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EDITORIAL

The lazy language of 'lifestyles'

The Oxford English dictionary defines lifestyle as *"A style or way of living (associated with an individual person, a society, etc.); esp. the characteristic manner in which a person lives (or chooses to live) his or her life."*[1] By definition, lifestyle is about personal responsibility; the autonomous, intentional ways in which a person or group exerts free choice to live their lives. Its usage as a term is ubiquitous in society (e.g., celebrity lifestyle, middle-class lifestyle), including in the world of health promotion (e.g., active lifestyle, sedentary lifestyle, risky lifestyle). While the concept of lifestyle has been the subject of academic critique, drawing on Bourdieu and others to emphasise the structural aspects of lifestyles, including social class and power, such context is typically lacking in health research and, in particular, in lay understandings of the term.[2] Indeed, the first example of using the term lifestyle in a sentence provided by the Cambridge Dictionary is *"He doesn't have a very healthy lifestyle."*[3]

Unsurprisingly, the influence of one's 'lifestyle' in the prevention of chronic disease in Australia continues to permeate national and jurisdictional public health policies, and the professional and public discourse. The Queensland 2020 Chief Health Officer report, for example, contains almost 50 mentions of the term and has a whole section devoted to *"Our lifestyle"* (the use of the word "our" arguably also reinforcing the idea that smoking, alcohol consumption, diet and physical activity is primarily about individual agency). The Public Health Association of Australia, which has been at forefront of countering personal responsibility messaging, included a session at its 2022 Prevention Conference dedicated to examples of research and practice around 'lifestyle.' In both cases, the use of the term lifestyle is in the context of reports and organisations that explicitly recognise that it is the social, cultural and commercial forces that have the strongest influence on a population's health.[3,4]

1 | WHAT IS THE PROBLEM?

The problem is that the 'lazy language of lifestyles'[5] perpetuates the myth that improving the public's health is a personal responsibility. In some cases, this is done inadvertently or implicitly. In others, this is explicit – a deliberate "pollution of health discourse," driven by commercial industries with vested interests,[6,7] or by those with particular ideological standpoints.[8,9] Regardless, the outcome can be a diversion of attention away from those upstream primary preventive actions that are likely to be most effective at bringing about equitable, sustained improvements in health, towards action focused downstream on individualistic treatment and improving health attitudes and behaviours.

Take obesity as an example. It is implausible that the dramatic rise in the prevalence of overweight and obesity across most high-income countries, including Australia, has been due to a sudden, concurrent, generational shift in everyone's personal responsibility. Yet, this narrative continues to pervade, leading to weight stigma among those experiencing overweight and obesity[10] and preserving the belief that improving knowledge and redressing a supposed lack of individual motivation is the obvious solution. This is despite overwhelming evidence that such approaches have marginal, if any, impacts on trends at the population level.[9] 'Lifestyle interventions,' while important for supporting behaviour change at the individual level, can only serve to mitigate the effects of the structural determinants of health at the population level,[11] and may in fact widen population health inequities.[9,12,13]

The recently published National Obesity Strategy refers to lifestyle, on average, once every three pages.[14] Thus, despite being underpinned with principles of creating equity and addressing the wider determinants of health, the strategy was felt by some to be *"pushing the onus back onto everyday Australians and relying on behaviour change (which is) is simply not going to move the needle."* This is perhaps because the third principle is *"Empowering personal responsibility to enable healthy lifestyles."*[15] This points to the notion of 'lifestyle drift,' a term coined to describe the tendency for policy to start off recognising the need for action on upstream political and social determinants of health inequities only to drift downstream to focus largely on individual behaviours.[12,16,17]

The translation of the National Obesity Strategy at the jurisdictional level is perhaps an even more ostensible case of such 'lifestyle drift' than the national strategy itself. The New South Wales strategy, published last month, includes negligible reference to the commercial drivers of overweight, heavily emphasising action at the individual level *"to achieve lifestyle changes"* including, for example, *"lifestyle programs," "lifestyle guidance," "lifestyle information"* and *"lifestyle support."*[18] This contrasts with the Queensland Obesity Strategy, which instead emphasises the need for a systems approach to shift the conditions that hold overweight and obesity in place.[19] A similar approach was also taken in the 2022 National Preventive Health Strategy (which, incidentally, includes no mention of the word "lifestyle").[20] This marks an important, albeit small, shift away from neoliberal lifestyle ideology in current health policy discourses in Australia.

There is an argument that more careful use of our language to shift people away from the 'lifestyle, choice and personal responsibility' paradigm, risks creating a sense of disempowerment and loss of agency to control one's own health.[21] It can also be argued that the

large systemic issues that drive health behaviours and outcomes, such as income distribution and institutional racism, can be viewed as wicked or intractable policy problems that are too difficult to address or too overwhelming to change.[21] Indeed, such framing has been found to be encouraged by commercial actors as it creates a "smokescreen" that masks the need for evidence-informed public health action.[22]

Behavioural determinants of health (i.e., smoking, alcohol consumption, diet, physical activity, sleep) – are important – and, as mentioned previously, supporting and empowering individuals to improve their own health through programs remains a necessary tool in the health promotion toolkit. However, such approaches must be situated in the broader context where social, cultural, economic, environmental, ecological and commercial drivers shape health behaviours. The growing emphasis on well-being economies,[23] place-based approaches,[24] cultural responsiveness and trauma-informed care,[25] and the application of systems thinking[26] all hold promise for a more nuanced understanding of, and action on, public health improvement at local, national and global levels.

Language matters. How we communicate public health concepts influences how they are received, understood and acted upon. The COVID-19 pandemic has illustrated this splendidly.[27] This is at the core of recent research on public health framing, covering topics including obesity,[28] the social determinants of health[29] and alcohol consumption.[30] Consistent across the guidance is the avoidance of reinforcing the 'zombie hypothesis' that one's health is simply down to one's choices. We need to consciously reframe this narrative, which, as highlighted by Smith and colleagues, requires purposeful action by those working in health promotion.[17] Examples include challenging the dominant public discourse on personal responsibility; preferencing evidence that addresses the social, ecological, cultural and commercial determinants of health in health promotion planning and implementation; and contributing to the scholarly debate on this important topic. Avoiding the lazy language of lifestyles would be a good start.

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