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Title: Men's understandings of social marketing and health: Neo-liberalism and health governance

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Abstract

Social marketing for health has become a core component of UK government strategies to improving wellbeing and tackle inequalities amongst diverse populations, including men. Social marketing strategies adopt the methods of commercial marketing to promote social good through encouraging behavioural change in individuals. These methods have been employed with men in the UK as part of a wider movement to improve male health. Drawing on original empirical data collected with 50 unemployed men in the UK, this paper and considers men's responses to social marketing strategies and their own understandings of health, its determinants and personal responsibility. Data presented illuminates men's critical stance towards social marketing for health and its imperatives for behavioural change in the face of wider societal determinants of wellbeing which shape both their health behaviours and experiences. Critical discussions of the use of such strategies as part of neo-liberal models of health governance are offered.

Introduction

> Our public health problems are not, strictly speaking, public health questions at all. They are questions of individual lifestyle – obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease' (Tony Blair, 2006).

> Social marketing is: the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good (French and Blair Stevens, 2005)

> Your asking the wrong people who are on benefits aren't you really? You can't afford choice (Research participant).

In the above quote, UK Prime Minister (1997-2007) Tony Blair neatly summarises what have become, in the UK and beyond, prevailing neo-liberal ideologies which position responsibility for health and its management with the individual. These ideologies have infiltrated recent public health work, promoting individual responsibility for the management of health and wellbeing and focusing upon what has been described as the 'politics of behaviour' (Furedi, 2006). Where once, the aim of public health was to improve environments, strengthen communities or tackle inequalities (Ashton and Seymour, 1988), newer strategies emphasise the role of the individual in determining their own health (Rose, 2001), typically focusing upon the promotion of behavioural change. Perhaps nowhere else are these imperatives so apparent than in social marketing strategies which have recently become a key aspect of UK government public health policy at national and local levels (French, 2009). These strategies are indicative of newer forms of health governance which move beyond the provision of services to integrate health as a core aspect of the lives of individuals and communities and elevate it to a core goal of self actualisation within late modern western 'health societies' (Kickbusch, 2007).

Social marketing aims to promote 'social good' (National Social Marketing Centre (NSMC), 2007) using the methods of commercial marketing. These methods include: a customer/consumer orientation, setting of behavioural goals for a social good, use of a marketing mix to achieve those goals, audience segmentation to target customers effectively, and use of the concepts of 'exchange' and of 'competition' (Robinson and Robertson, 2010). Social marketing for health typically targets individuals and communities (the sick, but more often, and most significantly for this research and discussion, the 'worried well'), with the aim of encouraging behavioural change, often with populations deemed to be 'at risk'; for example (male) smokers (see **Figure 1**).

These objectives are achieved through a complex 'mix' of methods which includes recognising the relationship between product, price, place and promotion characteristics in intervention planning and organisation (Lefebvre and Flora, 1988). This mix is operationalised by beginning with specific target audiences as the basis of campaigns, gaining full understanding of how audiences construct the product, considering the costs and benefits of behaviour change and understanding the place or settings in which both audiences will be targeted and in which changes will take place. How these elements are combined, and which are given precedence varies according to the social goal of the given intervention or campaign (Lefebvre, 1992).

The adoption of social marketing as a strategy is driven by the observation that many of the health challenges facing Western societies have significant behavioural elements including obesity, alcohol misuse, infection control, recycling, saving for retirement and crime (French, 2010: 1). These challenges are coupled, French (2010) argues, with growing resistance to state paternalism and its perceived propensity to breed dependency (ibid).

The combination of these factors opens the door, so it is argued, for methods which position the citizen/ consumer centrally in the delivery of interventions. Social marketing, with its emphasis on understanding people as the starting point (French, 2010: 2) is proposed as a potentially powerful methods for achieving this. Thus it works with consumers as its starting point, guided by the nostrum (supported by the UK Kings Fund (2004) which states the: 89% of people agree that individuals are responsible for their own health) that under the right guidance and with appropriate 'nudges' (Thaler and Sunstein, 2009), individuals can and should be able to take responsibility for wellbeing. To achieve this, social marketing typically uses advertising and other forms of media to encourage behavioural change, alongside interventions. For example, the recent UK Change4Life campaign combines advice and encouragement to engage in more physical activity (advertisements on public transport ask 'why not get off one stop earlier') with events which are free to access, for example, offering free dance classes around the UK in Spring 2010. In this way strategies use a 'marketing mix' (Lefebvre, 1988) to most effectively target populations.

We argue that these approaches represent a rupture from more established public health strategies, whether classical interventionism (Rosen, 1993) or more recent new public health approaches which have emphasised enabling environments and social change (Ashton and Seymour, 1988). Social marketing for health, although ostensibly intended to bring about 'social good', rather, eschews the social in favour of an individualisation of responsibility for the management of the body, health and self. Such strategies assume a rational, active individual capable of monitoring their own wellbeing, and that of their families, and who is able to moderate and 'improve' behaviours where appropriate. As noted, this reflects prevailing

neo-liberal approaches to health governance wherein the individual becomes central to the management of their own wellbeing.

Despite reiteration that 'Social marketing really works – but only if it is done properly' (Andreasen, 1995), there is still limited evidence that this is the case (Stead et al, 2007). In a recent systematic review, Stead et al (2007) analysed fifty four interventions, finding significant positive effects in the short term but not the medium and longer term. Further, of these fifty four, forty eight relied heavily on face to face methods like counseling and peer support. Stead et al (2007) thus argue that the marketing elements of these were less effective than direct intervention with populations and the individual. As already hinted, perhaps the most significant problem with the 'touting' (Herrick, 2007) of these strategies as a panacea for health improvement is the continued overwhelming evidence of the structural determinants of health. Research into health inequalities has long identified the material basis of the distribution of morbidity and mortality amongst populations (Black, 1980). Thirty years of subsequent research has documented how the Western industrialised nations continue to grapple with structural inequality and its impact upon all aspects of social life (Wilkinson and Pickett, 2009).

A recent comprehensive UK study of health inequality, the Marmot Review (2010) concludes: 'Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society' (p. 16). The many policy recommendations which follow are based upon social and policy strategies (i.e. development and implement standards for a minimum income for healthy living (p. 186)). None suggest that the social and economic inequalities which lie at the heart of unequal health chances can be effectively tackled through use of marketing strategies to promote

behavioural change. Marmot (2010) does not discount entirely the role of individual responsibility, however, the report stresses that this can only come about as a result of 'social action' (p. 16). Although social marketing strategies attempt to promote change in the contexts in which health behaviours take place, they are unable to address wider structural factors which both determine and inhibit behaviours at a local level. The recent report of the Commission on the Social Determinants of Health (2009) chose as its main recommendations; improve daily living conditions and tackle the unequal distribution of power, money and resources. Such calls for direct intervention are indicative of the weight of evidence which illustrates the structural determinants of wellbeing and the barriers these pose to individuals engaging in healthy behaviours. As such, as Herrick (2007) has recently discussed with regards to obesity, settings and place become highly significant:

> 'The pragmatic logic of social marketing is that the goal of long term behavourial change is best achieved by communicating risk and reducing the structural and environmental barriers to healthy behaviour. However, actually achieving this means acknowledging the role of locale in health – especially in the context of eating, exercise and access to health services – and thus grounding social marketing within the recursive socio-spatial relations that condition wellbeing' (p. 92).

Add to this the significance of socio-economic status, itself inextricably linked to place (Dorling, 2010) and it is the wider social determinants of health (CSDH, 2009) that become most significant factors in both determining health and health behaviours and the ability or orientation populations have to change.

These criticisms echo those long levelled at health promotion which has consistently been accused of placing responsibility for health upon individuals without acknowledging wider social, political and economic determinants (Crawford, 1977; 1986). As Griffiths et al (2009:269) have recently noted the theories of social marketing and health promotion have much in common:

> 'Good health promotion and good social marketing have a shared and consistent core theory and practice base – they both have a driving concern with achieving social good through the use of ethical approaches that engage, mobilise and empower individuals and communities. They are both also behavioural, going beyond simple message based communications to find ways to help people achieve and sustain positive behaviours'.

In both social marketing and health promotion health and its attainment become a form of consumption (Bunton and Burrows, 2005), as individuals are positioned as rational actors able to make judicious and informed choices from a range of options made available to them. It is perhaps unsurprising then that social marketing for health adopts commercial methods to promote wellbeing, premised upon targeting populations of reflexive agents capable of monitoring and managing their own health. A key contention of this discussion is that such strategies are indicative of prevailing neo-liberal ideologies of welfare which posit solutions at the level of the individual.

Neo-liberal rationality emphasises the role of the individual who has the freedom to choose from available resources to construct their own self identity. These resources are made available through, and determined by, markets, however, and individuals become governed both through a process of domination yet also techniques of the self. Petersen (1996: 194) describes this as a form of regulated autonomy, premised as it is upon

rational self conduct. Such rationalities champion the enterprising individual as neo-liberalism calls upon them to enter into the process of self governance through endless self examination, self care and self improvement (p. 194).

Under such conditions, which Kickbusch (2007) has described as core aspects of the 'health society', new concerns with men's health have emerged. Men are increasingly constructed as an 'at risk' group, by virtue of a combination of biological, psychological and social factors which are said to create an increased vulnerability and weakness in terms of health. Men's health has thus become the target of social marketing campaigns in the UK and beyond (Robinson and Robertson, 2010), as governments attempt to ameliorate the perceived crisis in the health of men using diverse methods to change attitudes and challenge the problem behaviours which are said to result in increased risk.

These contexts provide the starting point for the present discussion. Robinson and Robertson (2010) have highlighted the growing use of social marketing in the UK over the past decade to improve the health of men, a recent example being the Institute of Cancer Research Everyman campaign. As a method which attempts to encourage more reflexive engagement with personal health in 'well' populations, social marketing may be a more recent manifestation of the 'health society'. Kickbusch (2007) suggests that under the conditions of the health society, we witness two key processes; expansion of the territory of health and expansion of the reflexivity of health. Social marketing for health is indicative of both these processes as it simultaneously expands health into a wide range of settings (the home, the school, the workplace, public space) whilst, through attempting to promote greater health awareness and behavioural change, encourages populations

to be ever more reflexive and self monitoring. Through its focus upon commercial methods congruent with prevailing neo-liberal political and economic models, and its emphasis on the citizen/ consumer as the starting point for interventions, social marketing is perhaps an exemplar of what Kickbusch (2007) diagnoses as the health society, combining attempts to foster increased health reflexivity, starting with consumers who may or may not identify health as high ranking concern in their own lives, with an opening up of all social settings as appropriate sites for intervention.

Recent social marketing strategies targeted at male audiences have tended to use stereotypical models of masculinity (Robinson and Robertson, 2010). Robinson and Robertson (2010) contend that these strategies, at the very least, run the risk of reifying the hegemonic masculine discourses which the new men's health movement (Courtenay, 2000) has sought to challenge. A key argument presented in the following discussion is that such strategies also have the potential to contribute to a more insidious process of positioning men as responsible for their own wellbeing, obfuscating wider social, political and economic determinants of health. There is compelling evidence that these wider structural determinants, alongside the existence (as well as the impact) of inequality itself (Wilkinson and Pickett, 2009) are the most significant factors in determining health both within and between populations. As such, social marketing strategies have the very real potential to contribute to a process of victim blaming (Crawford, 1977; 1986) through positioning responsibility for the management of health and wellbeing with the individual whilst simultaneously failing to draw attention to the wider determinants of health. In this way, social marketing for health contributes to the construction of 'healthy citizens' (Petersen and Lupton, 1996; Crawshaw, 2007); individuals who are willing and able to take responsibility for the management of their own wellbeing under the governance of distant

expert discourses (Dean, 1999). Such approaches reflect broader neo-liberal models of welfare governance which have increasingly shifted responsibility from the state to communities and individuals.

These strategies do not impact upon men in a simplistic way, however. As the data presented below illuminates, men involved in this research actively resist the communication of health messages, and recognise the complex multiple determinants of health over and above individual behaviours. The implications of this for social marketing for health are discussed.

The following presents new qualitative data collected with men in the UK (n. 50) in 2009. Data highlights men's own critical stance towards health and the use of social marketing strategies, exploring their subjective understandings of health, choice, responsibility and possibilities for change, their responses to social marketing and health promotion campaigns and their potential resistance to them. The data was collected as part of a research project funded by a Primary Care Organisation in the North East of England.

Social marketing, surveillance and 'health governance'

Under the conditions of the 'health society' (Kickbusch, 2007) it is perhaps unsurprising that men's health has come under the gaze of newer forms of surveillance medicine (Armstrong, 1995). As new forms of health governance encourage reflexivity across populations, promoting health in an ever wider range of settings, men have become targeted as a group said to have particular health needs, often as a result of a perceived propensity to engage in risky behaviours and a reticence to seek help. Such strategies promote continual self monitoring and surveillance under the guidance of distant experts (Petersen and Lupton, 1996) and reflect prevailing neo-

liberal modes of welfare which position the individual as the expert in their own lives and compel them to regulate their own behaviours (Rose, 2001). Under these conditions, men have become the object of diverse interventions, including social marketing, with the ultimate goal of raising health awareness to improve wellbeing.

These processes have not gone without critique (Crawshaw, 2009; Fitzpatrick, 2006, Rosenfeld and Faircloth, 2006). The potential for 'medicalising masculinities' has been identified, and as Robinson and Robertson (2010) highlight, an uncritical understanding of men and their masculinities has the potential to be counterproductive through reifying dominant, hegemonic forms of masculinity which are themselves constitutive of wider structural factors said to be damaging to men's health (Scott-Samuel et al, 2009, Crawshaw et al, 2010).

Surveillance medicine refers to a new model whereby the relationship between symptoms and illness are reconfigured, as the former come to be understood, not exclusively in terms of concrete evidence of illness housed in the space of the body, but as 'a more general arrangement of predictive factors'; the factors of risk (Armstrong, 2002: 110-111). Such risk factors open up spaces of future illness potential and require surveillance and monitoring of diverse aspects of pathology, behaviour and lifestyle. Under such conditions, health is reconceptualised as a more complex multidimensional phenomenon than merely the absence of illness, and the role of states becomes much wider than the provision of services. Here, the focus of medicine and health work becomes less illness *per se*, but the 'semi-pathological, pre-illness, at-risk state' (ibid). These newer forms of health governance (Kickbusch, 2007) are congruent with wider neo-liberal approaches to welfare which promote reflexivity and self regulation. In many

respects social marketing for health epitomises this new health paradigm, attempting to change behaviours by raising awareness of risk factors which can be ameliorated through the rational actions of the individual. In the case of men, awareness of a variety of risks is promoted, typically around themes designed to appeal to an 'innate' or essential masculinity. For example, the potential of cigarette smoking for increasing risk of impotence.

Insert figure 1 here.

Here, the 'risks' associated with cigarette smoking are not limited to chronic disease, but present a threat to masculinity itself through reducing men's sexual performance; a core attribute of hegemonic masculinity. Thus, men are warned of potential hazards and urged to change their behaviours to avoid future illness, and in this case, sexual dysfunction. Most significantly, the solution is behavioural change.

As Robinson and Robertson (2010) note, although aiming to improve men's health, such techniques often appeal to simplistic stereotypes and run the risk of reinforcing hegemonic masculinity. If men will not change their behaviours for the sake of their hearts, so the arguments goes, perhaps they will do it for their penises. As all men are presumably motivated by their potential to perform sexually, such strategies are deemed to be effective in communicating health messages to men and raising their reflexive awareness of their own bodies and wellbeing. The potential of these techniques to reinforce hegemonic masculinities are clear and a paradox thus emerges, as, as Robinson and Robertson (2010: 51) note '..social marketing becomes problematic if it uses homogenised images of hegemonic masculinity narrowly as a promotional tactic.'

Discussing social marketing for health, Courtenay (2004) powerfully argues that social norms are highly significant in shaping men's understandings of health and their health behaviours and suggests that in order for men to change, social norms will have to change (p. 275). Marketing strategies such as the one shown above do little to challenge social norms of masculinity, but rather, work to reinforce crude, attributional forms of hegemonic masculinity which conform to the idea that men are highly motivated by sex. Such strategies, rather than challenging social norms, as Courtenay (2004) advocates, work to reinforce gendered ideologies in the most fundamental way. These strategies thus run the risk of tacitly reinforcing gendered male stereotypes (Robinson and Robertson, 2010). Moore (2010) has similarly pointed to the negative influence of using gendered stereotypes to market breast cancer awareness in the form of pink ribbon merchandise and their potential to accentuate health anxieties amongst 'well' women (p. 126). Further, and core to the argument of this paper, these strategies posit individualised solutions to problematic health behaviours which may be social in their origins, reflecting newer neo-liberal modes of health governance.

Methods

Data was collected as part of a research project commissioned to inform the development of a social marketing strategy to improve the health of unemployed men for a regional Primary Care Organisation (PCO) in the UK. Unemployed men were selected as they had been identified by the PCO as a hard to reach group who experience significant health inequalities. Data was collected between February and September 2009. Qualitative methods were used. This involved three semi-structured focus groups and thirty semi-structured interviews. All participants were men aged between 20 and 55 years. All were unemployed when the interviews took place. When in

employment, all were skilled, semi-skilled or unskilled manual workers. Participants were accessed via local training providers commissioned to provide routes back to work for the long term unemployed and the employment service.

Qualitative research can be defined as "detailed description and analysis of the quality or the substance of the human experience" (Marvasti 2004: 7). Qualitative methods were chosen because of their potential to elicit in-depth understandings of men's own constructions and experiences of health and wellbeing. Focus groups and interviews were conducted on the premises of the various gatekeeper organisations in a room allocated specifically for these purposes. Data was collected by a research assistant using a topic guide developed in consultation with the wider project team. Pilot focus groups and interviews were conducted. Data from these was analysed by the research assistant and project supervisor. This data provided the basis for development of further questions and complete interview guides. Focus groups ranged in length from 1 hour to 1 hour 30 minutes. Interviews ranged in length from 30 minutes to 1 hour and 30 minutes. Data from both were analysed using the conventions of thematic qualitative analysis (Burnard, 1991). This began with open coding, moving on to more detailed axial coding. The analysis was conducted collaboratively between the research assistant and project supervisor.

The following presents some key themes which emerged from the research including, understanding health; determinants of health and health and responsibility.

Understanding health
Participants presented diverse understandings of health and wellbeing, referring to factors such as being able to avoid illness.

The healthier you are your body looks after you more, doesn't it? (aged 22)

Free from disease and stuff like that, that is what I class as being healthy, lack of colds and that sort of stuff (aged 37)

The more healthy you are the more it fights off infections, the chance of being infections cut down (aged 38).

Such responses were frequently given to the question, 'What does being healthy mean to you?' These responses reflect what has been described elsewhere as a functional relationship with the body; one whose main concern is the body's ability to fulfill its normal everyday practices and activities. Such responses bear out what Morrison (2004) has described as a 'body as process' orientation, whereby the body is viewed in terms of what it can do, it's potential to successfully engage and interact in the social world. Freedom from illness is a key aspect of this. As Salstonstall (1993) has noted, for men, conceptions of health are often linked to the ability to manage and control their bodies and maintain their functionality for everyday life.

Other participants emphasised the importance of mental wellbeing, with health being equated with happiness.

Live longer, healthy and peace of mind, just be happy in yourself that to me is always the main thing. If you're not happy in yourself you start getting stressed out you know worrying about your weight and what people think you know various other problems etc etc., your health can just..it's gone your health it just deteriorates and it can happen so fast (aged 51)

> *Health to me means peace of mind and being happy with yourself,
> once your happy up there, everything will sort its self out you lose it, if
> you want my advice that's when you lose the body as well* (aged 53).

Participants also frequently suggested that poor mental health had a direct impact upon individual dispositions toward physical wellbeing. For example:

> *I think a lot of people suffer from depression, I think that's why a lot
> of people don't bother with their health* (aged 45).

The benefits of being healthy included, longevity, with particular emphasis upon spending more time with children, looking and feeling good and perceived attractiveness to potential partners. Health was thus, unsurprisingly, presented as a contested and diverse issue with multiple meanings and constructions in men's everyday lives. Here, participants illuminate Morrison's (2004) distinction between body as process and body as object. The latter considers the aesthetic potential of the body, the former, as noted above, is focused upon what a body can do.

The very contested and diverse understandings of health presented illustrates how more simplistic social marketing campaigns that seek to tap in to (and reinforce) crude masculine stereotypes (i.e. Think with your penis? See **Figure 1.**) are potentially flawed, in that, if for men in this sample, the benefits of health are being free from illness in order to function normally in everyday life or experiencing a more general wellbeing and or happiness, strongly linked to their mental health, then perhaps more subtle forms of health promotion are required than those which simply reduce men to crude masculine stereotypes.

Participants consistently noted that health is a complex and contested concept which is notoriously difficult to define and which evades consensus and shared definitions. It was argued that the complexity of health material provided through methods such as social marketing was often difficult for lay

people to engage with, and that they were more likely to understand their bodies in more process oriented or functional ways.

> *All we know is healthy and unhealthy, that's all we know, we don't know these in-betweens (aged, 20).*

Here, as discussed further below, the issue of making individuals responsible for the management of their own health was raised, as participants highlighted the challenge of interpreting expert knowledge and applying it to their own health beliefs and behaviours within their own situated social contexts.

> *It's quite hard to get actual decent facts, you don't know what's true and what's not about things (aged 37).*

In societies governed by expertise (Petersen and Lupton, 1996), a paradox emerges when individuals are impelled to make sense of technical discourses (nutritional advice, proposed exercise regimens) in order to more successfully manage their own wellbeing. Social marketing strategies represent a form of government at a distance (Dean, 1999), whereby individuals are required to take control of their own lives under the guidance of expert discourses which are removed from their everyday experiences and interaction. What such forms of government or health governance may fail to acknowledge is the highly complex context of individuals everyday lives in which their health experiences and behaviours are played out (Herrick, 2007).

Determinants of health

Participants were asked to consider what factors directly impact upon health and responded in a variety of ways. When discussing this, reflection upon health promotion and social marketing campaigns was encouraged and some examples used. These typically stimulated significant discussion, with men

most often describing a wide range of factors outwith their own control which impacted upon health and wellbeing. In this way, the simple imperatives of social marketing to make changes to behaviours and lifestyles were challenged.

> *But yeah I suppose it all boils down to money at the end of the day, diet things like that everything costs and not having a decent education and not having a job just have nothing to do* (aged, 31).

Here socio-economic factors are highlighted as key determinants of both health and health related behaviour; financial resources; formal education and employment status. These key elements of what Dahlgren and Whitehead (1992) define as the 'social determinants of health', are themselves vital in determining individual behaviours. Participants recognised this, and were aware that their own socio-economic position was a significant determinant of health behaviours and status, and further, that these were a more powerful determinant of health than any behavioural changes they could make as individuals.

> *So I say social, social like standings which give you health standards really so it's pointless* (aged 20).

A significant factor reiterated throughout the research was financial barriers to behaviour change.

> *You go to the swimming pool or you go to the gym, it's money, money you don't have, especially now with the way it is with the economy, I mean everything's going up, you just cannot afford to do it anymore* (aged 35).

> *The price of healthy food, it's cheaper to buy a burger than it is to buy a bag of sprouts* (aged 47).

> *Do you think, if you think about it well your on the dole* (unemployed) *do you have the money to live, eat healthily, or do you only have the money to go out and shop in Netto (a discount retailer) and buy nine pence tins of beans and fucking shit like that* (aged 22).

Expressed most simply:

> *If you can't afford to eat healthily you're not going to eat healthily, you know what I mean* (aged 22)

Participants expressed how financial constraints regularly dictated their behaviours, particularly in terms of access to healthy food for themselves and their families.

> *Well yeah there is obviously if you can afford nice food and food that's good for you but I mean you're more likely to buy it you know what I mean, but I mean if you can buy a peach, say you buy a peach, a bag of peaches for fucking eighty pence. Something you can buy a tin for twenty pence you're going to buy the tin aren't you* (aged 24)

> *If I had enough money to buy my kids healthy all the time I would, but there is nothing I can do about that* (aged 22).

Here, participants expressed that very real financial barriers existed to them being healthy, and that government strategies should perhaps focus upon redressing this issue, rather than simply advocating behavioural changes which in reality might be unlikely or even impossible. As two focus group participants argued:

> *So the government need to up the money that they are giving us if they want us to live healthier* (aged 25)

> *Or drop the prices of food you know what I mean, I'm not been funny it's fucking ridiculous, weekly shop for us is, we can spend seventy quid a week on food* (aged 22).

Time constraints were also cited as a factor which limited men's ability to monitor their health behaviours and think reflexively about their wellbeing. For example:

Having the time in the day when you've got two kids to look after, the last thing on your mind is being healthy, you know what I mean the last thing "oh best go for a run", fuck that (aged 34).

Some respondents also cited family influences as being significant in determining attitudes to health and behaviours.

So in a sense it's, it's in a sense it goes what your parents feed you as a kid as well don't it, it goes on your background of eating and your health through your family, if your family aren't active why are you going to be active (aged 22).

These influences and constraints led to some respondents feeling fatalistic about both their physical and mental wellbeing and the possibilities for change.

I think some people get depressed with life basically the way they are (aged 37).

If you want to eat good you would do but like you say I don't know what is you fall into a rut I think you just fall into it, you know you start doing it and just keep on doing it you know (aged 47).

As one participant suggested, the fact of being on limited income dictated that these men often found themselves unable to choose more healthy lifestyles.

Your asking the wrong people who are on benefits aren't you really? You can't afford choice (aged 47).

For participants in this research, it was clear that the imperatives of behavioral change promoted through social marketing strategies were viewed cynically in light of both the ineffectiveness of such approaches and their own inability to implement them due to financial and other pressures

and amidst the wide range of social determinants of wellbeing. Recent reports of the Commission on the Social Determinants of Health (2008) have placed the social determinants of health at centre stage and highlighted them as an urgent priority for policy makers, health professionals and health researchers alike. The lay accounts presented above support this emphasis on determinants which lie outside of individual control, and as such, make problematic the behavioral approaches which characterise social marketing.

Responsibility for health
In contrast to much of the discussion presented above regarding external and social determinants of health, men often positioned themselves as responsible for their own wellbeing. That is, ultimate responsibility was said to lie with the individual for the management and monitoring of health. However, this was often played out as a form of resistance to strategies which attempt to inculcate behavioural change; men would often disregard these as unobtainable and unrealistic, as discussed above, and suggest that it was rather, more obvious aspects of their daily lives which they could manage and control. In this way, men eschewed the imperatives of expert discourses (Petersen and Lupton, 1996) and rather argued for more situated understandings of health and wellbeing which were relevant to their own lived experiences.

Thus a paradox was played out, with men recognising the diverse factors which mitigated against health and wellbeing, whilst simultaneously arguing that they could manage their own health more effectively if they chose to do so. This was to be achieved, not through the more significant lifestyle changes promoted through health promotion and social marketing, however, and more through a return to simple strategies such as walking.

Men did not necessarily feel that it was not their own responsibility to manage their health, but, as discussed above, numerous factors mitigated against this, such as time, financial resources and work commitments.

> *Say you are working all the time you are not eating properly, you will be getting in just have a quick sandwich or something then there be if you drink you go out for a couple of pints and then back home go to bed and you are up for work, you are not looking after yourself, you are not controlling your health, you are not in control of it* (aged 28).

Participants felt that social marketing and health promotion strategies where often an ineffective way of addressing health problems, diverting attention away from core issues such as delivery of, and access to, services.

> *If the NHS spent less money on advertising and campaigns and more on actual services we wouldn't be in the state we are now* (aged 37).

Further, it was felt that the use of such strategies represented an imposition upon men's own private and personal behaviours, despite recognition that the latter were themselves dictated by wider social factors.

> *They can advise but it's not up to them to try and dictate to you what type of lifestyle you actually have* (aged 38).

> *Most people would think like that they think to themselves it's up to me what I want to do nobody is going to tell what to do* (aged 49).

Participants felt that these strategies represented surveillance of their everyday lives and activities which was unwelcome, precisely because it remained at the level of advice and was not in itself cognisant of, or sympathetic to the complexities of their everyday lives and lifestyles.

I think it is wrong how they try to tell you what you should and shouldn't do, it's right they are advising you but they can't tell you what you should and shouldn't do (aged 22).

I will live my life my way and I am not going to have somebody else tell me how to live it (aged 49).

I want help I don't want a lecture (aged 51).

Parallels were frequently drawn between social marketing and health promotion strategies and more 'popular' representations of health found in the media. Men were often cynical about such representations of health and their potentially negative consequences. As one participant noted with reference to the typical images found on the UK edition of the magazine *Men's Health*.

*That's why they say just because he looks like that doesn't mean he's healthy he could be killing himself to look like that (*aged 37).

The potential effects of such images on men and others were discussed. For example:

They read OK magazine and think I got to look like this and it's impossible to look like that (aged 37).

Yeah I think it's getting just as bad for blokes these days and your flicking through the magazine it's all in there (aged 38).

Further, men recognised that the marketing of health and idealised forms of wellbeing from both state and commercial sectors represented a commodification of health.

Everything is turning into products now, like a razor simple thing to shave it's a product (aged 45).

> *It's now a product it's now a globally mass produced product, it's in the top markets and stuff like that, I don't see health like that, I see health like either if you live or you die and it's your choice to sort it out in the middle* (aged 21).

Although some participants may have expressed that health was their own responsibility, it was reiterated that social marketing and health promotion strategies where ineffective ways to achieve better health, given the complexities of their everyday lives, the realities of unequal access to resources and lack of motivation due to external pressures and more immediate concerns such as family and employment. As one participant neatly summarised:

> *You need a little more than an advert to push you into doing what you should be doing* (aged 49).

Here, and elsewhere, the governance of health through marketing was said to be destined to fail, both because of the myriad determinants of health and attitudes towards it, and further, and significantly, because of the assumptions laden in such approaches that men are a homogenous group with shared values and interests.

> *Again it is how the individual how they read into it, everything is down to that person, that person, that person, you can't view that as a group and expect the entire group to have the same opinion* (aged 40).

The key premise of social marketing is to bring about behavioural change in individuals. This in itself is not a social endeavour, and is, in reality, more indicative of the death of the social (Rose, 1996), the result of attempts to work upon atomised individuals to encourage them to change themselves, to govern at a distance through the inculcation of new beliefs and behaviours, rather than to address the determinants of health at the level of the social;

the level from which we know many of the most urgent health problems of our time arise (Commission on the Social Determinants of Health, 2008, Marmot, 2010).

Conclusion

French and Blair-Stevens (2006) suggest that the aim of social marketing is to achieve individual behavioural change for social good. This brief statement belies a powerful ideological commitment (echoed by Blair, 2006) to positioning the individual as the starting point for bringing about social change, and more specifically health improvement. Such a standpoint fails to acknowledge not only the complex social determinants of health and wellbeing tied to socio-economic status, employment, environment, locality and so on, but also the complex lived experience of health for men, and others, in their lifeworlds. To abstract health behaviours from these contexts, as Herrick (2007) notes, risks failure by ignoring the powerful influence of environments, physical, social and cultural, and further, succeeds only in inculcating individual responsibility for the management of social problems.

Men interviewed as part of this study have highlighted how health is a complex and multifaceted phenomenon, inextricably linked to their social position as men, being in or out of employment, their financial status and familial responsibilities and associations. For these men, the reduction of health to a simplistic set of behavioural characteristics to be improved and sustained is anathema. They recognise that bringing about such changes are likely to be beyond their control and that, if they are not, the motivations to do so are lacking due to a variety of circumstances. Within their own lives there remains a cultural logic to their behaviours which resists imperatives to change from abstract and distant authorities who seek to promote a

generalised form of health and wellbeing which has little bearing upon their everyday experiences.

In adopting the methods of commercial marketing, it is perhaps unsurprising that social marketing strategies reflect prevailing neo-liberal approaches to health governance that seek to construct a rational, risk averse, health seeking subject or citizen, able and willing to take responsibility for the management of their own wellbeing. These strategies assume an autonomous individual able to choose their own practices and behaviours and care for the health and wellbeing of their families under nothing more than the guidance of expert discourses (provided through the advice and information that constitutes many social marketing strategies). Men in this sample recognised a very real disjuncture between this idealised neo-liberal self and their own position as unemployed men within a social context which mitigates against being healthy. As a mode of governance, social marketing for health is perhaps destined to fail with such groups, as, through eschewing the social by focusing upon individual behaviours, it is unable to account for the multitude of external factors which render individuals incapable of looking after their own health, and, or strip away any motivations to do so, as our participants consistently highlighted.

Robinson and Robertson (2010: 59) conclude by discussing a key challenge raised by the NSMC (2007): 'to enable consumers to *critically interpret mass media messages* in order to make informed decisions' and '*to gain greater control over the factors that influence their health*'. If social marketing for health (aimed at men or otherwise) is to meet this challenge, it must recognise that the starting point is not necessarily interpretation and individual action, but rather, the wider social determinants of health which continue to exert a profound and lasting influence on the health and wellbeing of individuals and communities (Marmot, 2010). Hopefully further research will continue to highlight this and begin to redress a situation

whereby, as Furedi (2006) notes decision makers who are unable to come up with a decisive social policy, resort to targeting individual behaviours and lifestyles.

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Figure 1