Individualism vs. Collectivism: Implications for Health Promotion

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This paper examines the strengths and limitations of various health promotion strategies as they relate to individualism-collectivism. Individualism-collectivism is discussed in relation to the types of strategies adopted for improving health: active vs. passive measures; the strategies of education, engineering and enforcement. Findings on individualism-collectivism in the area of communication research are applied to the health promotion domain. It is hoped that the conceptual framework presented in this paper would contribute to the development of culturally appropriate health promotion interventions.

Successful health promotion efforts are likely to be those that are sensitive to the cultural context of health. It is therefore important to select health promotion approaches consistent with the cultural orientation of a community. Individualism-collectivism is perhaps the broadest and most commonly studied dimension of cultural variability (Gudykunst & Ting-Toomey, 1988). The purpose of this paper is to present particular approaches to health promotion as they relate to individualism-collectivism. A brief overview of the individualism-collectivism dimension of culture will be presented followed by a discussion of its potential influence on the effectiveness of health promotion strategies.

Individualism and Collectivism

Hofstede (1980) describes individualism-collectivism as the relationship between the individual and the collectivity that prevails in a given society. In individualistic cultures, individuals tend to prefer independent relationships with others and to subordinate ingroup goals to their personal goals. In collectivistic cultures, on the other hand, individuals are more likely to have interdependent relationships to their

ingroups and to subordinate their personal goals to their ingroup goals. Individualist cultures are associated with emphases on independence, achievement, freedom, high levels of competition, and pleasure. Collectivist cultures are associated with emphases on interdependence, harmony, family security, social hierarchies, cooperation and low levels of competition. Collectivist cultures are thought to be exemplified in Asian, African, Latin-American and Southern European cultures while individualist cultures are exemplified in mainstream American and Western European cultures (Triandis, 1988).

A concept similar to individualism-collectivism is the independent vs. interdependent contruals of the self. Markus and Kitayama (1991) have suggested that people hold divergent construals of the self—an independent view of self as opposed to an interdependent view of the self. The independent view of the self considers the self as separate from the social context. Individuals seek to maintain their independence from others by expressing or emphasizing their unique inner attributes (abilities, thoughts and feelings) and by promoting their own goals. In contrast, the interdependent view of the self assumes a fundamental interconnectedness among individuals. The self is defined in relation to others in specific contexts (statuses, roles, relationships). The emphasis is on "fitting in", promoting others' goals, and maintaining harmony with the social context. The independent-interdependent self-construal has been conceptualized as an individual difference factor while individualism-collectivism has been conceptualized as a cultural factor (Singelis, 1994).

Individualism-Collectivism and Health Promotion Strategies

A particular approach to health promotion may be more appropriate for individualist cultures while other approaches may be more appropriate for collectivist cultures. A key issue in health promotion policies and programs is how much constraint the collectivity can impose on individuals to accomplish its health-related goals. If group goals are more important in collectivist cultures than in individualist cultures, then collectivist cultures may allow a greater degree of constraint on individual health behaviors than individualist cultures. For example, health promotion that deals with matters of lifestyle such as overeating and smoking may be seen by some individuals in

an individualist culture as an effort to interfere with their right to privacy. From a collectivist perspective, however, collective health is seen as outweighing the individual's loss of freedom. Varying degrees of constraint on the individual are reflected in the types of strategies adopted for improving health: active measures vs. passive measures; and the strategies of education, engineering and enforcement.

Active vs. Passive Measures

"Active" and "passive" are opposite poles of a dimension that along which measures to prevent disease and injury can be usefully classified. The dimension is defined in terms of the amount of action required by individuals in order for them to be protected. Active measures emphasize the role of the individual in adopting healthy behaviors (e.g., eating a balanced diet, regular exercise). In contrast, passive measures are techniques that protect individuals automatically without any cooperation or action on their part (e.g., flouridation of water supply, automatic seat-belts). Historically, major health gains have been more the result of implementing passive measures at the community level (e.g., improved sanitation, pasteurization of milk), or relatively passive actions on the part of individuals (e.g., immunizations), rather than actions that require frequent actions on the part of the individual to be protected (e.g., vigorous exercise; Williams, 1982). Although the adoption of passive measures may be applicable to both individualist and collectivist cultures, it may be especially useful in individualist cultures. The use of passive measures may be a subtle way of overcoming the resistance of individualism. For example, at the societal level, changing food in ways that would result in healthier diets (i.e., producing low-fat foods) may be more effective than encouraging individuals to adopt and maintain healthy diets.

Education, Engineering, and Enforcement

The "Three E's" program of education, engineering and enforcement has been examined within the context of health promotion by Alonzo (1993) based on the U.S. Forest Service's "Three E's" program to protect public forests from misuse. This program as applied to health behavior further illustrates the issue of constraint in health promotion. Education is viewed as a solution to a health problem when it is perceived that

a lack of information is inhibiting individuals from behaving in their own best interests (e.g., providing information on the modes of HIV transmission). Engineering is an effort to design or manipulate the environment to reduce risk and avoid harm to societal members (e.g., increasing taxes on alcohol and cigarettes). It is somewhat similar to the concept of passive measures discussed earlier. Enforcement refers to the creation of rules and regulations regarding individual and collective behaviors and enforcing them (e.g., banning smoking in public places). Education presents the least constraint on the individual while enforcement imposes the greatest constraint. Thus, for individualist cultures, education may be a more culturally appropriate means of enhancing health as compared to enforcement. Conversely, for collectivist cultures, efforts aimed at enforcement, as well as education and engineering, may be more acceptable. However, it is important to note that the success of any one approach depends on certain considerations. For example, within an individualist culture, it may be necessary to go beyond educational strategies and address social and environmental barriers in order to improve health. Within a collectivist culture, enforcement assumes that there is a consensus as to the appropriate course of action. In both individualist and collectivist cultures, enforcement can raise ethical issues such as coercion, although presumably less in collectivist cultures. McLeroy (1988) suggests that in order to minimize the problems associated with coercion, the active involvement of the community members in problem definition and the selection of appropriate interventions is necessary.

In sum, health promotion strategies that are least restrictive for the individual (e.g., passive measures) may be more suitable to an individualist culture while more restrictive strategies (e.g., enforcement) may be more appropriate for collectivist cultures. However, the use of any one strategy will have to take into consideration important issues such as social-environmental support for individual health change and ethical issues concerning civil liberties.

The next section focuses on persuasive communication used in health promotion. Findings on individualism-collectivism in the area of communication research will be applied to the health promotion domain.

Persuasive communication in Health Promotion

Research in the field of communication has shown that cultural differences in individualism-collectivism play an important role in persuasion processes both at the societal and the individual level, influencing the prevalence and effectiveness of different types of persuasive appeals. Two studies have examined the extent to which individualism-collectivism is reflected in the type of persuasive appeals that tend to be used in the United States, an individualist culture, and Korea, a collectivist culture (Han & Shavitt, 1994). Study 1, a content analysis of magazine advertisements, demonstrated that advertisements in the U.S. employed appeals to individual benefits and preferences, personal success and independence to a greater extent than did advertisements in Korea. Korean advertisements employed appeals emphasizing ingroup benefits, harmony, and family integrity to a greater extent than U.S. advertisements. Study 2, a controlled experiment conducted in the two countries, demonstrated that in the U.S., advertisements emphasizing individualistic benefits were more persuasive whereas advertisements emphasizing family or ingroup benefits were less persuasive than in Korea. In both studies however, product characteristics played a role in moderating these overall differences. Cultural differences emerged strongly in Studies 1 and 2 for advertised products that tend to be purchased and used with other people (e.g., over-the-counter medicines, groceries, insurance, cameras) but were much less evident for products that are typically purchased and used individually (e.g., cosmetics, jeans, greeting cards, credit cards). In other words, for shared products, there were strong differences between the U.S. and Korea in the prevalence and effectiveness of appeals. For personal products, however, individualist appeals were generally favored in both countries. This distinction between personal and shared products is significant in relation to the distinction between health behaviors that affect only the individual concerned vs. health behaviors that affect other people as well. The implications of this distinction for health promotion will be discussed later.

Persuasive communication, often in the form of media messages, can play various roles in health promotion. It can be the primary agent for change in a community health promotion program or solely a means

of complementing or promoting existing services (Flora and Cassady, 1990).

One component that is often included in media messages is a statement of the benefits and/or the costs of engaging in a preventive behavior. How individuals perceive the benefits relative to costs of changing behavior may depend, in part, on their cultural orientation along the individualism-collectivism dimension. For instance, if smoking is viewed as having high costs and low benefits for others, such as one's family, and is considered as potentially threatening to one's relationships with others, then individuals in collectivist cultures might be more encouraged to stop smoking. Alternatively, if smoking is viewed as a character weakness (e.g., as reflecting poor will or lack of personal control) and the costs of continuing to smoke (e.g., loss of self-esteem) outweigh any benefits, then individuals in individualist cultures may be more likely to stop smoking. Thus, framing the costs and/or benefits of behavior change in more culturally meaningful ways (i.e., in collectivist cultures, in terms of relationships; in individualist cultures, in terms of inner attributes) may increase the effectiveness of media messages.

For some health behaviors, however, cultural orientation may not necessarily influence the effectiveness of the health message. For example, in individualist cultures, it is expected that the likelihood of adopting a regular exercise regimen would increase when the message is framed in terms of benefits vs. costs to the individual. However, since the adoption of an exercise regimen does not directly involve others, then the same kind of message—benefits compared to costs to the individual—may be equally effective in increasing the likelihood of action in collectivist cultures. In contrast, the use of condoms to prevent sexually transmitted diseases, when framed in terms of the possibility of infecting a loved one, might be more likely to be effective for collectivist cultures than for individualist cultures since the use of condoms has direct implications for the health of others. Thus, the effectiveness of framing a health message in terms of individualism-collectivism would tend to depend on whether the adoption of the health behavior has a direct effect on others or an exclusive effect on oneself. This notion is similar to the findings in advertising research discussed

earlier in which personal products, which offer predominantly individually experienced benefits, were unlikely to be convincingly promoted in terms of group benefits whereas shared products can be convincingly promoted in terms of personal or group benefits. Thus, although individualism-collectivism may have a significant main effect on the effectiveness of health messages, it is necessary to identify possible moderators of this relationship.

Implications for Health Promotion in the Philippines

The conceptual framework presented in this paper can be further examined in relation to current health promotion efforts in the Philippines. For example, in December 1993, the Department of Health launched the anti-smoking *Yosi Kadiri* campaign with the youth as the target population. The mascot Yosi Kadiri was created to portray the negative characteristics of a smoker: rude, disrespectful, filthy, and violates people's rights to clean air. The objective was to quell the erroneous image of smoking portrayed in advertisements as glamorous for females and macho for males. Instead, smokers were portrayed as people who were uncool and unpopular. Thus, the message focused on the potential negative consequence of smoking—a smoker could be ostracïzed by others. Since relationships are highly valued in a collectivist culture such as the Philippines, this strategy would be appropriate.

The *Yosi Kadiri* campaign has increased awareness of the negative health effects of smoking (Trabaho, et al, 1995). However according to the National Smoking Prevalence Survey conducted by the Department of Health in 1996, the number of young smokers has increased from 22% of the population in 1987 to 56.2% in 1995. The survey also reported that most young smokers learned the habit from their fathers. Thus, other factors such as parental influence, need to be addressed. To encourage parents to stop smoking, particularly in collectivist cultures, smoking cessation could be phrased in terms of protecting the welfare of their children. Emphasis could be placed on the significance of parental modeling of smoking behavior and on the ill effects of secondhand smoke on their children.

Conclusion

This paper examined the effectiveness of various health promotion strategies as they relate to the individualism-collectivism dimension of culture. It is suggested that empirical research be conducted to test the proposed relationships between individualism-collectivism and health promotion strategies. Hopefully, this research would lead to the development of specific guidelines that could be used in the design and implementation of culturally sensitive health promotion interventions.

Notes

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