Management of Health Risk Visibility and Construction of a Healthy Citizen

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SUMMARY

The article is a sociological discussion on mediated pervasiveness of health concern in contemporary society. Under the umbrella of the World Health Organization, which is one of the most influential health trend-setter organizations, health is nowadays treated as a matter of 'total well-being' – of both – an individual and a population. Positioned in the social constructionism reasoning, I suggest that public health authorities together with the mass media hold a central role in constituting identity of a 'healthy' citizen, which is closely linked to an idea of a good consumer – a consumer who is familiar with his/her private interests, consumer rights as well as obligations, and who is aware of the risks and gains of his/her consumption choices. These issues will be discussed on the Slovenian case. The trend in shaping the health risk agenda and the rise of mediatized health communication interventions will be demonstrated with the data gathered by mixing methods: descriptive quantitative research on 472 health communications interventions in Slovenia that have been financed by the state and implemented in the period from the independence of Slovenia in 1991 to 2003; and in-depth interviews with the main actors in health promotion activities in Slovenia.

Key words: health care, media influences, sociology of health, healthism, ideology of health, mediatization of health, Slovenia

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Introduction

It is a matter of great political concern, as we can nowadays read in public health programs (for example, WHO documents), that people live long and healthy life; only in this way can they fully participate in social activities and contribute to greater cultural and economical prosperity of a certain society. However, the main question is who and how deals with the need to achieve longer and more productive life of a population, how it manipulates social circumstances, calculates and manages pervasive risks, be it individual (for example, risky lifestyles) or environmental. Furthermore, how do the various social institutions and individuals interfere with, follow and shape, produce and reproduce modern health constraints and constitute health itself? And finally, how do they present the interests and justify activities in a way to be recognized as acceptable to the conditions of late modern society? For the late-modern, individualized subject (Giddens, 1991; Beck, 1992) and the political circumstances in which liberal principles proceed in the foreground, explicit health normalization is not admissible, just as the accenting of societal interests ahead of the interests of individuals is inadmissible for.

In the article following social constructionist reasoning (Burr, 1995; Lupton, 1999), I present the thesis of healthism and suggest that the public health authorities, together with the mass media, hold a central discursive[1] role in constituting the identity of a modern 'healthy' citizen. Furthermore, I suggest that construction of this identity is closely linked to an idea of a good consumer – a consumer who is familiar with his/her private interests, consumer rights as well as obligations, and who is aware of the risks and gains of his/her consumption choices.

I will support this thesis by presenting some of the data from the quantitative and qualitative research on public health communication in Slovenia[2] from 1991 to 2003 and discuss the public health authority's management of health risks visibility in Slovenia. The data will focus, firstly on the trend in shaping the health risk agenda in the country, secondly the rise of mediatized health communication interventions, and finally its discursive consequences.

Health crusade

Viewed from the perspective of various health advocates, for example, public health authorities, new health movements, advertisers, mass media, etc., health is not simply an opposition to ill-health, but it is rather

a process, a project that should be worked on all the time. The struggle over an all-inclusive definition of health becomes more and more evident, not least in the public health discourse of which the World Health Organization (WHO) is the leading steward. Health is constructed as an all-embracing benevolence, a goal in itself, and a process that is dependent on continuous measuring, monitoring and (self)controlling (WHO, 1981, 1996, 1997, 1999, 2001). In this way, health is constituted as a way of life or, according to Mechanic (1999: 713), as a form of behaviour that accompanies ordinary everyday activities. Crawford (1980: 380) even speaks of "super health", which includes the whole spectre of values: "a sense of happiness and purpose", "a high level of self-esteem", "work satisfaction", "ability to engage in creative expression", "capacity to function effectively under stress," ability "to celebrate one's life", etc.

A lot of research nowadays supports Crawford's idea of super health. According to a Slovenian public opinion survey, for example, health is becoming the highest value in ones life (Toš and Malnar, 2003). The same research shows that the majority of the respondents think that they care well for their health, but would be prepared to do even more for it. Similar findings of recent qualitative research on food scare in Slovenia (Tivadar and Kamin, 2002) show explicit worries concerning health and in particular the feeling of powerlessness in its management. People think that no matter how much they care for their health, they have the feeling of not doing enough for it. What makes people feel constantly guilty with regard to health? Why would they want to do more about health, if they think they already take good care of it?

The all-inclusive property of the health concept, which is proposed by health authorities and is more and more reflected in various areas of everyday life, could be emphasised with the statement that no area of everyday life remains unaffected by health. Considered in this way it is absolutely impossible for a person to manage all health dimensions of his life at all times.

Although differently conceptualised, health has been more or less a matter of consideration in all preceding societies (Turner, 2000; Lupton, 2000; Ule, 2003; Albrecht et al, 2000). Nevertheless, the concern with health issue has never before been so omnipresent as it is now on the individual and the societal level. The reason for such a high value attached to the body and health has to do with need for self-discipline and self-denial in difficult economic conditions and life in general (Crawford, 1993). Our bodies, in Crawford's opinion, are the final metaphor of the greater need for everyday struggle. There is nobody that one can rely on but one-

self. Therefore, one is supposed to unquestionably invest in health and by doing so invest in his or her future. Like all investments, also investment in health becomes constituted as one that could and should be maximized (Metcalfe, 1993; Crawford, 1980). As such, health is constructed as a possible place of constraint, as well as a space of self-realization.

Nowadays almost nobody dies simply of old age. People die due to injuries or diseases of some kind, and even old age itself has become a sort of disease that could be postponed if not cured (Bauman, 1992). From this perspective, people apparently gain power and hope to trick disease and overcome old age. But what they also gain is the notion that they are "constantly potentially ill" (Conevey, 2000: 123). In this respect, it is only a matter of time when one will fall from grace due to the lack of good will, emotional imbalance, irrational choice, lack of love towards life, etc., and suffer unhealthy (not normal) life and the dysfunction of one's body organs. This speaks of a modern phenomenon, which is in theory discussed as healthism and medicalization of everyday life (Zola, 1972; Illich, 1975; Crawford, 1980).

Crawford (1980: 368) understands healthism as "preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help /…/ solutions are seen to lie within the realm of individual choice." These choices are either right or wrong. They are right, if they are subordinated to medical authorities' recommendations and they are wrong, if they are not in accordance with the dominant demands. In this way, health discourse shapes good and bad identities: those who follow the norms and those who don't: responsible and irresponsible, beautiful and ugly; successful and unsuccessful, etc. Healthy identity is therefore identity that suits the dominant health discourse.

Healthism – the new (moralizing) ideology of health, 'ideally' bridges the gap between explicit collective health normalization, constraint and control on the one hand, and liberal, sovereign consumer choice and private interest on the other hand. Led by the authoritative and demanding voice of the medical discourse, spread as well as exploited by the mass media and other economic forces, healthism transforms the collective need and social obligation into individual interest and private responsibility (Crawford, 1980). In the ideology of health, taking care of his or her own health, an individual works for him/herself and his or her interests; and at the same time he/she fulfils social expectations of good

(healthy) citizenship (Kamin, 2004: 47), which is more and more treated from the perspective of consumption.

From the moment that health becomes understood as a by-product of ordinary everyday activities, health becomes widely opened to various spaces of consumption, beyond the services that are organized by the health care system and national public health system. It is true that 'health' is a very lively part of the contemporary policy debate. But since health is more and more considered as part of a lifestyle (and various consumption activities: eating, clothing, jogging, dwelling, etc.), health itself is an important economic field: for example for cosmetic industry, wellness centres, fitness industry, food industry, pharmaceutics industry, not least the media industry, social marketing communication agencies, etc. From an individual perspective, therefore, health could not only be achieved but could as well be consumed.

Mediatization of health

The mass media see themselves both as a mediator and a producer of "health". What started as a place for the dissemination of public health intervention messages, took on its own production life in the form of life-style and health journalism (Bunton, 1997; Kamin, 2004). By producing and/or disseminating various health messages, the media play integrative role between citizens-consumers, the state and industry: they connect information and interests surrounding health, which is more and more perceived as capital that an individual, social or economic body can and must possess.

When I use the term mediatization, I explicitly stress the role of the mass media in the process of mediation – "movement of meaning from one text to another, from one discourse to another, from one event to another. It involves the constant transformation of meanings, both large scale and small, significant and insignificant, as media text and texts about media circulate in writing, in speech and audiovisual forms, and as we, individually and collectively, directly and indirectly, contribute to their production" (Silverstone, 1999: 13).

Mediatization of contents in the first instance indisputably determines what knowledge is important for society and, consequently, what is on the other side of the perceived social reality and therefore 'unimportant.' In the broadest sense of the agenda setting model, mediatization speaks of the potential – what, to whom and in what form can something become visible. It speaks of power to legitimize certain themes, issues and the

ways of their discussion. In this respect, mediatization is connected to the "management of visibility" (Thompson, 1995). It acknowledges that the media are the fundamental generator of meaning networks to contemporary mankind (Thompson, 1995: 11; Beck, 1992; Giddens, 1991; Castells, 2000). Together with science, they are empowered to structure and disseminate knowledge (Beck, 1992: 23-46).

This is especially true of knowledge about health, which is inseparably connected to risk discourse. Evaluation of health risks is ever more dependent on scientific measurements and it represents 'real' dangers as well as a market niche, since bad news and negative research results about dangers tend to attract public attention. In this respect, Skolbekken (1995), for example, speaks of epidemical focus on risks in academic circles, Glassner (1999) writes on the role of journalism in (re)producing the culture of fear, and Castel (1991) acknowledges a misleading technocratic dream of absolute control of coincidences and dangers. There are differences between the terms 'risk' and 'danger', since they apply to different social situations. Danger means an event, which has happened (or not) independently of us. Risk includes the act of decision, in which, by proceeding to a certain aim, we knowingly take into account possible harmful consequences (Mali, 2002: 165).

In general, the mass media constitute a field where the agenda of 'relevant risk' or health issue is shaped, where the behaviours relevant to health is exposed, the meanings of health and illness are outlined, and a whole range of risks which individuals are supposed to calculate and be responsible for is communicated.

Many researchers have found effects of mediated health risks on the population's perceptions of health risks: Verbeke and others (1999); Chapman and Lupton (1994); Seale (2002); Tivadar and Kamin (2002); Johnson (1998); Gibney and others (1997); Robertson (1978); Brodie and others (1999) ascertain that the media, apart from the profession, are the main sources of health and risk information.

Information on health and risks is particularly attractive to the media industry itself. American studies show that among information programmes the audience chooses most frequently those contributions that deal with health issues (Johnson, 1998; Atkin and Walack, 1990). From this point of view, mediatization of health in the first instance is the managerial question of attracting the audiences and advertisers' money. In Slovenia there is a constantly growing offer of programmes, periodicals and media sections on health. Especially successful seem those that do not speak of ill-health and diseases, but rather teach you how to

achieve "super health" and how to keep your health and improve it (Kamin, 2004: 69).

One could distinguish between at least four types of mediated health production: health journalism (for instance, production of articles and other journalistic contributions on health problems and health care system), production of entertaining contents about health issues (for instance, movies and series on dramatic intrigues in health care, such as Emergency, Chicago Hope, Schwarzwaldklinik, etc.), production of infotainment on health issues (e.g., lifestyle journalism, production of soap-operas, etc.) and advertising which explicitly (e.g., public health interventions) or implicitly (facial cream for healthy looking skin; yogurt for healthy start of the day etc.) communicate health.

All types have grown in number in the last few decades. Analyzing the magazine Good Housekeeping from 1959 to 1995 Bunton (1997) recorded a three-time increase in the number of contributions connected to health. He also found a growth in number of advertisements that explicitly express the health value of advertised products, which are usually juxtaposed with symbols of discipline, happiness and profit.

There is a significant increase in public health communication interventions as well (Kamin, 2004), and the trend will probably continue, judging by the efforts of a vast number of theorists, researchers and practitioners to increase the effectiveness of health communication campaigns. Many people look for improvement in health communication interventions by hybridization of mediated health types; by integration of health information content into news and entertainment programming (Atkin et al, 1990, Wallack, 1990); and integration of health information from public health authorities into advertisements for various products.[3]

In what follows, I will introduce some data from the research on public health communication in Slovenia and discuss the public health authorities' management of health risk visibility in Slovenia.

Method

The research included public health authorities' communication interventions for health promotion implemented in the years from the declaration of independence of Slovenia in1991 to the end of September 2003, and were fully or partly financed by the Slovene government. The data were collected from September 2002 until September 2003. Our informants on communication interventions for health promotion were all the main agents who – in the mentioned period and under the mentioned

conditions – communicated healthy life contents. We surveyed 58 informants, includingly directors of advertising agencies, public relations people, heads of relevant civic associations and non-governmental organizations, representatives of the Institute of Public Health of the Republic of Slovenia and the Ministry of Health of the Republic of Slovenia. The Response rates were 74% for advertising and other marketing communication agencies and 46% for the governmental and non-governmental organizations and associations. The main unit for the analysis was the whole campaign for certain communication interventions, which were studied according to the following variables: performer of the communication intervention, organization placing an order for the communication intervention, the year of communication intervention, means of communication intervention, theme of communication intervention, title of communication intervention, and the main message of the communication intervention. In the final database we gathered 472 units of communication interventions for health promotion.

As a follow-up to the descriptive health communication interventions analysis, we conducted in-depth interviews with 6 main representatives of the health promotion activities. These were selected in such a way, that representatives of different actors (interest groups) in health communication interventions implementation were included: one representative from the Health Promotion Centre of the Institute of Public Health of the Republic of Slovenia; one from the Slovenian Ministry of Health; one from a regional Institute for Health Care; one from a pharmaceutical company implicitly related to public health promotion campaigns; two from marketing communications companies – one from an advertising agency that designed and implemented one of the biggest recent health promotion campaign in Slovenia and one from a smaller, 'freelance' marketing communicators participating in health communication interventions. The interviews with carefully selected respondents were conducted to better understand the insights of health communication intervention practice – from the point of view (and in the words) of actors in the health promotion process.

Health risk agenda

In Slovenia, the number of health communication interventions increased by 98% from 1991 to 2003. In the period of twelve years, have been implemented at least 472 health communication interventions, which addressed different health issues. We divided the main themes of

health communication interventions in Slovenia into 17 groups: AIDS, alcohol, smoking, recreation, cardiovascular diseases, cancer, other diseases, vaccination against diseases, healthy eating, stress, drugs, health education, Red Cross, blood donation, teeth, breastfeeding, healthy environment, and other. The health promotion themes that got most attention in the last twelve years were "injuries" (17,4%) and "cancer" (17,2%). They are followed by "vaccination" (12%), "smoking" (11,2%) and "AIDS" (10,8%). However, the themes were differently represented over time.

There is a constant trend of attention in the last twelve years on "injuries", "health education", "smoking" and "vaccination". We can notice an increase in attention on "alcohol", "drugs", "healthy eating", "cardio vascular diseases" and "recreation". These are the themes that increasingly interfere with the way of life of individuals since they address their lifestyles. Prioritization of such health themes stresses the power of an individual to avoid the main health risks and stay healthy. The collection of certain themes as such constructs health as being totally in the realm of an individual's will and responsibility.

The data also show the constant increase in the number of different health themes communicated each year. This helps construct the all-inclusive health concept, since there are more and more health risks communicated to the public. Among these, as noted before, especially those are increasing, which speak of an individual lifestyle and voluntary risk taking, ignoring advice from the health authorities. For example, in 1991 there were 3 main communicated themes in health communication interventions: AIDS (20%), vaccination (40%) and injuries (20%). In 1996 there were 9 main themes in health communication interventions: AIDS (23%), diseases (10%), vaccination against diseases (16%), breast feeding (3%) smoking (10%), injuries (19%), cancer (3%), cardiovascular health (3%) and stress (3%). In 2003 we can notice a further increase of the communicated themes in health communication interventions. The increase was especially marked in the following themes: alcohol consumption (23%), healthy eating (18%), physical activity (3%) and drugs (9%).

With the help of interviews we identified four reasons for a greater frequency of certain health themes: the ability of those who order health communication interventions to raise money, the epidemiological nature of certain health problems, the quickly visible results from the communication intervention, the financial support from pharmaceutical compa-

nies, health issues in European political and strategic context under the directions of the WHO.

Although the themes tackled by communication interventions construct the main health problems in a given country, these are not necessarily in accordance with the most urgent and 'real' health problems in that country. As one of the informants said:

"There is a difference between real health problems and potential health problems. If you are the one who raises money by applying for public tendencies, you know very well which need to apply under to convince the committee to give you the money."

Prioritised themes are therefore also a reflection of different power relations and the need of organizations – for their financial survival – to make their activities publicly visible.

The rise of mediatized health communication interventions

The health themes are communicated to the public by different means: through brochures, leaflets, posters, mass media, etc. In each health communication intervention there is one or a pack of media, which are used as a primary communication channel of the intervention. The use of the mass media for the primary communication channel in health communication interventions is increasing. Figure 1 shows of the distribution of traditional mass media (television, radio, newspapers, magazines, and big outdoor posters) over time. In 2003 more than half (55%) of all health communication interventions used the mass media as a primary communication channel. Communication interventions which use the mass media as a primary communication channel are usually more extensive and consequently more visible than the communication interventions that use other means for the primary communication channel, as for example brochures, posters, leaflets, etc. In this way, the themes, which are addressed via mediatized health communication interventions, are more exposed as primary health problems in the country.

One of the reasons for the increased use of the mass media in public health communication interventions is a common belief, revealed by the interviews, that what is not in the mass media, doesn't exist in the consciousness of the people. The following statements made by two of the interviewers support the agenda setting reasoning:

"Without the media you don't exist. We still don't use the media enough to open certain health themes in the public mind and make them interesting."

"In an informal research we asked youngsters, what they thought was most harmful to human health. We got answers such as drinking, smoking, drugs, and other themes that were the most prevalent health themes in the mass media."
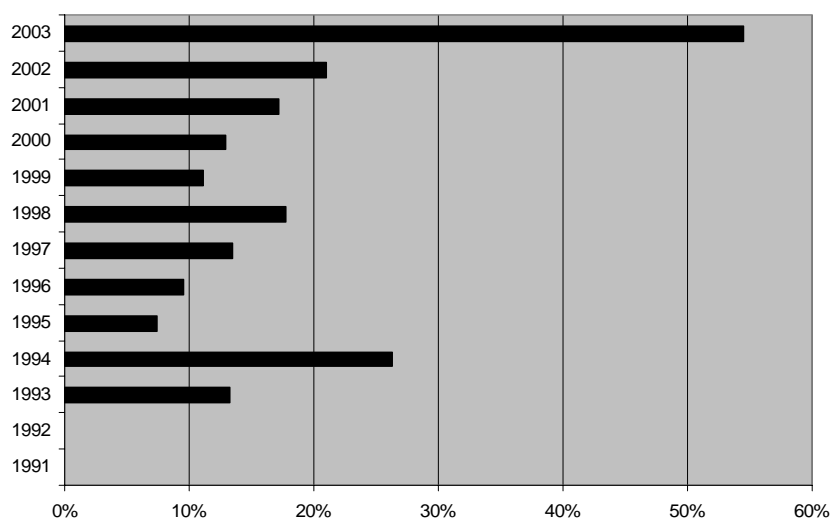

Figure 1: The increase of public health communication interventions in which the mass media were used as a primary communication channel (n=472)

Figure 2 shows the health themes that were communicated to the population in Slovenia by using the traditional mass media (such as television, radio, newspapers, magazines, and outdoor jumbo posters) for the primary communication channel in a particular health communication intervention. Until 1996, the most represented theme was "injuries" (labelled with trend 0). In the year 2003 the most covered themes were "alcohol consumption" (labelled with trend 1), "healthy eating" (trend 7) and "forbidden drugs" (trend 4). Other better represented themes over the years were "smoking" (trend 3), "cardiovascular health" (trend 6) and "vaccination" (trend 2). Label 8 represented a decreasing trend of attention to AIDS, label 9 represented communication regarding blood donation, and label 5 communication regarding the Red Cross. Recreation as a health communication intervention was represented in the mass media only in 1997 (20%).
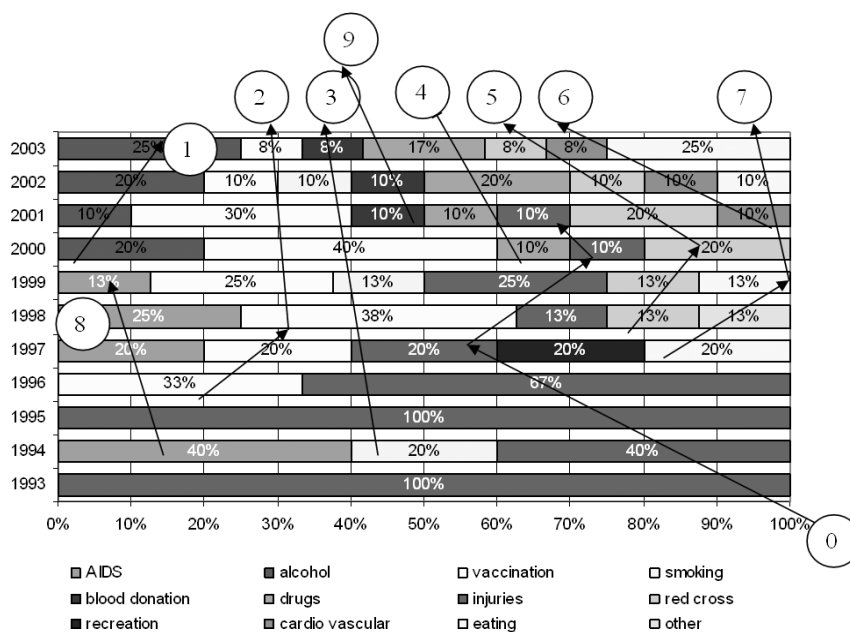
Figure 2: Distribution of the public health communication intervention themes in the cases when the primary communication channel of the intervention were the mass media

Besides explicit health communication interventions, public health authorities try very hard to enter the mass media in other forms. One of the greatest efforts is to get health themes in editorial contents. For this reasons public health authorities cooperate with their permanent, so called "health journalists." These are supposed to help them get the massage across the media efficiently and for free. For this reason, public health authorities prepare articles and expert opinion, together with journalists; they also prepare shows for radio and television, arrange interviews, and organize press conferences and pseudo events.

In general, the interviewers were quite satisfied with their relations with the media, but they expressed also some problems that they have with their negative news logic:

"I find a big problem in the fact that good news is not news for the media. Most of media are focused on revealing secrets and affairs. /.../ once, we had a seminar about the media and health promotion. The main discussion revolved around how to prepare news in such

88

ways to be interesting for the media. And this is difficult. For example, we can't get through a message about non-smoking, unless we don't mention at least 3500 dead each year."

This brings us to another issue regarding agenda setting, namely management of risk visibility. It concerns not only the frequency of a theme in the media but also the way the themes are presented. In other words, it doesn't only mater what themes are present in the media, but rather how they are present, what meanings of health they offer, how urgent they are, given the particular health risk, etc. These meanings could be analysed in different ways, one of them being the analysis of the appeals in the communication interventions.

Conversationalisation of public health discourse

In Slovenian health communication interventions, paternalistic and fear inducing appeals prevail. The right, healthy behaviour are mostly ordered, in an explicit or implicit way. "Don't be a fool, get vaccinated!" for vaccination against hepatitis B, "The decision is yours!" for stop smoking, "Aids doesn't choose, you can!" "Enjoy!" for eating fruit and vegetables. These are some of the appeals addressed to the population in the last few years. However, public health authorities are more and more thinking about speaking to the public in a more positive and playful way. The same is typical also of commercial advertising: "Healthy life" brand, "5 a day. Let's put some colours in our lives" for eating fruit and vegetables, "Health is basic. Start with your skin" for cosmetic products, etc.

Public health authorities increasingly make an effort to inform citizens about health issues in an impartial way, while at the same time their communication activity consists of 'effective' persuasion in order to achieve 'favoured behaviour'.

This raises the following dilemma: public health authorities often employ regulation strategies that are supposed to be perceived as consumer oriented, in terms of an offer without coercion. This is to say that individuals are instructed in a way that gives them a feeling of a free decision regarding whether or not to accept the recommended or advised health behaviour and whether or not to participate in risky behaviour. What is also given to the individuals in this way is the feeling of their own responsibility for their health.

The need to somehow disguise the 'obligation' and 'regulation' discourse by all means, even in the state regulating bodies, is connected with the "climate of consumer authority", or sovereignty (Heward, 1994; Fair-

clough, 1994; Keath et al, 1994, Slater, 1997). The dilemma that was mentioned above thus derives from a fusion of two different 'concepts of society' and approaches to the one and only task: 'health regulation'. The first concept is about citizenship and the idea of common good, and the second is about consumerism and the idea of the individual's take. This (con)fusion could be discussed also as a feature of the "sub-process" commodification of that Fairclough (1994) conceptualises as a "conversationalisation of public discourse".

Conclusion

Most of researchers note that people get much of their health information from the media. This information could be in the form of articles and other journalistic contributions to the discussion of health problems and health care system. These are followed by movies and serials on dramatic intrigues in health care, then by lifestyle magazines, soap operas and straight forward advertising for various healthy products and services.

A great amount of health information in the media is directed by the public health authorities. These are usually recognized by the public as health campaigns. However, explicit health campaigns are only one side of public health communication interventions; the rest take some other form of mediated health.

As our research indicates, public health authorities make an effort to cooperate with journalists who might translate the bureaucratic discourse into a more friendly journalistic, either informative or entertainment, type of mediated health. And the media welcome health contents since they realised, like all other industries, that health sells. The volume of editorial contents dealing explicitly with health, has – in Slovenia, like in other Western countries – significantly increased. There are several new magazines dealing with health or health and beauty, as well as new health supplements in national newspapers and there is more and more space for health topics in lifestyle magazines (Kamin, 2004: 69).

Therefore, when speaking about the management of health risk visibility, we should think of implicit and explicit mediated health communication. It needs to be noted that health communication is not always driven by the same interests. The pharmaceutical industry will communicate health with different interests than a local organic farm, and still different than the institute of public health and the mass media. The last is often geared to audience animation, which can lead to sensationalism and false health risks alarms.

90

Nevertheless, the public health authorities together with the mass media play the central role in the management of health risk visibility and in constituting the identity of a modern 'healthy' citizen. Among the most represented topics in health communication interventions and, consequently, among other mediated health contents, are increasingly those that address individual lifestyles. And since a lifestyle is distinctly connected to the processes of individualization and consumption, or the least consumption sphere in general, the idea of a healthy citizen is more and more related to an idea of a good consumer – one who is familiar with his/her private interests, consumer rights as well as obligations, and who is aware of the risks and gains of his/her consumption choices.

NOTES:

[1]   Discourse is a term that has not jet achieved general agreement on what it stands for. I understand discourse as a limited body of knowledge and the ways of its usage, recognized as particular comprehension of different phenomenon, their understanding through words, images and relations between them (more in Fairclough, 1995).

[2]   The research "Znanja, spretnosti in izkušnje na področju komuniciranja vsebin zdravega življenja" conducted by the research group at the Faculty of Social Sciences in Ljubljana and led by Zlatko Jančič, was financed by the Slovenian Ministry of Health and Ministry for Education, Science and Sport.

[3]   In the USA, the Federal Trade Commission has since 1984 "encouraged food producers to make health claims in their marketing campaigns as a way of communicating more health-related information to the consumer" (Novelli, 1990:80). Similar efforts are seen in Slovenia with one of the biggest retailer's advertisements for fruits and vegetables, which at the same time promote products and the importance of consuming fresh vegetables and fruits, using the same claims as public health authorities in their campaigns.

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Tanja Kamin

Upravljanje vidljivošću zdravstvenih rizika i stvaranje zdravoga građanina

SAŽETAK

Članak je sociološka rasprava o medijskom utjecaju na brigu o zdravlju u suvremenom društvu. Pod okriljem World Health Organization, jedne od najutjecajnijih zdravstvenih organizacija, zdravlje se danas tretira kao pitanje 'potpunog blagostanja' pojedinca i populacije. Sa stajališta socijalnog konstruktivizma, tvrdim da javni zdravstveni autoriteti i masovni mediji imaju ključnu ulogu u konstrukciji identiteta 'zdravog' građanina koji je usko povezan s idejom dobroga potrošača – potrošača koji poznaje svoje osobne interese, potrošačka prava i obveze i koji je svjestan rizika i dobiti koje proizlaze iz njegovih/njenih potrošačkih izbora. Ova pitanja su analizirana na primjeru Slovenije. Trend oblikovanja rasporeda zdravstvenih rizika i uspon medijaliziranih intervencija komuniciranjem o zdravlju bit će prikazan pomoću podataka prikupljenih različitim metodama: deskriptivnim kvantitativnim istraživanjem provedenim na 472 komunicirane zdravstvene intervencije u Sloveniji, koje je financirala država i provedene su nakon proglašenja slovenske neovisnosti od 1991. do 2003. godine, te iscrpnim intervjuima s glavnim čimbenicima promocije zdravstvenih aktivnosti u Sloveniji.

Ključne riječi: zdravstvena skrb, medijski utjecaji, sociologija zdravlja, zdravizam, ideologija zdravlja, medijalizacija zdravlja, Slovenija