, Wilson (1987) brought attention to the fact that individual poverty matters more strongly in neighbourhoods where the population is overwhelmingly socially disadvantaged. Introducing the notion of 'concentration effects', he suggested that disadvantaged people often deal with a double burden: they must grapple with the multiple problems arising from their own lack of income as well as the social effects of living in a disenfranchised neighbourhood. The idea of concentration effects has developed in more recent health and place research by considering the reciprocal relationship between people and place.

Recent advances in relational theory help us understand this reciprocal relationship by viewing places as dynamic ecosystems. The relational approach to place views places and the resources they provide as shaped by political powers, social networks, regulation by various actors, and local interactions with people (Cummins et al., 2007). A relational conception of place allows us to concentrate on the processes and interactions occurring between people, places and their health over time. Fostering a relational perspective requires a reassessment of existing articulations of location and scale typically used in the study of health and place in the past. Relational geography rejects the structure-agency dichotomy, for instance. Additionally, these theories posit that populations engage in important place-to-place mobility on a daily basis, as well as over the life-course. This implies that individuals often influence, and are influenced by, conditions in multiple spatial locations over multiple time scales: over the years – the ‘life course of place’ (Pearce, 2015) – as well as over 24-hour periods – the ‘daycourse of place’ (Vallée, 2017). Places are contemplated from a non-Euclidean perspective where place boundaries are fluid and distances are relative. Relational theories have thus moved beyond their former focus on neighbourhood effects on health.

Recent empirical examples of relational place considerations involve the exploration of people’s experience of place. The concept of ‘activity spaces’ – understood as the multiple settings where people study, work, or otherwise spend time in the course of their daily activities – has been introduced to gain insight into the role of daily mobility in place exposure and in the production of (social) health inequalities (Shareck et al., 2014). An alternative relational consideration of place involves the exploration of neighbourhood experiences. Empirically, this can involve asking people to draw and discuss their own self-defined neighbourhood, for instance. By allowing people to self-define their neighbourhoods, information can be gathered about past and future spatial behaviours in relation to health; they capture an individual’s effective past access as well as potential future access to neighbourhood resources (Vallée et al., 2020).

The COVID-19 pandemic has brought to the fore the inequitable effects of activity spaces and neighbourhood conditions on exposure to the virus. For more privileged people, easy access to parks, other green spaces, summer homes and areas where one could safely visit and do exercise with minimum exposure to other people has led to lesser exposure to the virus. For those less privileged, the experience of crowded housing and neighbourhoods, the need to use public transport to go to work, and the type of work required during the pandemic has put them at a higher risk of contracting COVID-19, leading to important inequities in both who contracted and died from the disease.

Whereas sociologists conducted many of the early health-related community studies, sociology and sociological theory have been less apparent in the recent literature on the role

of place and health, dominated largely by epidemiologists and medical geographers. Yet relational theory, and other relevant theories of pertinence to sociology, such as phenomenology, post-humanism, and others, could be of great utility in helping us better understand how place shapes the distribution and experience of health and illness. Future work in medical sociology, we would argue, should therefore pay heed to its classic heritage and not leave the concept of 'place' solely to other disciplines.

See also: Environment; Material and Cultural Factors; Psychosocial Factors; Social Class.

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SUGGESTED FURTHER READING

- Kawachi, I. and Berkman, L.F. (eds) (2003) *Neighborhoods and Health*. Oxford: Oxford University Press.

This book brings together a wide range of theoretical, methodological and empirical research not only from the fields of public health and epidemiology, but also from sociology, psychology and social policy. It illustrates the prominence of the ongoing 'context' versus 'composition' debate and is a reference textbook for many scholars involved in neighbourhood-level research.

- Moon, G. and Pearce J. (2020) 'Twenty-five years of *Health & Place*: citation classics, internationalism and interdisciplinarity', *Health & Place*, 61: 102202.

This article discusses some of the key articles and themes from *Health & Place* over the last 25 years of its existence. This interdisciplinary journal offers comparative perspectives on the difference that place makes to the incidence of ill-health, the structuring of health-related behaviour, the provision and use of health services, and the development of health policy.