Wellbeing in Health Geography: Conceptualizations, Contributions, and Questions

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This chapter focuses on wellbeing research in health geography and the ways in which health geographers have made important contributions to understanding the socio-spatial and place-based dimensions of wellbeing. We seek to answer two key questions: What is wellbeing? And why is it important? To answer these questions, we first outline the varied conceptualizations of wellbeing in health geography and some of the challenges associated with its application. In the second section, we highlight some of the major contributions of health geography to understandings of wellbeing. We then conclude with questions for future wellbeing research in health geography.

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The World Health Organization's definition of health as "a state of complete, physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1948, p.100), expanded the concept of health beyond medical matters to encompass a much broader range of human experiences. Wellbeing subsequently became a popular idea with varied applications, coming to be understood as a policy goal, a purchasable commodity, a desirable status, and a valuable analytic lens for scholars interested in diverse aspects of health and health care (Fleuret and Atkinson, 2007; MacKian, 2009).

The emergence of the sub-field health geography in the early 1990s, alongside a broader socio-ecological turn in conceptualizations of health, led geographers to consider holistic ideas of emotional, social, and physical contentment (Kearns and Andrews, 2010). Concurrently, wellbeing emerged as a focus in geographical research. However, the term itself remained loosely defined and understood, both within and beyond disciplinary boundaries. While we know what wellbeing is not – it is "not merely the absence of disease or infirmity" (WHO, 1948, p.100) – what does it consist of? And why is it important?

This chapter seeks to answer both of these questions. In the first section, we outline the varied conceptualizations of wellbeing in health geography and some of the challenges associated with its application. In the second section, we illustrate the relevance and significance of wellbeing in health geography research. We then conclude with questions for future wellbeing research in health geography.

Conceptualizing wellbeing

Components of Wellbeing

Fundamentally, the concept of wellbeing entails a positive focus on various dimensions and experiences that contribute to human potential. The strength of the idea derives from its breadth and holistic nature, encompassing various aspects of quality-of-life, both material and subjective. However, by including diverse experiences and dimensions, the term is also difficult to nail down. A variety of definitions exists within health geography, as highlighted in Table 1:

"a good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity. The state of feeling healthy and happy" (MacKian, 2009, p.235)
"an experienced state of being, in terms of healthiness and happiness" (Kearns & Andrews, 2010, p.309)
"a longer-term state-of-mind (and body, if not spirit) … often regarded as synonymous with quality of life" (Kearns & Andrews, 2010, p.311)
"a state of positive mental and physical health and welfare, attained or obtained in some way by fulfilling personal needs" (Andrews, Chen & Myers, 2014, p.214)

Table 1: Select definitions of wellbeing in health geography

These definitions focus on the combination of physical health and positive subjective or emotional experience (e.g., happiness, state-of-mind) at the individual level. Several also incorporate material aspects (e.g., prosperity, needs, welfare), which imply a connection to social and economic conditions. These conditions arise partly from the experiences of individuals and households as they engage in economic activity and perform work in particular places, and partly from larger socio-economic systems that shape the distribution of opportunities and affluence. These systems play critical roles in the complex mechanisms that give rise to the socio-economic

determinants of health and the uneven distribution of wellbeing across the population. To the extent that increasing affluence allows for greater satisfaction of needs, it contributes to individual and collective wellbeing (Fleuret and Atkinson, 2007). However, in some cases it can have detrimental impacts on wellbeing, as when economic growth is generated through environmental degradation (MacKian, 2009). Additionally, material needs can vary between places, and as such, the significance of wealth and income is contextual (Fleuret and Atkinson, 2007).

In important respects, quality-of-life is produced and experienced collectively – in terms of both material and inter-personal needs. Adequate income, meaningful employment, social support and community integration have strong positive effects on health status, as powerfully illustrated by the Whitehall II study of over 10,000 civil servants working in London, England (Ferrie, 2004). Thus, the concept of wellbeing necessarily encompasses both personal and collective components; being well is experienced at multiple scales, from the individual, to institutions (e.g. schools and employers) and neighborhoods, and the national state (MacKian, 2009, Kearns and Andrews, 2010).

Dichotomies in wellbeing

Fleuret and Atkinson (2007) provide three theories for understanding wellbeing. The *theory of needs* stems from the work of Maslow and the connection between material affluence and wellbeing. Here wellbeing is an outcome of consumption, objectively and universally delineated by needs. However, needs are related to context and circumstances, leading to the second approach: *the relative standards theory*. This approach focuses on the contextual components of

wellbeing, positing that "wellbeing is therefore linked to individual happiness and conditioned by the individual's perception of the context in which he or she is living" (p.109). However, this approach's focus on the subjective experience neglects consideration of the physical aspects of wellbeing. A third understanding of wellbeing is the *theory of capability*, which seeks to integrate the material aspects of the theory of needs with the subjective aspects of relative standards through the idea of capabilities. Capabilities are "a range of attainable and valuable functionings including sets of skills and power" (p.109). Here we see a connection between wellbeing and understandings of health as a resource for everyday life, and a positive set of capacities that enable the fulfilment of human potential (Ottawa Charter for Health Promotion, 1986). However, approaching wellbeing in this way can be difficult due to the problem of operationalizing capabilities (Fleuret and Atkinson, 2007).

These three theories illustrate a set of dichotomies that constitute wellbeing – health and happiness, material aspects and dimensions of human experience, objective and subjective, universal and contextual, and individual and collective. There is a particularly fundamental divide between *subjective wellbeing*, associated with dimensions of human experiences and context at the individual level, and *general or objective wellbeing*, associated with universality and material aspects at the collective level (MacKian, 2009). However, such tensions do not necessarily detract the utility of wellbeing as a concept. Rather, they illustrate the breadth of the term and "the various linkages to a range of domains of human experience" (Kearns and Collins, 2010, p.27). Additionally, while it is often simpler – for example, in research – to focus on a single aspect of wellbeing, operationalizing the concept in this way means that its breadth and holistic nature is lost from view.

Health and wellbeing

Health geography's focus on wellbeing reflects a sub-disciplinary move away from a biomedical focus on individual, diseased bodies and spaces of medical intervention. At a more epistemological level, it also indicates a rejection of the Cartesian dualism, which separates body and mind. These shifts, combined with a concern for socio-spatial context, mean that wellbeing is by no means the sole (or even primary) domain of biomedicine (MacKian, 2009; Kearns and Andrews, 2010). From one perspective, a strength of the term wellbeing as a focus for inquiry, and a goal of interventions, is that it is difficult to medicalize due to its breadth and diversity. From another perspective, wellbeing can be understood to imply "a progression away from being ill or impaired [and thus] the natural positive outcome that medical intervention seeks to achieve" (Kearns and Collins, 2010, p.19). Evading medical capture of the term is, thus, far from assured. This is particularly evident with regard to common ways in which wellbeing is measured, which often focus on life expectancy, mortality rates, and incidence of disease, rather than more positive subjective dimensions, such as contentment, life satisfaction or capability (Fleuret and Atkinson, 2007; Kearns and Collins, 2010).

One tool for addressing this disconnect is the *WHO-5 index*, which was developed in 1998 to enable measurement of subjective wellbeing. It consists of a questionnaire with five positively worded statements, including "In the last two weeks, my daily life has been filled with things that interest me" and "I have felt active and vigorous", which respondents are asked to rank on a scale of 0-5. This index helps to operationalize positive notions of wellbeing, at the same time as

it reduces inherently subjective experiences and states to numbers. Moreover, it does not include direct questions about social wellbeing. As wellbeing is conceptualized at multiple scales, it should also be measured at multiple scales, from individual markers of health to indicators of national wellbeing. Measures of the latter now extend beyond primarily economic indicators such as gross domestic product to include more social and quality-of-life aspects, as in the *Human Development Index* and the *Happy Planet Index* (Fleuret and Atkinson, 2007; MacKian, 2009). Thus, operationalizing and measuring wellbeing continues to be an area for growth.

With respect to operationalization of the term, the example of the *New Public Health* movement is instructive. It focuses on enhancing population health by empowering and expecting individuals to take responsibility for their own wellbeing (Kearns and Collins, 2010). Through emotionally charged and persuasive messages about nutrition, exercise, sun exposure, and smoking, for example, wellbeing is presented as "both a status and feeling, [which] can be achieved through individuals being responsible for and assisting themselves mentally and physically" (Andrews, Chen and Myers, 2014, p.212). It also links to neoliberalism via the responsibilization of the individual, and the associated rise of a wellbeing industry to enable healthy choices – at least for those who have the resources to afford them (MacKian, 2009). In *New Public Health*, wellbeing is an inherently political project, in which hopes and fears, and visions of dystopia and utopia, are operationalized to propel certain actions and pre-empt possible health harms (Evans, 2010).

So, what can be said about wellbeing? At its core, the term points to a sense of completeness and balance in varied aspects of life, including the emotional, social, material, and physical

(MacKian, 2009). It is also the positive sense of having potential and ability within each of these dimensions of human experience (Kearns and Collins, 2010). It is possible to have a sense of wellbeing while living with a chronic illness or disability (Coleman and Kearns, 2015), and as such, physical health is not the dominant component of wellbeing (Kearns and Andrews, 2010). Wellbeing also implies an embodied experience of *being-well*, which is anchored in place and context. Thus, it invites geographic research into the places and spaces of wellbeing (Kearns and Andrews, 2010). In the next section, we explore the significance and influence of wellbeing in health geography research will be explored.

Significance and influence of wellbeing in health geography research

Within health geography, wellbeing is a significant and influential concept, centered on the place-based resources and experiences that support health and quality-of-life. In this section, we document some of the major contributions of health geography to understandings of wellbeing, as developed in three areas of research: spaces of wellbeing; therapeutic landscapes; and emotion, place, and wellbeing. Each of these themes is explored in turn.

Spaces of wellbeing

The relationship between place and mental and physical health is central to inquiry in health geography (Kearns and Andrews, 2010). Fleuret and Atkinson (2007) identify three key ways in which this focus enables health geographers to contribute to the study of wellbeing: "a socio-economic focus on spatial and social injustice"; "an environmental approach… and the therapeutic virtues of the landscape"; and "a social welfare approach in which the consequences of vulnerability in terms of health and quality of life are studied" (p.107). Reflecting a

broadening of interest beyond institutional sites of medical intervention, health geographers have studied the rise of landscapes of wellbeing in the context of community and home-based care (Kearns and Collins, 2010). There is increasing recognition of the informal care work and *caringscapes* that contribute to wellbeing (Kearns and Andrews, 2010, p.320). These "spaces of care are therapeutic environments produced by, for, and through the interest of one person in the wellbeing of another" (DeVerteuil and Evans, 2010, p.291). They include sites as varied as drop-in centers and homeless shelters, as well as also traditional hospital-based settings, provided they offer "refuge, support, and essential resources" (2010, p.291).

Fleuret and Atkinson (2007) conceptualize spaces of wellbeing as informed by four other spaces: spaces of capability, integrative spaces, spaces of security, and therapeutic spaces. Spaces of capability focuses on experiences of wellbeing and self-fulfillment based, and acknowledge how these may be hindered by factors such as (dis)ability, ageing and stigmatization. Integrative spaces include those domains and experiences with positive links to wellbeing and health, such as social contacts, while also identifying the processes that produce spatial and social inequalities. Spaces of security include social, spatial, and individual supports that contributes to wellbeing. Lastly, therapeutic spaces, which have been a major focus of wellbeing research, are those environments that positively contribute to wellbeing. This four-part conceptualization reflects the multidimensional nature of wellbeing itself, as well as the way in which it is positioned outside of biomedical knowledge and medical spaces.

Therapeutic landscapes

Therapeutic landscapes positively impact wellbeing in a myriad of ways, including via stress relief, social connections, security and belonging – an overall sense of restoration and renewal (Duff, 2011). Here, landscapes are understood as "the complex layerings of history, social structure, symbolism, nature, and built environment that converge at particular sites" (Kearns and Collins, 2010, p.19). Some landscapes – most often those with considerable natural value – are widely understood as enhancing human wellbeing. For example, bluescapes – which include river, beach or island environments - "are commonly interpreted as possessing restorative benefits since they offer opportunities for stillness, reflection and respite" (Coleman and Kearns, 2015, p.207). However, as Duff (2011) warns, this idea that there is something innately health-promoting about these natural landscapes contributes to the exclusion of built and urban environments that can contribute to wellbeing.

Additionally, the idea that it is the essence of places that is restorative neglects the activity that occurs in those places. Coleman and Kearns (2015) write that "therapeutic experiences cannot be presumed but rather are the product of peoples' diverse and complex relations with place" (p.206). They support this argument in their study of bluescapes and older adults residing on a New Zealand island, highlighting the ways in which wellbeing is produced via emotional connections to the water and the island. These emotional connections were also expressed in the complex relations around staying or leaving the island as participants' health declined, with many to choosing to stay because of their sense of connection. Critically, it is "the experience of place rather than the place itself that is generative of wellbeing" (Coleman and Kearns, 2015, p.216).

Emotion, affect, and wellbeing

Health geographers' engagements with wellbeing are increasingly concerned for the emotions and affects generated through human encounters with place. In broad terms, emotions refer to the feelings experienced and expressed by individuals, while affects refer to shared, non-cognitive capacities. Both specific emotions and the more diffuse and collective energies and intensities that constitute affects are routinely mobilized in initiatives to promote forms of wellbeing (Evans, 2010). However, Andrews, Chen and Myers (2014) contend that wellbeing should be conceptualized as an affective environment, rather than as the result of a given intervention or the product of experience. From this perspective, wellbeing is "the environmental action, then feeling of that action, prior to meaning" (p.219). Under this approach, wellbeing is temporally short, whereas in previous approaches it was understood as having some endurance or state of being (Kearns and Andrews, 2010).

Affect is dynamic and diverse, changing between people and over time (Duff, 2011). This variability is highlighted in Coleman and Kearns' (2015) analysis of how bluescapes impact aging and wellbeing. In this study of older adults living on a small island in New Zealand, participants expressed a deep sense of connection with both the water and the island, but these changed over time and with their experiences. For example, one participant commented how after her husband passed away, the island felt isolating but the water helped with her grief.

Emotions and wellbeing can also be connected through music and soundscapes. In some instances, this connection is explicit, through lyrical focus on the topic or through support for events like *LiveAid*. More generally, soundscapes and wellbeing interact primarily through emotion. For example, the internalization of lyrics and creation of soundscapes "transports [individuals] from their current situation, to help them forget, feel better, and hope" (Andrews, Kearns, Kingsbury and Carr, 2010, p.185). Listening to music is often a social event, particularly in the shared experience of attending concerts, which can contribute to feelings of community integration and support and thus emotional wellbeing. The intersection of emotional and health geography offers a particularly rich milieu for investigating the meanings and experiences of wellbeing in diverse places.

Directions for future research

In this section, we identify three areas for future health geography research into wellbeing. First, geographers have already undertaking important work linking the places in which we live and work with the social gradient of health (Kearns and Collins, 2010). Implicit in this research is a recognition that wellbeing – in terms of overall contentment and quality-of-life beyond satisfaction of basic material needs – is something the relatively privileged can afford to work on. Greater income and wealth often bring with them the time and resources to dedicate to nutrition, exercise, supplements, work-life balance, and more (MacKian, 2009). At the same time, neoliberal discourses can place the blame for poor health on individual choices, downplaying or denying the influence of socio-economic factors (MacKian, 2009). In studying wellbeing, researchers must continue to highlight the inequalities and inequities that impact wellbeing at both the individual and population levels (Kearns and Collins, 2010; Kearns and

Andrews, 2010). This is important, in part, to counter-act the individual as the locus of *New Public Health* imperatives, and to inform policy goals of increasing wellbeing across all sectors of society.

Conceptually, wellbeing is linked to both happiness and health (MacKian, 2009). However, there are times when these two ideas conflict, and as such it is important that there is a "realization that not all that contributes to personal wellbeing is necessarily good for one's health in a medical sense… for example, overtraining [or] taking performance-enhancing drugs" (Kearns and Andrews, 2010, p.315). Moreover, hedonistic activities such as drug use, smoking, and poor eating can create at least short-term feelings of contentment and satisfaction, often at the expense of longer-term physical and mental health. This creates tension in the idea of wellbeing. Do these activities produce (genuine) wellbeing? What separates pleasure from wellbeing? Moreover, some things that contribute to health, such as physical activity, can in certain instances contribute to negative emotional states. So too can *New Public Health* campaigns, which are often focused on fear (Evans, 2010) and the private wellbeing industry that promotes wellbeing as a consumption-based status (MacKian, 2009). Geographical analyses of wellbeing need to grapple with these conflicts and tensions, and in so doing, develop further accounts of how health benefits and health risks can be co-present in landscapes and place-based experiences.

Lastly, the term wellbeing is nuanced, complex, and difficult to translate and study in different languages (Fleuret and Atkinson, 2007). While the holistic, integrated concept of wellbeing is relatively new (or re-discovered) in the Western tradition, it has long existed in other traditions, such as among the Maori in New Zealand and Aboriginal peoples of Canada (Kearns and

Collins, 2010; Kearns and Andrews, 2010). However, under neoliberalism, wellbeing is increasingly linked to individual responsibility and choices (MacKian, 2009). Given these diverse interpretations and histories, wellbeing appears as "a relative notion that is socially and culturally constructed and as a result takes on different meanings depending on the context, [which] amounts to stating that the WHO definition of health cannot be universal as it subject to the effects of place" (Fleuret and Atkinson, 2007, p.111). How can wellbeing research better account for diverse contexts that influence how the idea itself is understood? How can cross-cultural analyses of wellbeing be undertaken? Is wellbeing necessarily a universal goal, as the WHO definition of health appears to suggest?

Conclusion

In this chapter, we have reflected on the concept of wellbeing and its rising prominence in heath geography. Wellbeing is a more complete and broad concept than health, combining varied indicators of quality-of-life and aspects of human experience, and connecting multiple disciplines and domains of life. However, issues of definition and measurement remain challenging. Here we see an enduring legacy of the Cartesian dualism: the "divorce in western rational scientific thinking [between body and mind] … that has resulted in subsequent confusion about what wellbeing is and how to comprehend, measure, or enhance it" (MacKian, 2009, p.235). Recognition of the impacts of place on physical, emotional, and social wellbeing have given health geographers a prominent position in the study of wellbeing. Research around therapeutic landscapes and the partial relocation of health care from the hospital to the community and the home invite continued geographic research. While the scholarship around wellbeing has increased with widespread adoption of the socio-ecological model of health, there

are still areas for additional research, particularly around inequalities, contradictions, and context.

References

Andrews, G.J, Chen, S. and Myers, S. (2014). The 'taking place' of health and wellbeing: Towards non-representational theory. *Social Science & Medicine, 108*, pp.210-222.

Andrews, G.J, Kearns, R.A, Kingsbury, P. and Carr, E.R. (2011). Cool aid? Health, wellbeing, and place in the work of Bono and U2. *Health & Place, 17*, pp.185-194.

Coleman, T. and Kearns, R. (2015). The role of bluescapes in experiencing place, aging, and wellbeing: Insights from Waiheke Island, New Zealand. *Health & Place, 35*, pp.206-217.

Evans, B. (2010). Anticipating fatness: childhood, affect and the pre-emptive 'war on obesity'. *Transactions of the Institute of British Geographers*, *35*(1), pp.21-38.

Deverteuil, G. and Evans, J. (2009) Landscapes of despair. In T. Brown, S. McLafferty and G. Moon (eds.), *A Companion to Health and Medical Geography* (pp.278-300). Wiley-Blackwell, Oxford, UK doi: 10.1002/9781444314762.ch16

Duff, C. (2011). Networks, resources, and agencies: On the character and production of enabling place. *Health & Place, 17*, pp.149-156.

Ferrie, J.E. (Ed) (2004): *Work, Stress and Health: Findings from the Whitehall II Study*. University College, London.

Fleuret, S. and Atkinson, S. (2007). Wellbeing, health and geography: A critical review and research agenda. *New Zealand Geographer*, *63*(2), pp.106-118.

Kearns, R.A and Andrews, G.J. (2010). Geographies of wellbeing. In *SAGE Handbook of Social Geographies*. Los Angeles: SAGE Publishing.

Kearns, R. and Collins, D. (2009) Health geography. In T. Brown, S. McLafferty and G. Moon (eds.), *A Companion to Health and Medical Geography* (pp.13-32). Wiley-Blackwell, Oxford, UK. doi: 10.1002/9781444314762.ch2

MacKian, S.C. (2009). Wellbeing. In R. Kitchin and N. Thrift (eds.), *International Encyclopedia of Human Geography* (pp. 235-240). Oxford, U.K.: Elsevier, http://dx.doi.org/10.1016/B978-008044910-4.00353-9.

Ottawa Charter for Health Promotion (1986). WHO, Geneva.

World Health Organization (1948). *Constitution of the WHO*. WHO, Geneva.

WHO-Five Well-being Index (WHO-5). (n.d.). Retrieved on February 27, 2017 from https://www.psykiatri-regionh.dk/who-5/Pages/default.aspx.