This glossary aims to provide readers with some key conceptual tools with which to address the issue of place and health; it is hoped that it will provoke thought and debate on the range of ways that places are connected to health.

**HEALTH AND PLACE(S)**

In this section we briefly review some of the conventional ways in which place has been shown to be related to health and some of the methodological dilemmas in this area. Research from geography, epidemiology, and public health shows that where people live significantly affects their health outcomes. This can include such dimensions as global differences in healthy life expectancy, comparisons of disease rates across regions of the world, reports of within country variations in health outcomes, and variations in life chances and health outcomes within specific localities.

Spatial considerations have traditionally covered the spread of infectious diseases and proximity to potentially health damaging sites but in recent years have increasingly focused upon chronic diseases. Quantitative geographical analysis of health has, however, long been criticised for methodological uncertainties suggested by issues of ecological fallacy, scale, the modifiable areal unit problem, and spatial autocorrelation. The ecological fallacy refers to the inference of group or area characteristics as individual (for example, assuming that in an area of high levels of illness containing many teenage mothers, that teenage mothers in that area will necessarily have high levels of illness). Issues of scale relate to the size of the units of analysis (whether local, regional, national, etc); while the modifiable areal unit problem refers to the choice of such units and how this reflects the relations observed. Spatial autocorrelation simply refers to that fact that many phenomena are spatially dependent—unemployed people tend to be located near other unemployed people. These issues can thus be summarised as follows: making assumptions about people given their locality, not being concerned about the size of places in studies, or how places are constructed, or how they are interrelated.

More recently methodological debate has been provoked by a tranche of research that has sought to separate out “area effects” from those of aggregate population characteristics, often using the statistical technique of multi-level modelling. Characteristics of places are typically distilled in this type of analysis to a few limited variables; “area effects” are sometimes not found and when found, tend to be small. This analysis of “area effects” frequently fails to conceptualise what type of place is meant by “area”—home, street, neighbourhood, workspace, society or indeed what is meant by “effects”—what are the causal pathways by which place effects health? Instead place is frequently considered a black box (of variable sizes and shapes) in which unidentified “non-individual” processes take place. However, the connection of health and place can perhaps be enhanced by applying a broader and more nuanced conceptual toolkit.

**PLACES AND SPACES**

It is crucial to grasp the difference between place and space. A “space” describes where a location is. Place describes and theorising the meaning of place. Just as places are argued to create the nature of people and their health (living in a highly intense analysis at the micro scale, intricately describing and theorising the meaning of place. Just as places are argued to create the nature of people and their health (living in a highly
polluted environment can severely affect the health of the people living there) so too places are the creations of people (and occasionally conceptions of health and healing are a fundamental part of this formative process, as has been the case with Lourdes in France). This inseparability of people and places often leads to confusion over the direction of causation and claims of reverse causation when the two are artificially separated.

**PLACES AND CLASSES**

One of the ways in which we characterise places is by the type of people who live there—almost as if we view places as containers for categories of people. To consider social inequalities in health we look at places in terms of the proportion of their population in social classes. 

Reduction in time when there was enough capital available, and the dependent upon the place in which they live in. For example, places make people''. The proportion of people in each class is context, is somewhat artificial. People make places, and places often lead to confusion over the direction of causation and claims of reverse causation when the two are artificially separated.

PLACES AND CAPITALS

Social capital has become a favoured explanation for area differences in health that may be termed contextual effects or, put more crudely, the residuals left after the regression analysis has removed supposed compositional effects. Places where fewer people are ill than would be expected within these analyses are deemed to have high levels of social capital identified by researchers as being some kind of intangible community force. Critiques of the labelling of models’ residuals as social capital are beginning to emerge, however. One key strand of criticism suggests that it is difficult to meaningfully divide the social capital of places from their material capital. It is within places that the residual of material capital is laid down. The developed world is developed because under its streets lie the sewers built from the capital raised during earlier times (often from what is now the “less developed” world). Its homes, public buildings, and roads are the embodiment of past capital accumulation and the bodies of its peoples and communities reflect the collective benefits of material wealth accrued over time variously in each place (place histories). A methodological critique of work in this area is that pre-existing conceptions of health and healing are a kind of intangible community force. Critiques of the labelling of areas as “social” or “physical” are legion and have been comprehensively addressed elsewhere. However, these studies prioritise the study of time and places and do not contain enough detail to be able to consider the role of place. However, just as times (events, eras,
cohort) differ so too places are distinct and have distinct histories. Too often our limitations (of data resources and mental concentration) mean that place and history are dislocated; few studies consider the life course of places and how place histories influence life courses. The working definition of place in research on health could be widened to include peoples’ places in time as well as space to counteract the reductionism of the biomedical model.

PLACES AND MIGRATIONS

The study of population movements between places over time is a further conceptual dimension that the consideration of place can contribute to the understanding of health. Analysis of the impact on health of migration has traditionally focused upon modelling the role of population movements in the spread of infectious diseases. More recently longitudinal analysis of “selective” migration has contributed to the understanding of inequalities in mortality between places.

The consideration of population movements between places also has an important part to play in understanding the significance of genetics to health. The influence of genes upon health has been one of the greatest points of interest in health research in recent decades but this work has generally had little association with geography, despite the fact that differences in population groups’ genetics are largely the product of geography. The places in which our ancestors lived shape the characteristics of our genetic inheritance. Our health is therefore affected not only by the places we have lived during our life course and where our parents lived but where our ancestors lived thousands of years ago.

While ancient geographical migrations largely explain the genetic differences found today between population groups, very recent geographical migration permits consideration of genetically similar populations living in different places and so can be used to critique genetic explanations of “racial” differences in health between populations. For example, there have been a number of studies finding differences in blood pressure in “black” and “white” populations in the USA and it has been suggested that hypertension in “black” populations are genetic in cause. However, a review of studies comparing diurnal blood pressure in “black” and “white” populations that included analysis of places in USA and UK found the relation between “race” and blood pressure varied between countries.

CONCLUSION

To move current debates in public health forward it may be useful to view places as more than the sum of the current human populations living and dying within them. Places form people as much as places are formed from peoples. Places have and are histories; they have their own life histories made up of (and strongly influencing) the millions of points at which the life histories of individuals and families pass through each place. Places exist only in relation to one another. Their influence on health and how they influence turn are influenced by health depends on those links. Capital is accumulated in places. This can be seen most clearly in the physical fabric of places and the physical fabric is the most obvious and immediate direct determinate of public health. From the quality of sewers and fresh water courses, to the decency of housing to help people build stable homes, to the links which are both physically and socially built to other places, and to the grand buildings constructed to celebrate collective wealth—ranging from cathedrals to palaces to hospitals—places are much more than the sum of their parts. They are more than useful collecting units to attempt to measure something you would rather measure at the (so called) individual level. No person is an island because it is through places that their lives are lived and places are peoples, histories, classes, capital, and … health.

This glossary has presented arguments against the impulse within health research to ignore or abstract place and for considering place not as “context” but within context. In contemporary public health and epidemiology the study or inclusion of place is often seen as an academic back-water. It is true that the first Choropleth maps of disease were drawn by inmates of a lunatic asylum. It is true that you can eliminate the vast majority of apparent spatial variations in health by defining more and more characteristics in a model, such as social class, occupation, education, ethnicity, etc, as being purely “individual” and unrelated to place. But it is also true you are largely healthy because of where and when you were born. If you suffer from poor health that is mitigated by your geography and the health services you receive because of it. And, all this is true because of what happened in these places before you passed through them. Because place is in everything—in health, through space, through time, in genes, in class and in how capital is expressed—its omnipresence makes it all too often easy to ignore. There was, of course, a time when the importance of place to health was more obvious:

“In the dry hills the dead don’t smell bad; don’t really smell at all; or sometimes they smell of the thyme and savory in which they are lying, always in very noble postures because they have died facing a grand landscape. Sight of the free horizon, generally periwinkle-blue, gives the muscles a fluidity that makes them unclothen their death. He had observed that in the pine groves, where the scent of the resin joins with the sun to create an atmosphere like an oven, the corpses he encountered (one of them was a game keeper’s) had above all the mal du siecle: a certain nonchalance of style and melancholy in their attitudes, a look of ennui, a sort of well-bred contempt. The woods above Palette, when you approach the rocky spurs of Sainte-Victoire, look out over a billowing of hills, a network of little plains, valleys, copses, vistas, and aqueducts as Roman as could be. You are forced to think of the geese of the Capital, of the Cimbri wrapped in the Nordic mists like processionary caterpillars in their cotton nests. A man dying, especially of cholera and shaken by electric discharges of pain, no longer sees the present, he sees the past and the future through a magnifying glass for several long minutes.”

(An outbreak of cholera in 1830s Provence, as described by Jean Giono.)

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REFERENCES


