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Understanding Health and Illness: An Investigation of New Zealand Television and Lay Accounts

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Darrin James Hodgetts

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Abstract

Within contemporary society, television is a prevalent source of health information. This thesis draws on insights from health psychology, media studies, and medical sociology to explore the ways that people of lower socio-economic status draw on television health coverage to construct their views on health and illness. Three primary data sets are used in an interrelated manner to investigate the complexities of this process. First, an analysis of four New Zealand health documentaries investigates the ways contemporary health concerns are covered on television. Second, an analysis of the accounts constructed in twenty individual interviews is used to explore participants' views on health, illness, and these same health concerns. Third, an analysis of four focus group discussions is used to investigate the processes through which participants construct interpretations of the health documentaries and reconstruct their views. Generally, findings indicate that the programmes, individual interviews, and focus group discussions function as cultural forums within which various shared explanations are drawn on in order to make sense of four contemporary health concerns: the health reforms, the privatisation of medical services, men's health, and aging. By exploring these processes, this thesis contributes to knowledge of the shape and focus of health coverage and the role of health communication in the refinement of lay views.

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List of Publications and Conference Papers

- Hodgetts, D. J. (1996). Audience interactions with television health (Conference paper). *Mediated Communication Symposium: Sociolinguistic Symposium 11*, Centre For Language and Communication Research, University of Cardiff, Wales.
- Hodgetts, D. J. (1997). Media and lay narratives of health and illness: A multi-disciplinary approach. *Qualitative Health and Disabilities Conference: Book of Proceedings* (pp. 1-8). Taradale, New Zealand: Eastern Institute of Technology.
- Hodgetts, D. J., & Chamberlain, K. (1999). Medicalization and the depiction of lay people in television health documentary. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 3 (3), 319-335.
- Hodgetts, D., & Chamberlain, K. (in press). The social negotiation of people's views on the causes of illness. *Journal of Health Psychology*.
- Hodgetts, D. J., Chamberlain, K., & Cullen, A. (in press). The role of television health coverage in the construction of people's views on contemporary health concerns. *The Bulletin of the New Zealand Psychological Society*.
- Hodgetts, D., Chamberlain, K., & Hodgetts, I. (1999). The social negotiation of people's views of illness: How is cause assigned? (Conference Paper). *Reconstructing Health Psychology: Critical and Qualitative Approaches*, 29-31 July 1999, St Johns, Newfoundland, Canada.
- Hodgetts, D. J., & Martin, M. (1998). Documenting disease: An analysis of 'epidemic emergency' (Conference Paper). *Fifth New Zealand Health Psychology Conference*, 18-20 February, Okoroire, New Zealand.

Chapter One

Overview

People voice views about a range of health and illness concerns, such as how we ward off illnesses, catch colds, or remedy a fever. One might ask where these views come from and how they are constructed. Part of the answer lies in New Zealanders' being surrounded by health and illness stories emanating from interpersonal sources and a range of media including television. Although health stories appear regularly in newspapers and on the radio, no medium is as central to contemporary life as television. Television broadcasts stories about the latest breakthroughs in medicine, dietary trends, and changes in the health system, and how they impact on New Zealanders. Viewing such stories has become a means by which we relate our experiences to wider social concerns. Programmes function as resources which provide us with convenient summaries for making sense of health, and illness, and their place in the world.

This thesis proposes that our conceptualisations of health and illness are constructed over the course of our lives through interactions with television programmes and other people. In making sense of health and illness we appropriate ideas from television health coverage, and the accounts expressed by family members and health professionals, and tailor these ideas for our own purposes. Elements from these sources are woven together to create a person's view on health concerns. These views are made up of a range of socio-cultural explanations, which constitute common ways of understanding and thinking about health and illness.

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Clearly, there is a diverse array of television programmes providing explanations of various health concerns. There is also a range of audiences or interpretative communities making sense of these programmes. It is not possible to cover this diversity in programmes and audiences in adequate depth within a single thesis. Therefore, the ways people of lower socio-economic status (SES) actively draw on their views when interpreting contemporary New Zealand health documentaries are explored. This audience was selected because it is one I am familiar with, have access to, whose views are both under-valued and under-represented in health research, and who face persistent inequalities in health. Health documentaries were selected because of their factual status and long history as a source of health information in New Zealand. Key questions include: What explanations and solutions do the documentaries offer for the health concerns covered? What processes are involved in the integration of aspects of such coverage into people's views on these same concerns? And, at a wider level, what can this tell us about the social character of human thinking about health and illness?

For a thesis focusing on the explanations circulated via television and the interpretations viewers construct, it was necessary to draw on theory and research from a range of social science disciplines, including psychology, media studies, and medical sociology. With notable exceptions previous television research across such social sciences has tended to focus either on the context in which a programme is made, the resulting programme, or analysis of audience reception. Contextual and programme analysis, in isolation, cannot account for the audience; and audience research, without consideration for how an issue is covered or the wider historical context in which mass communication occurs, cannot adequately explain the interpretations viewers produce. This thesis investigates the coverage provided by four health documentaries, the views voiced in 20 individual

interviews, and the re-negotiation of these views when the 20 participants take part in one of four focus group discussions.

The health communication process explored in this thesis is inherently socially located. Therefore it is not adequate to analyse health documentary coverage and viewer interpretations without considering the social context within which they are constructed. Chapter Two provides a critical overview of health in New Zealand in the 1990s. It describes the context and provides a brief introduction to health inequalities, contemporary professional approaches to health and illness, social structures for the provision of care, and television's role in the construction of people's views.

The next three chapters provide the theoretical groundwork for the thesis and the integration of the health documentaries, individual interviews, and focus groups. An overview of the structure, origins, and focus of the contemporary New Zealand health documentary is presented in Chapter Three. Also explored are the ways health documentaries construct perspectives on health concerns and what previous research has identified as the health agenda on television. In Chapter Four approaches to investigating television reception are critically reviewed. Reception research is categorised into three approaches: effects, uses and gratifications, and influences. This categorisation is based on the level of audience activity and the level of television impact assumed. Chapters Three and Four set the foundations for Chapter Five, which outlines the theoretical stance used to explore the influence of health documentary coverage on people's views. Particular attention is given to the role of lay people in the social negotiation of health and illness and television viewing as a social interaction within which people negotiate their views.

Chapters Three, Four, and Five focus on a range of theoretical issues while Chapter Six outlines how the research was implemented. The

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research design encompassed four research groups, each made up of five participants. Members of each group took part in an individual interview, followed by a group screening of one of the four documentaries and a focus group discussion around that programme. As a result each programme was discussed by one of the research groups. Chapter Six includes a summary of the processes involved in selecting the four programmes from all available New Zealand health documentaries, in conducting the 20 individual interviews, and in conducting the four focus group discussions. Attention is also given to the purpose served by each corpus and the analysis and integration of the three corpora.

Subsequently, three chapters present the analysis of the three data sets. Analysis of the scope and shape of the coverage provided by the four health documentaries and the ways concerns are worked through is the focus of Chapter Seven. Each health documentary is approached as a mediated interpretation of a given health concern. This analysis anticipates the ways the audience is likely to interpret these mediated expositions. However, the results from such an analysis need to be related to actual viewer interpretations because there are likely to be points of divergence between a programme analysis and the interpretations constructed by the participants. This divergence should not be surprising given differences in conceptual resources drawn on by the participants. However, before exploring actual viewer interpretations of the four programmes, there was a need to explore the symbolic repertoires used by the participants in constructing their views. Chapter Eight presents an analysis of the views voiced by the participants when making sense of health and illness, and the specific concerns covered in the health documentaries. These repertoires constitute part of the background the participants drew on to interpret the programmes. Analysis of the individual interviews is also used to highlight salience and divergence between health coverage and lay views prior to the focus group discussions. In Chapter Nine an analysis of the interpretations

that participants express after viewing the health documentaries is presented. One goal of the audience component is to highlight the negotiated character of people's views. The focus group situation is designed to simulate everyday interactions in which people draw on their own experiences and conceptual resources to formulate, share, and negotiate their views on the concerns depicted in the programmes. Chapter Nine links the analysis of the health documentaries and the individual interviews with the participants' discussions of the programmes. The ways health documentary coverage is related to the participants' own experiences is a central concern, as are the participants' ideas about the adequacy of the coverage provided and views on the health communication process.

The thesis is completed in Chapter Ten with a general discussion of the main findings and the contribution made to academic knowledge. It is proposed that this research has contributed to health psychology and the recent focus on lay beliefs, as well as providing insights for health and media psychologists, public health practitioners, and social scientists interested in the health communication process. Chapter Ten revisits issues around the complex nature of health communication. The range of influences involved in the continued re-construction of health and illness in everyday social interactions are also discussed. From conducting this research a number of lessons have been learned. These lessons and recommendations for future research are also outlined.

Chapter Two

Setting the Context

This thesis investigates the ways people of lower SES actively draw on various health and illness explanations when interpreting health documentaries and constructing their views on health and illness and their place in the world. These views reflect the historical context within which people live and various social structures, institutions, and professional practices that have a bearing on the ways health and illness are conceptualised and addressed. If people's views are to be adequately understood then a discussion of the wider social context within which health communication occurs is necessary. Such a discussion is particularly important because this research was conducted during a period of social change that has been associated with negative health outcomes and increased social vulnerability and pessimism among lower SES groups (Paul, 1999).

Over the last two decades New Zealand has undergone dramatic social and economic change, resulting from public sector reforms. These reforms involve an emphasis on efficiency, financial restraint, and economic competition, which has led to increased inequalities in employment, education, and health, and reduced income levels for many New Zealanders (Cheyne, O'Brien & Belgrave, 1997). The 1990s have seen increased relative deprivation due to high rates of unemployment, benefit cuts, rising living costs, and static wage levels. The type of reforms evident in New Zealand have been linked internationally to the increased prevalence of a range of negative health outcomes, including respiratory diseases, infections, accidents, cancers, and cardiovascular diseases (Beaglehole &

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Bonita, 1997; Wilkinson, 1996). Stephens and Waldegrave have noted that in New Zealand, "Recent health reports indicate an increased incidence of poverty-related diseases such as tuberculosis, infant mortality, rheumatic fever, meningococcal disease, asthma, glue ear and iron-deficient anemia" (1997, p.105). The increasing prevalence of such ailments reflects a combination of health determinants, including inadequate living conditions and reduced access to health services, due to persistent financial barriers (*cf.* Howden-Chapman & Cram, 1998; Saunders, 1996; St John, 1996; Woodward & Kawachi, 1998).

It is no longer a startling revelation that the poorest members of a society such as ours are those who generally suffer more from ill health (*cf.* Beaglehole & Bonita, 1997; Bury, 1997; Davey Smith & Morris, 1994; Wilkinson, 1996). The lower one's SES, the more likely one is to have serious accidents, contract various illnesses, and die younger (Stainton Rogers, 1991). The most common causes of death in New Zealand - cancer, cardiovascular disease, respiratory conditions, and injuries - are most sensitive to SES (Woodward & Kawachi, 1998). That is, the more economically disadvantaged a person, the more likely they are to suffer from such ailments. Therefore, as the number of disadvantaged increases so does the incidence of such ailments (Wilkinson, 1996). In brief, a shortage of money can lead to a stressful existence and a lack of the basic necessities of life, which contributes to ill health (Malcolm, 1996; Saunders, 1996).

The influence of material inequity on health status has been reported at least since the industrial revolution (Engels, 1844). Last century it was proposed that bodies actively resisted disease but could be rendered more vulnerable by adverse circumstances such as poor housing, work environments, and nutrition (Berliner & Salmon, 1980; White, 1994). However, there remains much academic debate over the primary causes of

inequalities in health. Of particular note is whether health inequalities result from social selection, where weaker members of society somehow gravitate to the bottom of the socio-economic ladder, or whether health inequalities result from structural inequity (*cf.* Bury, 1997; Popay & Williams, 1996; Wilkinson, 1996). A growing consensus among social scientists is that health inequalities are the product of social, material, and structural inequalities, as well as individual lifestyle behaviours and perceptions (Bolam, Murphy, Gleeson & Hodgetts, 1999; Woodward & Kawachi, 1998).

This thesis is not concerned primarily with establishing causal pathways for health inequalities, but with the social construction of health and illness. However, an important consideration is that adverse material conditions have been found to act upon health in combination with an individual's understanding of their situation and feelings of social connectedness (Beaglehole & Bonita, 1997; Blaxter, 1990, 1997; Howden-Chapman & Cram, 1998; Wilkinson, 1996). The meanings people assign to their circumstances and health are an important consideration if we are to develop our understanding of the relationship between social circumstances and health inequalities (Blaxter, 1997; Bury, 1997; Popay & Williams, 1996). Yet to date the views of people of lower SES have received surprisingly sporadic attention (Blaxter, 1997; Chamberlain, 1997; Popay & Williams, 1996).

In exploring the social construction of the views of those facing material inequity, it is worth noting that the relationship between social and health inequalities is associated with a range of socio-demographic positionings such as gender and ethnicity (Bury, 1997; Howden-Chapman & Cram, 1998). For instance, there is a high proportion of Maori and Pacific Island people in the lower socio-economic sector of New Zealand society. Such social positioning is accompanied by high rates of morbidity and mortality amongst these groups. In addition to Western models of health and illness,

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members of such groups often hold distinctive ideas derived from traditional indigenous models that generally encompass a universal perspective on health which includes the individual, the group, environmental concerns, and spirituality (Durie, 1985, 1995; Howden-Chapman & Cram, 1998). An adequate exploration of such models constitutes a thesis in itself and is beyond the present scope. The focus here is on key ideas associated with western approaches to health and illness that have a general influence in shaping health coverage and the views of New Zealanders.

In exploring people's views one needs to emphasise that these views are not constructed in isolation from professional models and practice (Williams & Popay, 1994). In New Zealand society there is a range of professional models of health and illness (Beaglehole & Bonita, 1994, 1997) that contribute to the provision of health care services, the scope and shape of health coverage, and the ways people makes sense of health, illness, and their own place in the world. Various professional models and theories can be grouped, for explanatory purposes, into three broad approaches to health and illness: the medical, the lifestyle, and the socio-structural. Such a categorisation enables the exploration of the ways biological, agentive, and structural dimensions of illness are rendered meaningful, and the ways professional thought is drawn on in the social construction of both health and illness. Here the term approach is used to designate a general orientation, framework, or field of knowledge and practice. The three approaches constitute general frameworks for thinking about and addressing health and illness that are manifested in social institutions such as the hospital, the fitness centre, and state housing. These three approaches have also been found to shape the ways cause is assigned to specific ailments within health coverage (Clarke, 1991).

The first section of this chapter provides a discussion of these approaches as a way of establishing some key assumptions that have influenced the

relationship between the public and health care providers, the provision of health care services, the shape and scope of health coverage, and people's views on health and illness and their place in society. In the second section, attention is given to changes in the provision of health care which have been highly prevalent in health coverage throughout the 1990s and reflect wider social shifts that challenge the people of lower SES ability to access care and live happy, productive lives. The final section initiates a discussion of television's role in providing coverage of such events and influencing the scope and focus of people's views on such matters.

2.1 Approaches to Health and Illness

Constructing a path through the complexity of ideas and practical initiatives relating to health and illness is a challenging task that by necessity will result in simplification and omissions. However, categorising professional thought according to three approaches provides one way forward that allows for a consideration of the biological, agentive, and social aspects of health and illness. The medical, lifestyle, and socio-structural approaches can be differentiated according to where the cause of illness is attributed. In the medical approach disease is primarily attributed to biological pathogens that invade an individual's body. The focus is on the biological basis of disease and the restoration of 'normal' bodily functions. In the lifestyle approach many explanations from the medical approach are combined with ideas from holistic traditions dating back to the Greeks to conceptualise illness as being the result of an unhealthy lifestyle. Here the primary focus is shifted from remedying biological conditions to preventing illness through encouraging people to partake in health-enhancing behaviours. Illness is often attributed to individuals' engaging in 'unhealthy' behaviour. In the socio-structural approach the cause of illness is attributed primarily to social inequalities. The focus is on social policy interventions aimed at ensuring the provision of social justice. In essence, the first two

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approaches are concerned primarily with the individual while the third is concerned primarily with social structures.

Aspects of these three approaches are formally stated in theories of the cause of illness (Beaglehole & Bonita, 1994, 1997). However, this discussion is not intended as a detailed investigation of the historical origins of professional models of health and illness or theories of disease causation. Such investigations are beyond the present scope and already exist in the international literature (e.g., Armstrong, 1993; Bury, 1997; Cartwright, 1968; Coward, 1993; Davis & George, 1988; Lupton, 1994; Porter, 1985, 1996; Wear, 1992). This discussion provides a critical introduction to some key ideas, basic premises, and implications of the three approaches to health. In doing so it highlights the complex, contradictory, and socially contested character of this sphere of human experience. Each approach is discussed in turn but it should be noted that the three approaches overlap, are not static, and often can be identified within the same health initiative, television programme, or person's account. For instance, a public hospital is the product of both the medical and socio-structural approaches.

2.1.1 The Medical Approach

The medical approach remains the predominant approach to health care in New Zealand. This dominance over the practice and economic base of health care was initially cemented in with the passing of the Medical Practitioners Act in 1867. This act set out practitioner licensing rules and provided a legal basis for doctors' dominance over the official provision of health care. In discussing such dominance by the medical profession, as part of her analysis of New Zealand health care provisions, Finlayson states:

They [doctors] influenced the beliefs and practices of the people about health and illness and the appropriate methods and places of treatment. With their professionalisation doctors were able successfully to eliminate competition and create a medical monopoly. Medicine became an exclusive and protected profession (1996, p. 74).

The influence of the medical approach is reflected in a number of social institutions that we take for granted today, in particular the hospital.

Generally, the medical approach is referred to as the orthodox Western form of curative care. Within this approach, attention is primarily given to identifying the biological cause of a disease and the development and use of interventions designed to restore 'normal' or 'healthy' bodily functioning (*cf.* Muller & Koenig, 1988). Curtis and Taket (1996) identify a set of assumptions inherent in the medical approach. Firstly, there is a 'normal' state of biological functioning from which disease is a deviation. Secondly, disease is generic in nature, so that across contexts a specific disease will have the same symptoms. Finally, diseases have a specific aetiology, where a distinctive micro-organism is perceived to cause a specific disease. Diseases are primarily conceptualised in a way that renders them amenable to remedy via technological interventions (Mechanic, 1995). Problems are treated primarily at an individual, biological level, and as a result only limited attention is given to wider political, social, and economic influences (*cf.* Karpf, 1988; Salmond, Mooney & Laugesen, 1988).

Although undoubtedly contributing to the treatment of degenerative diseases such as cancer and heart disease, and eliminating or minimising the symptoms of a range of ailments, the medical approach has been criticised for its restricted focus. Since the 1970s growing discontent with the medical approach has been reported (Berliner & Salmon, 1980; Elston, 1991; Williams & Calnan, 1996). Critiques have come from both the left and right of the political spectrum. Those on the left have emphasised

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negative aspects of practitioners' power over patients, the lack of attention they give to social factors, and a lack of accountability. Those on the right have emphasised the increasing costs of treatments, a lack of demonstrated benefit, limited consumer choice, and a lack of accountability. The failure of the medical approach to adequately deal with chronic illness and the financial pressures placed on health care budgets owing to the continued development of medical technology have provided the context for increased emphasis on prevention rather than cure. Such developments are influenced by an array of social factors, such as the aging of the population, increased demands on the health care budget, and the prominence of individualistic ideologies. The impact of such social factors on the shape and focus of the medical approach and its relationship to the patient and lay thought requires some mention.

Critiques of the medical approach led to renewed interest in more holistic models of treatment which has been associated with the rise of private providers and consumer-oriented health care provisions (Coward, 1993; Saks, 1994; Sharma, 1996). Holistic models of health predate the rise of the doctor and the medical approach and became 'alternatives' when the medical approach became dominant (Porter, 1985). Contemporary manifestations of so-called 'alternative medicine' date back to the ancient Greeks and focus on the whole person through the balancing of energies. The individual is held to be responsible for working to obtain a state of 'well-being' or 'balance' (Coward, 1993). People are encouraged to dedicate themselves to promoting and maintaining their health by looking after themselves through natural methods such as the ingestion of dietary supplements. Such beliefs are evident in the contemporary emphasis on individual choice, self-reliance, responsibility, and the increased availability of an array of health products. However, before discussing the lifestyle approach, which reflects such developments, it is pertinent to briefly explore the ways renewed interest in holistic models has widened the treatment

options and focus of the medical profession and doctors' influence over more of human existence (*cf.* Crawford, 1980).

Holistic models may be less at odds with orthodox medicine than one might expect (*cf.* Coward, 1993; Crawford, 1980). In recent years doctors have become more accepting of and more willing to refer patients to 'alternative therapists', if not using 'alternative methods' themselves (Saks, 1994). Orthodox medicine and so-called alternative medicine are often combined within the existing medical system. Many alternative treatments such as acupuncture, chiropractic, hypnotism, and therapeutic massage are now referred to as 'complementary treatments' (Coward, 1993; Saks, 1994). As a reflection of these developments, many doctors now stress the need for a more holistic perspective in the form of a balanced diet, regular exercise, and the avoidance of stress (Bury, 1997; Karpf, 1988). This is an example of the expansion of the medical approach to accommodate critiques and competing explanations.

Traditionally, the medical approach was based on a notion of disease which does not completely encapsulate people's experiences of being sick. With the re-emergence of holistic models, the medical approach has moved towards taking illness as the experience of disease into account (Williams & Popay, 1994). An emphasis on treating the person, not just the disease, has enabled doctors to address a wider range of human phenomena that were previously seen as non-medical concerns (Crawford, 1980). This process is often referred to as 'medicalization'. Medical ways of thinking about health are no longer restricted to institutions such as the hospital but now extend to the practices of everyday life (*cf.* Crawford, 1980; Zola, 1972). Medical ideas about appropriate actions to minimise risks to one's health and detect and remedy diseases have been found to shape lay views. They have encouraged people to draw on medical explanations to categorise and treat illness at an individual level.

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The assertion that the medical approach has considerable influence over how people perceive health and illness need not be expressed in an overly deterministic manner. Being overly deterministic about such influences can lead to the assumption that the evil medical empire is colonising the consciousness of helpless lay people. Such deterministic assumptions about public dependence on the medical approach have been questioned in recent years because of the neglect of the 'active' role of lay people in constructing various views on health and illness and not just passively accepting medical explanations (*cf.* Conrad & Schneider, 1980; Elston, 1991; Williams & Calnan, 1996). The relationship between lay people and the medical approach is far more complex and, in some instances, less 'dependent' than is often assumed. People do not simply subjugate themselves to medical authority and in many cases they negotiate a relationship with medical and other practitioners that suits their personal needs.

Expansions in treatment options, increased public dissemination of medical knowledge, and an emphasis on individual responsibility have been associated with the rise of the health consumer (Elston, 1991). As consumers, people are expected to be active participants in their health who shop around for the best deal and choose the treatment option most suited to them. Recent research indicates that the passive patient, who unquestioningly complies with the doctor's instructions, is being displaced by the active consumer, who is at times critical of medicine (Elston, 1991; Kearns & Barnett, 1997; Lupton, 1997; Williams & Calnan, 1996). This is not to say that lay people are no longer dependent on the medical approach for understanding disease and remedying ailments, but that people may be becoming more critical than they once were.

In fact, it is difficult to maintain a strict distinction between the passive patient and the active consumer when discussing the medical approach. Research indicates that people can oscillate between supporting and criticising aspects of the medical approach (Calnan & Williams, 1992; Lupton, 1997; Williams & Calnan, 1996). People can be critical of some aspects of the medical approach, such as an over-reliance on drug treatments, while maintaining faith in the benefits of medical care more generally (Bury, 1997; Calnan & Williams, 1992, Lupton, 1997; Williams & Calnan, 1996). Depending on the context, people can adopt both passive patient and active consumer stances in various ways (*cf.* Lupton, 1997).

Although recent research has demonstrated that lay people can be critical of aspects of the medical approach, it is premature to generalise from the existence of some criticisms that there is a widespread erosion of medical legitimacy or patient dependence (Elston, 1991). What is evident is that the relationship between doctors and lay people is more complex than has been assumed (*cf.* Zola, 1972). From the late 1970s a more contractual model of interaction between many doctors and patients has been developed due to critiques of the medical approach and a shift in the incidence of ailments from acute to chronic conditions, which reflects, in part, an aging population (*cf.* Beaglehole & Bonita, 1997; Bury, 1997). Treatment of chronic illness often requires the active cooperation of patients, for example, to take their medication unsupervised. This necessity may partially explain the rise of the health consumer who, despite being encouraged to choose between health care professionals, is still more often than not dependent on medical care. The rise of the health consumer is also indicative of the influence of developments in the lifestyle approach. This consumer is encouraged to be health-conscious and to engage in health-enhancing behaviours in order to both prevent illness and aid recovery (*cf.* Crawford, 1980, 1994; Glassner, 1989).

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2.1.2 The Lifestyle Approach

In recent years the lifestyle approach, developed out of a combination of aspects of orthodox medicine and various holistic models, has gained increased prominence, as is evident in the attention given to behaviour change in contemporary public health initiatives (Atkin & Wallack, 1990; Davison, Frankel & Smith, 1992). This approach places considerable responsibility for maintaining health and preventing or recovering from illness with health consumers (Coward, 1993; Crawford, 1980). It emphasises the need for individuals to eat a 'healthy' diet, engage in regular exercise, and refrain from excesses in life such as heavy alcohol consumption. The focus is on the virtues of living a balanced, controlled and generally healthy lifestyle. This approach encompasses what are often referred to as the behavioural or cultural explanations of health inequalities, which focus on the aspects of a person's health-related behaviours that contribute to the incidence of illness among lower SES groups (*cf.* Macintyre, 1997). It is assumed that, if people are educated about the unhealthy aspects of their lives, they will change their ways by making healthy choices and thus preserve their health.

In a somewhat uneasy alliance, health professionals, politicians, government bureaucrats, and academics in many Western countries have promoted the lifestyle approach through the media as a means of preventing illness. This approach is prominent in attempts to control health care spending and the proliferation of expensive technological treatments resulting from the predominance of the medical approach (Upton, 1991). As an alternative to expensive medical interventions emphasis is placed on the prevention of illness and the maintenance of health through behaviour change. Such developments also reflect the rise of individualistic ideologies since the late 1970s, where responsibility for ensuring health and preventing illness is placed primarily with each of us (*cf.* Bury, 1997;

Davison et al., 1992; Research Unit in Health and Behavior Change [RUHBC], 1989).

Although both the medical and lifestyle approaches focus on the individual, the lifestyle approach reflects a shift in thinking from the medical approach. The medical approach distinguishes between the person and the disease and assigns responsibility for disease to an external causal agent, not the person. With the shift from cure to prevention evident in the development of the lifestyle approach, emphasis is placed on the person's actions as the cause of illness. People are encouraged to think about health in individualistic terms, where the individual is the cause and potential remedy for illness (Tulloch & Lupton, 1997). Illness is seen as primarily the result of individual choices and behaviours. For instance, heart disease is conceptualised as a result of smoking and alcohol consumption, chosen behaviours that are identified as primary risk factors (Peterson & Lupton, 1996). If it is assumed that an individual's behaviour is the primary cause of illness, then it follows that the individual should take responsibility and change his or her ways. All that is needed for the health status of the population to be improved is for each of us to gain some self-control over our lives and exercise more personal restraint (Crawford, 1980).

As a result of this individualistic focus, the lifestyle approach has been subjected to considerable criticism (e.g., O'Brien, 1994; Waitzkin, 1989; Wallack, 1990). Clearly, a person's behaviour has a bearing on their health (Beaglehole & Bonita, 1997), yet the focus on individual behaviour and risk factors as a preventative strategy is severely limited (McGee & Elwood, 1994; Wallack, 1990). Behavioural risk factors explain only a small proportion of the cause of conditions such as heart disease. Even if all such risk factors were eliminated, heart disease would still remain the most likely cause of death in the Western world (Wilkinson, 1996). Social pressures and inequalities appear to be more important. Material

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constraints such as an inability to pay for an adequate diet, poor housing conditions, adverse work and life pressures, and general insecurity must not be overlooked (RUHBC, 1989). However, such contextual influences are all but ignored within the lifestyle approach owing to its individualistic focus. Attention is directed to behavioural change through people accepting their responsibility. As a result collective and political conceptualisations can be marginalised (O'Brien, 1994). Individualism becomes central to notions of health, while social factors are less prominent (*cf.* Waitzkin, 1989). In short, as a result of the focus on individual responsibility, health is decontextualised and solutions for illness are presented devoid of context or people's social circumstances.

The individualistic focus of the lifestyle approach is problematic because it absolves the social structure of responsibility. This approach can lead to the individual being conceptualised as an overly autonomous consumer who is in control of his or her lifestyle and functions somewhat independently of society. Such a conceptualisation may be used to further adjust people to a social system which is increasingly maladjusted to many members of society. A narrow focus on promoting a healthy lifestyle may do little to alleviate socio-economic inequalities that led to health inequalities (Coward, 1993; Wallack, 1990; Wilkinson, 1996). For instance, a person's alcohol consumption may contribute to the onset of cancer, but researchers need to ask why some sectors of society engage in such behaviours more than others. What is it about such people's lives which encourages them to abuse such substances? Explaining excessive alcohol consumption amongst young working class men may go some way towards accounting for the strong relationship between income distribution, cirrhosis, chronic liver disease, and car accidents (Wilkinson, 1996). Kieger, Rowley, Herman, Avery, and Phillips write:

To understand and ultimately prevent inequalities in health associated with social inequalities, we must be guided by the "why" questions of explaining population patterns of disease

causation... If our goal is to alter the web rather than merely break its strands, it is time to look for the spider (1993, p. 109).

This statement by Krieger and colleagues reflects the wider recognition of the complex and socially determined character of health among many health professionals, including health psychologists, epidemiologists, sociologists, nursing professionals, and many doctors (Spicer, Trlin & Walton, 1994). However, health interventions are still aimed primarily at individual behaviour change and curative treatments. Such interventions are based on the belief that informed choices can be made from the dissemination of knowledge about what constitutes healthy and unhealthy behaviour (Stevens, 1993). This may be due, in part, to the individual responsibility rhetoric dominating political circles, which identifies individual behaviour as the prime cause of illness, the key to prevention, and the primary means of health maintenance (Crawford, 1994; RUHBC, 1989).

2.1.3 The Socio-structural Approach

Although the medical and lifestyle approaches held centre stage when this research was conducted, the socio-structural approach was also evident. Unlike the medical and lifestyle approaches, the socio-structural approach places primary responsibility for ill health with structural factors such as income levels, general living and social conditions, and social fragmentation and stress (Bennett & Murphy, 1997; Bury, 1997). It proposes that, although individuals bear disease, in many respects the incidence of disease and responses to it are social in origin and influenced by one's life chances. The socio-structural approach emphasises that by relying on individualistic ideologies governments often do not pay enough attention to social factors (Beaglehole & Bonita, 1994).

This approach was initially associated with the work of Engels (1844) and was developed in opposition to the medical approach. Emphasis is placed

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on communal as opposed to individual responsibility and interventions are directed at the structural rather than the individual level (Cheyne et al., 1997). Drawing on aspects of this approach, Wilkinson (1996) points out that illness is a social product and that, “the development of effective forms of prevention means understanding how social and economic structures impinge on people and what kinds of policies might be beneficial” (1996, p. 14). Social reform and the provision of resources to lower SES groups is targeted as a means of increasing equity and as a result reducing health inequalities (*cf.* Woodward & Kawachi, 1998).

The socio-structural approach is important because it highlights the impact of the social context on people’s health. However, it has been criticised for focusing exclusively on structural factors and not giving adequate attention to the role of individual agency (Beaglehole & Bonita, 1997; Bury, 1997). Within the socio-structural approach, the individual is often presented as a ‘victim’ of society and circumstance, rather than an active participant in his or her health. As a result, this approach can lead to an overly deterministic perspective, where the role of the individual is neglected (*cf.* Bury, 1997; Wilkinson, 1996). This is the opposite problem to the lifestyle approach where the focus on the individual as an autonomous consumer leads to the neglect of social circumstances. In short, the socio-structural approach cannot fully account for health inequalities because it does not adequately explain a person’s health-related actions (Elstad, 1998).

The socio-structural approach was influential in the development of the welfare state, providing universal access to health care and a range of public health initiatives (Cheyne et al., 1997). Furthermore, over the last 150 years public health practitioners, working from primarily this model, have contributed significantly to improving the population’s health and addressing the material conditions brought about by social inequality. Yet the socio-structural approach was less prominent in government circles at

the time when this research was conducted because the focus on communal responsibility conflicted with individualistic ideologies driving public policy.

There appears to be a resurgence in the emphasis placed on socio-structural influences, as part of a wider framework evident in recent policy advice to the minister of health (National Health Advisory Committee on Health and Disability [NHACHD], 1998). This advice reflects the need to strike a balance between social and individual influences on health. Such a balance, although necessary and evident in health care provisions for some time, is yet to be fully developed or theorised. Within professional circles, particularly in the area of public health, there are signs of the systematic development of a fourth approach that draws on aspects of the medical, lifestyle, and socio-structural approaches. For instance, the recent development of the Causal Web Model reflects moves to account for the biological, behavioural, and social dimensions of illness (Beaglehole & Bonita, 1997). This socially oriented model places emphasis on a range of factors operating cumulatively to influence health (Davis, Howden-Chapman & McLeod, 1996). Reflecting such developments recent policy advice to the Minister of Health has emphasised the need to ensure the state provision of adequate housing and welfare benefits, prompt access to health services, and the material resources to allow people to engage in health-enhancing preventative activities (NHACHD, 1998).

The development of an approach that addresses limitations in the medical, lifestyle, and socio-structural approaches is still in its inception. Developments in this area reflect the growing recognition of the need for health initiatives to focus both on individual and social influences and the realisation that health is more than an absence of disease (Beaglehole & Bonita, 1997; Bury, 1997; Macintyre, 1997). Health is a physical, psychological, relational, environmental, economic, and inherently social

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phenomenon, which includes people's ability to participate fully in social life (NHACHD, 1998; Tones, 1996). The ways this fourth approach is being worked through in health coverage and participants' accounts will be explored in the analysis chapters.

It is worth noting that during different historical periods one approach may be more salient than another approach. However, aspects of all three approaches have impacted on the ways health and illness are conceptualised and addressed. For instance, the establishment of a publicly funded health system in the 1940s was primarily a result of calls for social equality based on the socio-structural approach and the valuing of medical treatments. Notions of individual responsibility, financial restraint, and the increased prominence of the lifestyle approach have significantly influenced the provision of medical care in the 1990s. The following section explores changes to the provision of health care at the time in which this research was conducted. These health reforms require specific attention because they reflect general shifts in social policy in New Zealand that have a bearing on the lives of people of lower SES. Furthermore, people constructed their views on health, illness, and their place in the world within the context of monetarist social reform, increased individual responsibility, the reduction of access to health services, uncertainty, and increased inequality. The health reforms have also been a substantial source of social conflict that has brought certain health concerns to the forefront of public consciousness. In short, this overview of the health reforms provides a background for the exploration of such issues in the health documentaries, individual, interviews, and focus group discussions.

2.2 Funding and Providing Health

The provision of health care in New Zealand has traditionally been supported through a mixed privately and publicly funded system. Although

it includes government subsidises, primary care has generally been structured along market lines, involving a 'fee-for-service' system (Barnett, Barnett & Kearns, 1998). Conversely, secondary care has been structured according to a mix of private and public funding (Finlayson, 1996). This section focuses on the provision of secondary care during the mid-1990s, a period of continued substantial government funding and renewed emphasis on private funding of health care (Kearns & Barnett, 1997).

Government funding and provision of health services can be generally located within three historical periods (*cf.* Laugesen & Salmond, 1994). The first involved limited government funding up to the passage of the 1938 Social Security Act, which established a model of communal responsibility for the provision of care. Before 1938 medical developments were dominated by Friendly Societies, which provided medical benefits in return for an annual fee. The second period, from 1938, involved the development of a health system that was primarily funded by government through tax revenue. In 1946 universal free access to hospital care was established on a tax-funded needs basis. However, in the tight fiscal environment emerging during the 1970s the publicly funded health system has come under increased financial pressure, leading to controversial monetarist-orientated health care reforms which have reshaped government involvement in the provision of health care (Mooney & Salmond, 1994). During this third period there have been a range of calls to shift the focus from expensive curative treatment to preventative strategies. Critiques of the medical approach were used to justify the shifting of financial responsibility from the state to the individual (*cf.* Bury, 1997; Upton, 1991).

In the 1980s the fourth Labour Government introduced health reforms that established 14 Area Health Boards. These boards were tasked to function as businesses that provided services on a population-funded basis. The National Government continued the Labour Government's monetarist

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agenda, announcing further health reforms on budget night in 1991 (Ashton, 1995). These reforms included a split between purchaser and provider. As was the case in Britain, the rationale behind the purchaser-provider split was to enable local authorities to develop appropriate services for the assessed needs of local populations (Hunter, 1994). The hospital boards were replaced with four Regional Health Authorities (RHAs) tasked with purchasing health services (Tully, 1996). The service assets of the Area Health Boards were divided into 23 Crown Health Enterprises (CHEs) tasked with providing health services. These enterprises acted as businesses, bidding along with private providers for contracts from the RHAs (Ashton, 1995).

With the election of subsequent governments further cosmetic changes have been made including the merging of the RHAs into one funding body. As a result of controversy over these health reforms, the health policies introduced by the National and New Zealand First Coalition Government in late 1996 included increased health care funding. However, these changes did not result in a significant departure from the monetarist agenda shaping the health reforms. The emphasis on increased private sector participation, cost containment, and individual responsibility continued under the National minority government.

The primary justification for the National Government's restructuring of the health system was an increase in health spending from 1980 to 1991. Change was said to be necessary to control the escalating financial burden on taxpayers of providing universal medical care (Upton, 1991). The government argued that the pie (the economy) was not growing fast enough and that there was not enough for all. New Zealand could not afford the increasing costs of medical care, education, and general welfare initiatives. This line of reasoning has been criticised by many commentators (e.g., Easton, 1994; St John, 1994; Tully & Fountain, 1993).

For instance, St John questions whether, "...belonging and participating is more to do with how the pie is shared...?" (1994, p.103). Other commentators have shown that claims of an increase in health spending are misleading (Bowie, 1992; Easton, 1994). Government spending appeared to increase from \$1.1 billion in 1980 to \$3.8 billion in 1991, which constituted a 27% increase over the rise during that period in the Consumer Price Index. However, the 1991 figures include additional levies such as GST, rents and fringe benefit tax, whereas the 1980 figures do not. Such levies can account for the increase in spending. When population growth is added to such additional costs, spending on health may be seen as falling by 0.7% from 1980 to 1991 (Bowie, 1992).

The health reforms were presented as a move to control spending and maximise the efficient use of resources through the adoption of a quasi-market model. Competition was thought to act as a discipline to make organisations efficient and responsive to consumer demand (Upton, 1991). Hospitals no longer had the sole role of health care providers; they now had to function as effective business entities, where accountants had as much, if not more, say than doctors (Malcolm & Barnett, 1994). However, these health reforms were introduced despite a lack of evidence to support the assumption that competition would reduce the cost of medical care and increase equity and access (*cf.* Ashton, 1995; Haworth, 1994; Kelsey, 1995). Competition has existed in the United States of America since the 1970s but has not resulted in cost control (Gray, 1992). Within the US context, Loewy found competition led to higher health care costs due, in part, to increases in spending on medical technology and duplication in facilities across competitors. Loewy writes:

When competition and the market are used to 'regulate' health care, technology, instead of being used to benefit patients, is apt to be used primarily to maximise individual profit: it becomes a weapon in what is often painted as

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'warfare' among health care providers and institutions (1995, p.156).

In sum, competition appears to increase the cost of providing medical care by leading to duplications in expensive medical technology. Stated aims of the health reforms, such as to increase access, reduce waiting times, increase equity, and provide wider choice (*cf.* Upton, 1991), have become less attainable (Finlayson, 1996; Mooney & Salmond, 1994).

The rationing of secondary care according to waiting lists, particularly for elective surgery, and the public's paying for an increasing percentage of primary care costs have kept government health care expenditure down. However, these changes have also been found to reduce access and equity (Finlayson, 1996). As a result of waiting times of as long as two or three years, many who could afford it have joined private insurance initiatives to avoid the waiting lists. Such developments reflect a wider trend towards the private provision of care. Although people accessing treatment through private providers has relieved some pressure on the public system, it has also been associated with other more negative ramifications (*cf.* Finlayson, 1996; Loewy, 1995). Firstly, the increase in private health care spending may contribute to making prompt access to health care increasingly dependent upon a person's ability to pay. Secondly, if someone is already paying for private care there may be less motivation to want to contribute tax revenue to a publicly funded system. Thirdly, the overall cost to society of providing health care may be increased because of the additional expenses of private care, such as profit margins and secondary accounting systems (Scott, 1994).

The health reforms drew on the image of the health consumer in proposing that people needed to be provided with more options than those provided within the medical approach (Sharp, 1994). Providing patients with options and involving people in decisions about treatment is an important outcome of challenges to the medical approach. However, the focus on individual

choice can lead to the failure to acknowledge practical constraints on people's choices (Lupton, 1997). For instance, many people may not have the resources available to exercise choice. One can decide to pay for private care only if one has the necessary disposable income (*cf.* Kearns & Barnett, 1997). Those in lower SES groups may not possess the necessary resources to go private and therefore go without. Government policies may exacerbate inequalities in the scope of available services and the length of time that people have to wait for treatment, rather than address these issues (Cheyne et al., 1997; Howden-Chapman & Cram, 1998).

The monetarist agenda guiding the reforms has been found to be unpalatable to many New Zealanders (*cf.* Fougere, 1994; Salmond, 1992; Sharp, 1994). The challenge the reforms pose to notions of communal responsibility and increased inequality in access to care have resulted in resistance. Salmond writes:

The idea of health as a social responsibility is deeply grounded in the New Zealand psyche. The Social Security Act 1938 best demonstrates the strong underlying ethos of collective responsibility and universality which underpins the nation's attitude to health and the provision of health services. In more recent times the concept of universal entitlement has been gradually eroded but for most New Zealanders access to effective and efficient health services is seen as a basic right to citizenship and not as a welfare benefit (1992, p.11).

Such commentators propose that the health reforms have brought to the fore two competing explanations of responsibility. The communal explanation proposes that the state should provide access to care for all. Conversely, the individual explanation proposes that the people should provide for themselves. The communal explanation stems from the socio-structural approach while the individual explanation reflects the rise of the

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lifestyle approach and the health consumer. These competing explanations were reflected in considerable social conflict.

Many New Zealanders voice the expectation that the government should fund universal access to medical care (Sharp, 1994). Government attempts to shift responsibility to the individual have resulted in resistance which is represented in anti-reforms protests. New Zealanders have taken to the streets to demonstrate against the reduction in services and reduced access to medical care. In March 1998 a search on News Index New Zealand revealed over two thousand newspaper and magazine articles on health reforms protests in the 1990s. A recent example is 'Thousands Protest Cuts' (1997, p. 1), which described how 5,000 to 7,000 people marched in Dunedin against cuts to hospital services. Such protests have included a wide spectrum of New Zealanders and have taken place in regional centres and all major cities. Regional crowds have been particularly vocal in their opposition to hospital closures resulting from population-based funding levels. This is reflected in 'Big Crowd Supports Fight for Hospital' (1995, p. 14), which reported on a protest against the proposed downgrading of Napier hospital. Protests have also been nationally coordinated by groups such as Grey Power, as reflected in 'Grey Power to Protest Against Health Reforms' (1996, p. 2). These protests reflect public anxieties about the erosion of universal access to care and the shifting of responsibility to the individual. The newspaper articles also reflect how the media has not only carried the government's official messages, but has also voiced public concerns and the views of community groups and concerned citizens.

Conflict over the reforms was also evident between government officials and the medical profession. This conflict may have been inevitable given that the health reforms encompass government attempts to increase control over medical autonomy and to subjugate medical care to economic

rationale (Barnett et al., 1998; Wear, 1992). Conflict has emerged as a result of bureaucratic efforts to rationalise and regulate the health sector, which has traditionally been dominated and regulated by the medical profession (Powell, 1992). The deregulation of the medical market to include cheaper alternatives and the growing autonomy of other professional groups such as nurses has also contributed to conflict over the health reforms (Barnett et al., 1998). Such developments have a history of conflict and compromise between the medical profession and the government. Historically doctors have resisted government control over health care provisions, especially if it has inhibited members' commercial ventures or autonomy (Finlayson, 1996). This is not to say that many doctors have not opposed the reforms on the same grounds as community groups and do not act in the interest of their patients, for example, by subsidising poorer patients by spreading costs to other patients (*cf.* Malcolm, 1996). The point is that many doctors have also been self-interested. For instance, the Medical Association of New Zealand opposed the passing of the 1938 Social Securities Act that legislated for universal access to health care (Hay, 1989).

Controversy surrounding the health reforms, whether between public groups or the medical profession and the government, has been placed squarely on the media agenda. The attention given to the health reforms may reflect the dramatic potential of stories about needy patients and weary doctors, the amount of resources health care consumes (expenditure), and the growth in health consciousness in Western nations (Bury & Gabe, 1990; Crawford, 1994; Farr & Markova, 1995). Such health coverage influences the ways people make sense of health and illness, experience their bodies, and conceptualise their situation in life. Therefore, the final section of this chapter will explore the role of television in working through such concerns.

2.3 The Role of Television

This thesis investigates the influence of television health coverage on people's views of health and illness concerns, such as the health reforms. Television was selected because it is the primary source of news and common knowledge for the majority of people in contemporary Western societies (*cf.* Abercrombie, 1996; Corner, 1995; Desbarats, 1994; Gripsrud, 1999). As Desbarats writes, "for several decades, survey after survey has shown that most people rely on television for most of their news and that television is regarded as the most credible news medium" (1994, p. 80). Furthermore, television has provided persistent coverage of health and illness events and concerns since its inception (Kalisch, 1983; Karpf, 1988; Turow, 1989; Wallack, 1990). Signorielli writes, "from the earliest days of television, science and health have been prevalent thematic elements on both entertainment and news programming" (1993, p.17). Yet the functions of such coverage in the construction of people's views is unknown. What previous research does indicate is that television helps set the public agenda for what are seen as important health concerns (Livingstone & Lunt, 1994; Wallack, 1990). Television focuses public attention onto selected concerns from specific perspectives influencing what people think about and discuss with others, and the causes and remedies we relate to various health concerns. In short, television is an omnipresent component of our symbolic environment, which provides ready-made explanations for us to use in making sense of health concerns.

Proposing such an agenda-setting process need not lead to the assumption that programmes simply inject ideas into people. It is important that this research is not seen as media-centric (*cf.* Corner, 1995). Television programmes are clearly not the only influence on the meanings people assign to health and illness. However, many of the explanations people draw on may originate from television. For instance, television provides a way for people to access events they do not experience in their immediate

physical environments. Many people have never had an operation or been physically present in an operating theatre; yet they may have gained considerable knowledge of what is involved from watching operations on television.

Although television may influence the construction of people's views, its influence is not straightforward or direct. Generally, research indicates that health coverage constitutes one influence in people's lives (Parrott, 1996; Signorielli, 1990; Tulloch & Lupton, 1997). When interpreting specific programmes, audience members may draw on a range of explanations and experiences, some of which are reflected within health coverage, while others are not. As socially embedded beings, people do not shut off their previous experiences when interpreting health coverage, whether these experiences originate in personal or television-mediated interactions. As a result the ways people interpret health coverage are intertwined with and inseparable from their personal circumstances, interpersonal experiences, and previous viewing.

In sum, television health coverage constitutes part of the social background against which people judge their own and other people's health and develop their views. It provides convenient explanations which audience members can draw on in constructing their own views. If this thesis were to focus solely on health coverage, it could highlight potential influences on audience interpretations and, in turn, people's views. However, it could not answer questions about the meanings viewers assign to the concerns covered or the influence of that coverage on the social negotiation of lay views. To answer such questions reception research is required because any programme is open to multiple, though not unrestrained, interpretations. A balance is required between notions of the influence of health coverage and the autonomy of the audience when conceptualising the interpretations viewers construct. Therefore, it is imperative in striking

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such a balance that this thesis be informed by appropriate programme, reception, and social psychological theory. My attention turns to such theory in the following three chapters.

Chapter Three

New Zealand Television Health Documentary

As a source of shared experience, television functions as a complex, institutionally mediated cultural forum for the social negotiation of health and illness. Viewing television is a primary leisure activity where concerns of contemporary life are played out and where meaning is assigned to material existence. The images and stories broadcast on television are such an integrated part of our everyday lives that we often take them for granted. Yet, what does health coverage tell us about contemporary health concerns and what influence does this coverage have on our thoughts? Owing to the complex array of programmes providing health coverage, in exploring this question it was necessary to narrow the focus of this thesis.

Health documentary provides an appropriate focus because of its credibility as an information source, for generations presenting New Zealanders with interpretations of health concerns. The term health documentary is used to refer to a non-fiction form which, through the use of recorded footage, provides coverage of various health and illness concerns. As a sub-genre of television documentary, these programmes record aspects of history which are judged to be pertinent or worthy of consideration and transmit interpretations of such social events to members of society (*cf.* Barsam, 1992; Rosenthal, 1988).

Recently there has been growing international interest in television documentary (e.g., Corner, 1996; Ellis, 1989; Nichols, 1991, 1994; Winston,

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1995) which contains valuable insights that can enrich my exploration of New Zealand health documentary. This literature is drawn on to explore assumptions underlying documentary and the ways programmes construct perspectives on health concerns. The following section explores the origins of New Zealand health documentary, the theoretical relationship between the exposition provided and events in society, and the ways such coverage is constructed to promote a specific perspective. Such a discussion of the ways programmes are constructed is generally accepted as necessary to adequately analyse programme content (*cf.* Corner, 1995; McQuail, 1994). Within this thesis it is proposed that health documentaries promote certain health and illness explanations through the development of a perspective on a concern. This proposition is supported by an exploration of the means by which programmes order and present evidence to promote certain ways of making sense of a concern. Without paying attention to such issues I would be open to the criticism of offering general observations about the content of health documentaries without providing any account of the ways certain perspectives are promoted. As Corner writes, “clearly, this often means looking closely at examples of ‘content’ as well as of ‘form’ and seeing the interplay between the different kinds of things which television shows and the different ways in which it can show things” (1995, p. 3).

Once health documentary form has been explored attention turns to content and in particular to research findings on the shape and scope of television health coverage. In this second section theory on the function of television coverage within society is used to inform an exploration of what research indicates to be the focus and scope of health coverage. This enables me to propose that health coverage is an institutionally mediated cultural forum within which the meaning of health and illness is socially constructed. In short, this chapter sets the research context for my analysis of New Zealand health documentary coverage.

3.1 Health Documentary: History and Traditions

Television documentary has a history traceable to pre-television photographic and radio times. There are numerous international renditions of this historical development originating in still photography and growing through radio and film experimentation into network television (e.g., Barsam, 1992; Ellis, 1989; Jacobs, 1979; Rosenthal, 1988; Winston, 1995). Ellis (1989) links the development of documentary to the 20th Century expansion of journalism, aided by the development of mass media technologies. In particular World War II saw an expansion in the use of documentary for 'instructional purposes'. However, after World War II documentary was in decline internationally until the mass distribution of television. Television became the major channel of distribution, leading to an expansion in the subject matter covered and the number of documentaries made.

Health documentary as a sub-genre has been widely used as a means of instruction in educational and institutional settings at least since the 1930s. The 1940s was a significant period in terms of wide distribution. For instance, a newsreel magazine entitled *Weekly Review* was initiated during World War II as a vehicle for war propaganda. It quickly incorporated wider issues, including a range of health topics in such titles as 'Vitamin Industry...New Products from Cook Straight' (1944) until its final production in 1949. This was the beginning of health documentary as a prominent form on New Zealand screens. This tradition continued in the 1950s with the production of *Pictorial Parade*, a monthly magazine style newsreel which contributed such titles as 'Auckland – New X-ray Machine' (1958). Health documentaries continued to be broadcast with the development of television in the 1960s.

Owing to the fragmented character of television records in this country it is impossible to ascertain the exact prevalence of television health documentaries. Archival evidence suggests New Zealand health

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documentaries continued to be screened by state television throughout the 1960s, 1970s, and 1980s in such current affairs programmes as *Close-up*, *Inquiry*, *Eyewitness News* and *Frontline*. A wealth of New Zealand health documentaries have been broadcast throughout the 1990s. These programmes constitute the predominant forum for extended health coverage on television. Within one year topics ranged from medical manslaughter laws in 'Operating at Risk' (1995); youth suicide in 'Lost Youth Lost Hope' (1995); legal and ethical issues around DNA screening in 'The Tell Tale Genes' (1995); the effects of PCPs in 'The Poisoning of New Zealand' (1995); the Easter road toll in 'The Kiwi Killing Fields' (1995); to food hygiene in 'Enough to Make You Sick' (1995).

To adequately explore such programmes and their relationship to events in society it is necessary to clarify what the term documentary designates. John Grierson is generally acknowledged as one of the first to use the term, which he intended as a concept or idea rather than a mode of narration. Grierson drew on various film movements from the 1920s to found the influential 1930s British documentary tradition. Ellis writes:

Documentary has as its root word *document*, which comes from the Latin *docere*, to teach. As late as 1800, according to the *Oxford English Dictionary*, documentary meant "a lesson; an admonition, a warning."... Grierson would move the term from his initial use of it back to the earlier one of teaching and propagating, using the "documentary" of modern life as materials to spread the faith of social democracy (1989, p.4).

From the beginning the stated function of documentary for Grierson was to stimulate audiences to act on social concerns in an informed manner. Even in the early days it was the documentarians who attempted to direct public attention to what they considered to be important social concerns.

Grierson and colleagues are generally credited with having a significant influence on the shape of television documentary (Corner, 1995). Nichols (1988) identifies the Griersonian tradition, the dramatised illustrative lecture,

as the first coherent documentary style. Generally, this style involves an authorial commentary combined with dramatic images, to create a narrator-directed exposition on a topic. This was the style of documentary adopted along with public service broadcasting here in New Zealand. In fact, at the request of the government, Grierson visited New Zealand in 1940 to prepare a report on the public film industry. He quickly convinced the government of the usefulness of the medium for instructional purposes. Grierson's visit, coupled with the onset of World War II, resulted in the formation of the National Film Unit in 1941 (Fry, 1996). This unit was responsible for producing a large number of early New Zealand health documentaries and the establishment of general story-telling conventions, discussed later in this chapter.

The Griesonian style is not the only influence on the development of health documentary in this country. Conventions from other styles such as cinema vérité and direct cinema are increasingly evident. With the advent of portable technology, these newer styles aimed to record events as directly as possible and convey to viewers a feeling of being there while ordinary people went about their lives and talked about everyday things. Such practices began with cinema vérité, a self-reflexive realist style originating in France in the 1950s. In the United States in the 1960s cinema vérité techniques were built upon to develop a less reflexive style called direct cinema. Cinema vérité aimed to highlight the filmmaking process while direct cinema aimed to hide it and provide the viewer with unmediated access to the events depicted. Gradually elements of what is often referred to as the fly on the wall style of television vérité have been integrated with the Griesonian style as part of the production repertoire of documentary production staff. As a result contemporary television documentary is a hybrid form which utilises aspects of these and other styles (*cf.* Bondebjerg, 1996; Corner, 1999a; Kilborn, 1996; Leadbeater, 1997).

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Like European and North American programmes, New Zealand health documentaries utilise conventions from the Griersonian, *verité*, and various dramatic styles. In a sense contemporary health documentaries can be positioned along a continuum. At one end are those drawing primarily on the Griersonian style and at the other end those drawing primarily on a *verité* style. Many programmes draw on conventions from both ends of the continuum. Each style offers a range of conventions which can be utilised in a specific programme. For example, the opening sequences to 'The Great Kiwi Health Lottery' (1995) employ a lecture style that includes a narrator's voice-over, to set the context of the story, introduce key characters, and explain the significance of the events depicted. *Verité* conventions such as the combination of chronological images and extraneous sounds commonly associated with depicted locations are also used in the depiction of a meeting at which health care providers decide the fate of various patients.

As a hybrid form, New Zealand health documentary has inherited more than stylistic conventions from various international traditions. These programmes have inherited a realist mode of narration that reflects the assumption that the accounts these programmes provide relate directly to external events in society. For instance, a sequence in 'The Great Kiwi Health Lottery' (1995) depicting a health professionals' meeting is presented as evidence of how medical decisions are made. Programmes construct the appearance of a direct relationship between coverage and the outside world. The impression is given that happenings are simply being captured and communicated to the audience in a summary form. Stylistic conventions are used to preserve the illusion of non-mediation where the viewer is presented with highlights of what actually occurred. By presenting material images and the testimonies of those involved, coverage is rendered self-evident. The world is simply described as it really is. In short, the legitimacy of health documentary and

illusion of transparency are maximised by hiding the production process or adopting a realist mode of narration (*cf.* Nichols, 1994).

Health documentaries are presented as windows on the world through which viewers are provided with access to happenings in society. However, the relationship between coverage and the events depicted has invoked considerable academic debate. Discussion has revolved around the ways events are represented and the legitimacy of the very claim that coverage represents an external reality (e.g., Carroll, 1996; Corner, 1996, 1999a; Ellis, 1999; Nichols, 1994; Winston, 1995). Points of contention include how the filming of events changes what is captured; institutional influences on the focus and shape of coverage; an over-reliance on elite sources; difficulties in distinguishing between fiction and non-fiction programmes; the criteria for truth claims; and whether detached or objective coverage is possible. Such debates often lead to abstract speculation about the nature of 'reality' which are likely to remain unresolved in the near future and which can paralyse empirical research (Carroll, 1996; Plantinga, 1996).

It is not my intention to reproduce such debates because they are dealt with in considerable detail elsewhere (e.g., Carroll, 1996; Corner, 1996, 1999a; Kilborn, 1996; Nichols, 1994; Winston, 1995), and are not the primary concern of this thesis. I am interested in the ways health is depicted, rather than whether photographs have an indexical basis in reality (*cf.* Corner, 1999b). However, a moderate position, compatible with the philosophical stance taken in this thesis (see Chapter Five), is that health documentaries present interpretations of events (*cf.* Carroll, 1996; Corner, 1996). Health documentaries do refer to events in society, but do so from a specific perspective. These programmes have a referential basis, but translate events into mediated expositions for television. In other words, viewers' access to happenings in the world is mediated through coverage which provides them with a selective interpretation. This stance

is also compatible with the functions served by health documentaries for viewers (see Chapters Eight and Nine). People treat documentaries as interpretations of external events, not as the events themselves. Viewers are not blind to the mediated relationship between television and actuality (*cf.* Aron, 1998; Corner & Richardson, 1986; Plantinga, 1996).

For the purposes of this thesis I propose that health documentaries present a mediated perspective on health concerns. The windows on the world these programmes provide are not transparent but tinted and result in specific fields of vision. Rather than simply reflecting events, these programmes have provided interpretations of what is happening in society for generations of New Zealanders. Health documentaries capture and interpret selected events and communicate these interpretations to viewers. The very act of covering complex health concerns necessitates the application of a perspective from which to select and order evidence into a coherent presentation (*cf.* Carroll, 1996). This in itself is not problematic, unless it leads to the overemphasis of some approaches to health and the neglect of others. After all, without selection no account, whether a health documentary or a doctoral thesis, would be possible. I am not arguing that selectivity cannot lead to bias, but that the two are not always related (*cf.* Carroll, 1996). It is the possibility of the dominance of particular ways of explaining health and the implications of this that need to be explored.

Another issue worthy of mention, arising in recent writing on television documentary, is the influence of socio-structural forces on the prevalence, shape, and scope of coverage (Corner; 1996, 1999a; Kilborn, 1996; Leadbeater, 1997; Winston, 1995). For instance, Kilborn (1996) proposes that owing to increased competition and commercialism in Britain there is less opportunity for social criticism in documentary. Kilborn argues that because many investigative reports - the documentary style evident in the majority of New Zealand health documentaries - are expensive and time-

consuming to produce they will be less prevalent in increasingly commercially oriented networks. Implicit in such reasoning is the idea that the focus of documentary is shifting from the investigation of social concerns to entertainment and titillation (*cf.* Murdock, 1999), a process Leadbeater (1997) has referred to as the 'dumbing down of current affairs'. Supporting this view, Aron reports that in interviews conducted in Britain with production staff, they "...portrayed a struggle between the competing objectives of public service broadcasting and commercial survival..." (1998, p. 9). In other words, conflict may exist between the documentary principle of informing the public and the commercial imperative to maximise one's audience (*cf.* Corner, 1999a). It is appropriate to further relate these issues to the New Zealand context and health documentary prior to moving on to explore the ways programmes construct perspectives on contemporary concerns.

In line with other social reforms, the broadcasting industry in New Zealand has seen an increase in commercialism and competition. Television, in particular, has seen the advent of two more free-to-air national networks, the return of regional stations, cable networks, and satellite pay-per-view initiatives. This has increased the commercial component of the traditional commercial-public service hybrid system (of mixed license fee, pay-per-view, and advertisement funding). There is also a trend towards entertainment-oriented health documentary, reflected in the production of programmes such as *Middlemore* (1997) and *Hospital* (1997). However, a stringent distinction between entertainment and information neglects the practical necessity for programmes to be entertaining in order to attract an audience and build public awareness (*cf.* Bondebjerg, 1996). Programming can be both entertaining and socially significant (Corner, 1996). In New Zealand investigative reports are now part of a wider mix of health documentary which includes more commercially driven programmes. However, whether journalistic values of providing the public with information

are now displaced by the market imperative is yet to be established. There is only limited evidence that the public service tradition of providing in-depth coverage of social concerns and exposing the transgressions of those in positions of power is abating. This is not to say that increased commercial pressures will not detract from the quality of the research and coverage presented in health documentary in the future. However, the extent of this shift remains to be seen. Commenting on these issues, in a review of recent developments in British documentary, Corner proposes that it is prudent to be wary of recent developments in the increasingly commercial broadcasting system. Yet coverage of social concerns has not diminished to date:

The threat of a 'narrowing' and 'thinning' of documentary as a result of economic changes in the funding of broadcasting remains strong (one concisely explored by Kilborn, 1996), but there is evidence to suggest that documentarism has never been more imaginative and various than it is at the present, never more aware of both its discursive limitations and its distinctive potential (Corner, 1999a, p. 182).

3.2 Constructing a Perspective

In presenting coverage of contemporary health concerns, programmes develop a specific perspective that includes the identification of causes, assignment of blame, and recommended courses of action for remedying a given situation. For instance, a perspective on drink-driving might draw on explanations inherent in the lifestyle approach to support the proposition that the carnage on our roads is simply the result of individual decision making and a lack of self-control. Such perspectives have been conceptualised by Nichols (1988) as the 'voice of documentary' and constitute the general orientation or stance taken in a programme.

The construction of a perspective is shaped by decisions about what evidence is gathered and how it is integrated within a programme. Constructing a programme to present a specific perspective involves framing

(Entman, 1993; McQuail, 1994). Framing is a means by which a specific perspective on a concern is constructed through the ways that evidence is selected and presented within a programme. Entman provides a functional definition:

Framing essentially involves *selection* and *salience*. To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described (1993, p. 52).

The concept of framing provides a means of explaining how a perspective is manifested in a programme by production staff's drawing on certain explanations. For instance, if production staff draw on medical explanations, then filming for a cancer programme may take place in a hospital and focus on needy patients, diligent doctors, and the necessity of developing medical interventions. The perspective adopted is likely to espouse the benefits of prompt medical treatment and the wonders of modern medicine. As a result, issues around the side-effects of medical treatments or the benefits of complimentary treatments may be downplayed or ignored. Such issues would not be ignored if holistic explanations were drawn on to construct the perspective. In brief, when framing a concern importance is assigned to some aspects of the concern while other aspects may be downplayed or ignored.

In order to account for the construction of a programme it is appropriate to establish how a topic is introduced and evidence is subsequently presented. Health documentaries generally employ a strong initial exposition involving the host's opening speech and the initial sequences. These introductions present the topic and its worthiness, indicate the programme's direction, and identify the dominant issues that the narrative will pursue. After the introduction subsequent depictions illustrate and develop an exposition or pattern of commentary. The exposition is

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concluded with a brief postscript mirroring the introduction, answering questions raised or stating the present situation. In short, topics are framed within a story structure with a beginning, middle, and end. This process involves causally linking evidence from a range of sources in a way that provides a perspective on what is really going on.

Health documentaries often guide viewers through the evidence. Generally, a presenter, who can be a journalist or celebrity, narrates the story. The term 'presenter' designates the 'on-the-spot' person who investigates a topic and leads viewers through the evidence (*cf.* Corner, 1996). These presenters speak directly to the audience both from outside the story through an authoritative voice-over and from within the story as a traditional 'on-the-spot' reporter (Bondebjerg, 1996). Such direct address functions to establish the presenter as the viewer's guide who works like a detective in a mystery to investigate events and convey the evidence directly to the audience in a general, colloquial style that mimics the language of everyday life (Abercrombie, 1996; Corner, 1999b; Vaughan, 1988). However, this direct address is fictional in the sense that the narrator is addressing an audience that is absent and hypothetical in nature. Yet the rhetoric is constructed as if aimed specifically at us as individual viewers. This direct address is often evident in the use of the pronoun 'you' (*cf.* Corner, 1999b).

Progression through the exposition occurs through the presentation of evidence from a range of sources (*cf.* Ellis, 1999) including interviews, graphic images, and official reports. Evidence, including the stories of patients and depictions of events such as operations, is rendered meaningful through its positioning within the progression of the exposition (Plantinga, 1996). Such evidence is arranged into causally related sequences that are not necessarily presented in a chronological order. For instance, health concerns can be presented in the introduction and the

subsequent investigation focused on the exposure of the causes of the present situation. This is exemplified in 'The Great Kiwi Health Lottery' (1995) where the viewer is initially presented with the images and accounts of patients refused access to medical treatment. The subsequent investigation focuses on establishing why these people have been denied care and who is responsible.

Health concerns are often embodied through the personal stories of those with direct experience. Such personalisation renders a concern visible and helps to communicate complex issues by presenting them in a way which is readily comprehensible to the general public. For instance, the progression of cancer and its impact on the body can be depicted through images of cellular division and expert commentary. However, such events can be rendered more compelling through the depiction of the experiences of a patient. Personalisation is also a means of naturalising the perspective adopted in a programme and establishing the authenticity of the exposition. This can also challenge those in positions of power (*cf.* Corner, 1999a; Medhurst, 1989). As Medhurst writes:

The narrative devices of letting the participants speak for themselves helps to structure audience perception and confirm the narrator's privileged point of view. The narrator thus appears merely to be repeating what everyone (it seems) already believes (1989, p. 197).

A key aspect of such expositions is continuity or the smooth flow from one piece of evidence to another. Continuity editing provides a coherent perspective on an external social world through the seamless presentation of evidence from a range of sources. Such editing creates the illusion of coherence in time and space through the development of rhythmic, spatial, graphic, and temporal relationships between images and sounds (Bordwell & Thompson, 1997). As a hypothetical example an image might show a bottle of vitamin tablets on a table in front of a clock, which reads 6 p.m. Then an

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elderly person may be depicted running a marathon and looking at her watch, which reads 10 a.m. The viewer is led to infer that the vitamins enable the exertion the following day. Sixteen hours have elapsed but through the editing of the sequence continuity between elements is established. This is how events occurring over weeks, months, or even years can be condensed into a 45-minute investigation.

Health documentaries often use such *verité*-style sequences that depict people doing everyday things while seemingly unaware of the camera. This type of depiction closes the gap between the exposition and the events depicted. The depiction of the woman running can be presented as a representation of the active elderly who are taking dietary supplements and participating in regular exercise to extend their life and vitality. The depiction of this woman may be used to demonstrate the plausibility of the programme's perspective and in particular the proposition that dietary supplements are health-enhancing. She is shown reaping the benefits of a healthy lifestyle. Such sequences add to the realism of the exposition and are edited into a programme to enable viewers to spy on characters and settings (Corner, 1996), while being guided by the presenter's voice-over description of the situation (Medhurst, 1989). In the process, the Griersonian style is merged with journalistic enquiry (*cf.* Corner, 1999a).

Used as an aid to continuity, the presenter's voice-over provides summaries of key events, identifies important characters, describes the general situation, evaluates people's actions, facilitates the compression of time (through the use of summaries of evidence not presented), establishes connections between illustrative examples, and generally communicates superior knowledge. For instance, a voice-over may be used to reinforce the connection between the woman's running and the dietary supplements by stating, "its not just training that enables one to keep going", as the camera cuts from the image of tablets to the image of the woman running.

Like any story, health documentaries lead to a conclusion. Endings in these programmes do not reach closure in the sense of the resolution of a main problem, as in many dramas (*cf.* Corner, 1999a). Documentaries often end with a postscript stating a dilemma which requires action in society (Corner, 1995). This often involves a summary of the evidence and the point of awareness the viewer should have reached. These endings include the presenter's summary and a few segments from key informant interviews that establish the present situation and reinforce the programme's perspective. Such endings are the result of the early formulation of documentary as a means of stimulating public awareness and action. They reflect the idea that viewers have been presented with an in-depth report on the present situation and its antecedents and are now responsible for taking action.

In sum, through the use of stylistic conventions health documentaries develop a perspective on a topic that is punctuated in accordance with a given line of cause and effect. This perspective is the product of the presentation of evidence from a range of sources. The importance of stylistic conventions can change from one programme to another. This discussion has been based on the predominant conventions used in New Zealand health documentaries. Now that we have explored health documentary form, an exploration of the content of health coverage is appropriate.

3.3 Health on Television

Since the beginning of television there has been concern over what is depicted and what effects coverage has, particularly on poorer and less educated members of society (Abercrombie, 1996; Walkerdine, 1996). Early research was heavily influenced by a conflict between market forces and moral reactions, particularly in debates around television violence,

where perceived morality was positioned against consumerism for the control of the passive, impressionable masses (*cf.* Cruz & Lewis, 1994). When approached from such an 'anti-media' stance, television was seen as a site of struggle over the consciousness of the masses. Reviews of television research (e.g., Abercrombie, 1996; Corner, 1995; Curran, 1996; Fiske, 1989; Livingstone, 1998; Morley, 1996; Newcomb, 1994) persistently recount how studies have explored the ways television coverage draws on various dominant social norms, values, and beliefs to restrict the ways concerns are constructed and to support existing power relations in society.

Such research is generally associated with the critical approach, according to which television is a primary vehicle for the social and ideological domination of the masses. This approach proposes that television distorts reality and functions as an institution of false consciousness which obscures the harsh reality of contemporary life and weakens progressive movements by sustaining forces of social domination (*cf.* Curran, 1996; Newcomb, 1994). Television is seen as not only restricting the scope of coverage but also restricting democracy (*cf.* Herman & Chomsky, 1988; Murdock, 1999). For instance, when referring to the hegemonic or contested character of television coverage, Murdock proposes that the shared culture constructed by television is increasingly geared towards the consumer and the benefits of the market place as the answer to self-fulfilment. He writes:

This development undermines citizenship in two ways. First, it privileges personal spending over social and political participation, and addresses viewers as shoppers rather than as members of intersecting moral communities. Second, by equating social differences with variations in choice and style it negates any attempt to arrive at a conception of the 'common good' based on the negotiation of differences in their full complexity (1999, p. 10).

Although acknowledging that some programmes are more open to competing explanations than others and presenting a more complex model, this statement reflects a critical stance according to which coverage restricts who is allowed to speak and what they are allowed to say. Owing to increased commercialism contemporary television coverage is presented as undermining democracy by restricting the scope and focus of public debate.

The critical approach is not the only approach evident in the literature (Corner, 1995; Curran, 1996; McQuail, 1994; Newcomb, 1984; Philo, 1999). The liberal pluralist approach states that television is a vital force for social change from the bottom up. According to this approach coverage reflects events in society through various social meaning systems, but instead of restricting coverage these meaning systems function to expand coverage. Television coverage is approached as a progressive force which exposes abuses of power, voices public concerns, responds to public demands, and generally provides heterogeneous coverage which fosters democracy (*cf.* McQuail, 1994; Newcomb & Hirsch, 1984). This approach overlaps with Grierson's conceptualisation of documentary as a means of enhancing social democracy.

Questions concerning whether television challenges or supports established power relations have shaped research. As highlighted above, the critical approach constructs television as acting on behalf of powerful forces in society, while the pluralist approach constructs television as an institution that acts on behalf of the public (*cf.* Curran, 1996). Neither of these two approaches captures the complex and contradictory functions of health coverage. As a result, there has recently been some convergence between these two approaches. Recent research has explored television coverage as both a force for public accountability and social domination, both supporting and challenging the status quo, and reflecting and

restricting public opinion (e.g., Abercrombie, 1996; Corner, 1995; Curran, 1996; Ellis, 1999). What is emerging is an approach that draws on insights from both the pluralist and critical approaches to account for the ways television coverage is influenced by various forces in society from both the top and the bottom of the social stratum. According to this emerging approach, television can reflect a range of perspectives, including those of different dominant groups, such as doctors and government officials, as well as community groups, such as Grey Power and individual patients. Clearly, as critical researchers would point out, groups such as the medical profession have more influence over the scope and shape of coverage than groups such as Grey Power. However, as pluralists would point out, coverage may be more heterogeneous than is often assumed. While emphasising the pluralism of coverage, researchers need to investigate the impact of social power relations and institutions on the shape and scope of coverage without becoming overly deterministic.

Drawing on such an emerging approach, television can be seen as an institutionally mediated cultural forum where the meaning of health and illness is negotiated through the juxtaposing of varying points of view, but which is influenced by some viewpoints more than others. Such a stance provides a means of dealing with the complex and contradictory character of health coverage, without losing sight of the restraining influence of social power relations and institutions (*cf.* Ellis, 1999; Newcomb, 1984; Newcomb & Hirsch, 1984). Research conducted using this approach assumes that coverage reflects the complexities and contradictions of contemporary life (*cf.* Corner, 1995; McQuail, 1994). As a result the research focus is placed on the use of various socio-cultural explanations in constructing television coverage. The idea that television is an institutionally mediated cultural forum centralises the notion that health coverage reflects, circulates, and helps create communal explanations of health and illness (*cf.* Gabe & Bury, 1996; Kelleher, Gabe & Williams, 1994; Livingstone & Lunt, 1994). It

highlights the socially progressive possibilities of health coverage while also acknowledging the restrictions often imposed by social power relations.

Drawing on this third approach, health coverage can be theorised as a forum that is restrained by the dominance of some ways of explaining health and illness over others. Such coverage is a central element in the social negotiation of the meaning of health and illness. It is a cultural forum within which various courses of action are played out, where meaning is assigned to material events, and where solutions to life's problems are worked through. Health coverage deals with the concerns and dilemmas of a particular epoch and provides a means by which people can make sense of their situations in life. Competing viewpoints are used to explore contemporary concerns, establish the boundaries of public debate, and render such concerns meaningful. Newcomb writes, "television must be seen as dynamic rather than static, as procedural rather than merely as a product, as fissured and contradictory rather than monolithic, polysemic rather than univocal" (1988, p. 90). Health coverage can exhibit contradictory combinations of viewpoints, but this does not mean that all views are equally represented (*cf.* Abercrombie, 1996, Bondebjerg, 1996, Livingstone & Lunt, 1994).

The institutionally mediated cultural forum approach enables the investigation of the influence of health coverage while retaining the idea that such coverage also reflects events in society and is not just a force for social domination. The term agenda setting, coined by McCombs and Shaw (1972), is generally used to describe television's function in directing public attention to specific concerns from specific perspectives. As Dearing and Rogers write:

Agenda-setting offers an explanation of why information about certain issues, and not other issues, is available to the public in a democracy; how public opinion is shaped; and why certain issues are addressed through policy actions while other issues are not (1996, p. 2).

Agenda-setting research explores the influence of television on the importance viewers assign to issues and the ways concerns are conceptualised and dealt with (*cf.* Dearing & Rogers, 1996; Farr, 1995; Putnis, 1994). As part of the agenda-setting process, health coverage can be said to contribute to the establishment of health and illness concerns and the setting of boundaries within which public discussion occurs. These boundaries also influence how a concern is dealt with in society and what solutions are proposed (Wallack, 1990; Wallack & Dorfman, 1992). If cancer is presented as an individual lifestyle issue, initiatives proposed to deal with it may concentrate on individual behaviour change and not efforts to decrease inequality.

Health coverage is central to the working through of concerns which are not resolved but rather are continually worried over until exhausted (*cf.* Ellis, 1999; Newcomb & Hirsch, 1984). Ellis writes, “television attempts to define, tries out explanations, creates narratives, talks over, makes intelligible, tries to marginalize, harnesses speculation, tries to make fit and, very occasionally, anathematizes” (1999, p. 55). In the process no overall explanation is provided by television coverage owing to the range and complexities of concerns covered. There is no firm conclusion, only ongoing exploration in which public attention is focused and concerns are shaped and reframed across a range of forms from news and documentary to soap opera. A concern is picked up in a news item, explored further in current affairs and documentary and then developed through other forms such as soap opera and mini-series (Ellis, 1999). In the process a wider array of perspectives, voices, and explanations is introduced. During the process forms such as health documentary provide a cause-and-effect

framework within which various complexities and contradictions can be explored.

To propose that health coverage has an influence on the health agenda of society does not necessarily imply that viewers passively accept what they are told or that they construct the same interpretations from any given programme. Rather, it merely suggests that the images we are repeatedly presented with have a part to play in shaping our views on health and illness. Negotiation of the meaning of health and illness is a social process occurring at both the health coverage and reception levels. At the first level, production staff select what topics to cover, who to interview, and how to present the evidence (Newcomb & Hirsch, 1984). Such events can lead to certain health and illness explanations being highlighted and others being downplayed or ignored. The second level of negotiation occurs during reception where viewers draw on a range of experiences and explanations, which may be both similar to and different from the explanations used by production staff, to construct an interpretation of the programme. This second level of negotiation is explored further in the following chapter. The remainder of this chapter presents a discussion of research into health coverage, particularly studies relating directly to health documentary as a way of relating the arguments presented above to the health literature. Previous research, although demonstrating the dominance of medicine, indicates that coverage may be changing to include a wider range of explanations. This supports the idea that television is an institutionally mediated cultural forum for the social negotiation of the meaning of health and illness.

Research into health coverage on television has given considerable attention to public health campaigns (e.g., Atkin & Wallack, 1990; Parrott, 1996). However, recent research has begun to look further afield, focusing on popular culture forms such as drama, advertisements, and documentary

(e.g., Lievrouw, 1994; Turow, 1989; Turow & Coe, 1985). Within this second line of research specific health topics, such as depictions of the risks involved in tranquiliser use, HIV/AIDS, mental distress, and mad cow disease, have been an important focus (Brown, Chapman & Lupton, 1996; Bury & Gabe, 1994; Chapman & Lupton, 1994; Philo, 1999; Ratzan, 1998).

Generally, research indicates that health coverage is influenced by the dominance of the medical profession, through the emphasis given to topics such as medical procedures, technological cures, devastating diseases, and lifestyle behaviours (Clarke, 1991; Lupton, 1994; Signorielli, 1990; Turow, 1989; Wallack, 1990; Wallack & Dorfman, 1992). Health is predominantly represented as an individual issue and illness as a deviation from a state of health, amenable to remedy via medical technology or lifestyle change. The term medicalization (see Chapter One) has been used to refer to the dominance of medical knowledge and practice over health coverage on television (Karpf, 1988). Medical notions of the appropriate actions necessary to identify and remedy an ailment and to prevent illness are said to limit the focus of health coverage. This limited focus has been found to result in the neglect of issues pertaining to wider political, social, and economic influences. Thus, health coverage has been found to rely on the medical and lifestyle approaches and to disseminate a restricted range of explanations to viewers (Karpf, 1988; Turow, 1989; Wallack & Dorfman, 1992). In this usage the term medicalization denotes the influence of both the medical and lifestyle approaches. The development of the lifestyle approach is seen as further evidence of the spreading influence of medical hegemony over additional aspects of human life (*cf.* Crawford, 1977, 1980, 1984). However, despite research persistently highlighting the medicalization of health coverage, recent research has also highlighted contradictory aspects of health coverage and in some cases criticisms of medical practices and attention given to socio-structural issues (Brown et

al., 1996; Bury & Gabe, 1994; Clarke, 1991). The existence of these criticisms has opened a space for a wider range of explanations.

In a seminal study that highlighted the dominance of the medical approach in health coverage, Turow and Coe (1985) conducted a content analysis of United States prime time television programmes. These authors examined illness episodes in news, drama, movies, and advertisements. They found that, regardless of the type of programme, such episodes were represented in medical terms. The primary focus of coverage was identified as depictions of the prolongation of life through medical intervention. Regardless of the type of programme, medical interventions were emphasised at the expense of socio-structural explanations and issues such as housing and poverty. There appeared to be a gap between changes in the structure of health care in US society at the time and television portrayals that presented medicine as a non-political, unlimited resource. As Turow and Coe write, "all the programme formats overwhelmingly failed to confront the government and corporate activities that have been changing the contemporary medical system and the public's relationship to it" (1985, p. 49). Overwhelmingly, the hospital was presented as the location for interventions to occur. Within this location, patients were depicted unquestionably accepting medical judgements. The focus on the hospital and the treatment of acute illness was accompanied by a general exclusion of health professionals other than doctors and nurses. Emphasis was placed on depicting doctors as trustworthy curers or heroes with considerable technical skill, who did their best for needy patients. Such depictions contrasted with those of nurses who were seldom shown carrying out any skilled tasks. Nurses were predominantly relegated to performing background tasks such as emptying bedpans, pushing medicine trolleys, and taking orders from doctors, (*cf.* Kalisch, 1983).

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Although finding that coverage was medicalized, Turow and Coe (1985) also raised the point that health coverage was not static. Their research, in addition to other studies in the United States and Britain (e.g., Karpf, 1988; Turow, 1989), supports the view that television health coverage has been predominantly medicalized, but is historically variable. Turow's (1989) analyses of United States medical dramas, from the 1950s through to the 1980s, highlighted variations in medical dominance across this period. Dealing with a wider range of generic forms in the United Kingdom, Karpf (1988) found a similar pattern to that of Turow in her study of medical coverage from 1930s radio shows through to 1980s television dramas. Karpf found that the dominance of the medical approach over television coverage peaked during the 1950s and 1960s. Since that time, isolated coverage of wider social determinants and limited criticisms of medical technology have begun to emerge. Overall, research conducted in the 1980s indicates that perspectives adopted in health coverage, despite being shaped by the medical approach, may be changing to include a wider, more challenging focus (Karpf, 1988; Turow, 1989; Turow & Coe, 1985).

The idea that health coverage is changing to include more challenging coverage of health concerns, and medical practice in particular, has recently been investigated (Bury & Gabe, 1994; Lievrouw, 1994). Initiating an investigation of the extent to which television presents a challenge to medical knowledge, practice, and professional power, Bury and Gabe (1994) focused on television depictions of medical work in three British programmes. These authors acknowledge the influence of the medical approach in shaping television depictions, but found that rather than merely emphasising medical explanations some programmes also criticised medical treatments and the actions of health professionals. Critiques of the medical approach were exemplified through scenes invoking disgruntled patients, criticisms of doctor's actions, and problems resulting from management restructuring of

the health system. They concluded that health coverage at the time of writing reflected a more challenging perspective on medical practice than that reported in research during the 1980s.

Similar findings are evident in recent research that highlights the complex and contradictory character of health coverage. For example, Brown and colleagues (1996) show how doctors infected with HIV/AIDS are portrayed in Australian news and current affairs programmes as sources of infection or danger to patients. These doctors are depicted as negligent individuals who put their patients at risk. Risks of infection are associated with moral outrage that this danger should come from those meant to help, namely doctors. Brown and colleagues argue that such depictions are cast in a 'fall from grace' frame where the critical focus is not the medical profession per se but individuals who do not act according to expected professional standards. Responsibility for the placing of patients at risk is not solely attributed to doctors. Programmes also presented the proposition that the health care system places patients at risk because of 'bureaucratic bungling'. Brown and colleagues write, "the hospital system was represented as inept, chaotic and ultimately dangerous, with its administrators deficient in 'rational' strategies of minimizing risk to its patients" (1996, p. 1691). The issue of patient infection is treated as indicative of a failing health system. Such research highlights the existence of coverage of socio-structural issues on television. However, it also shows that such coverage is limited to inadequacies in the state provision of health care and the resulting medical risks faced by patients. A key point here is that the benefits of medical care in principle are not questioned, only inadequacies in the provision of such care. What is called for is better monitoring of such risky situations and diagnostic testing of health professionals to ensure there is no risk to patients. Such coverage still emphasises the usefulness of medical technology in providing answers and ensuring patient safety.

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Research shows that although heavily shaped by the medical approach, there is a range of complexity and contradictions in health coverage. Such complexity and contradiction across programmes can be garnered from studies investigating various facets of documentary coverage (e.g., Bondebjerg, 1996; Gabe & Bury, 1996; Juhasz, 1990). Juhasz (1993) analysed United States HIV/AIDS documentaries and found that medical notions of disease transmission were drawn on to associate the disease with specific risk groups such as the gay community and female prostitutes. These groups were presented as sources of infection due to their unhealthy lifestyles. Coverage overwhelmingly supported the medical system with an emphasis on the search for a technological (drug) cure. At the same time as presenting images of impartial medicine, the programme also drew on conservative morality to stigmatise various groups. Painting a somewhat different picture of the portrayal of medication, Gabe and Bury (1996) found programmes provided public service functions by expressing public concerns on tranquiliser addiction and medical incompetence. Coverage transformed addiction from an issue of deviancy to one of everyday risk. Programmes drew on moral notions of illicit drug use to depict people as caught in a 'spiral of addiction', in part, due to the oversubscribing of tranquilisers by doctors. Further supporting the view of the contradictory and complex character of coverage, Bondebjerg (1996) also found that programmes served public service functions as a forum for the expression of the concerns of the 'underdog', but that these same programmes present highly individualised portrayals, particularly when covering social issues.

Previous research indicates that the medical approach is extremely influential in shaping health depictions on television. However, the situation may be changing. For instance, Clarke's (1991) research on representations of cancer, heart disease, and AIDS in North American magazines indicates that the ways cause is assigned is primarily

influenced by medical and lifestyle explanations. Yet socio-structural explanations are also influential in a minority of cancer reports. Despite the persistence of medical dominance, there is also support for the idea that television health coverage involves more than the dissemination of medical knowledge. Some programmes marvel at the wonders of modern medicine. Conversely, some programmes raise questions not only of the incompetence of individual doctors, but also of the side effects of various treatments and the lack of available services for certain groups of people (*cf.* Kelleher et al., 1994). Health coverage not only highlights the life-enhancing aspects of medical interventions such as dialysis but also contains atrocity tales, including instances of medical misadventure (Brown et al., 1996; Williams & Calnan, 1996). Although influenced by the medical approach, coverage does present health concerns in a way that often legitimates the experiences and views of ordinary people and other professional groups. Lived experience is valued and used as a basis for exposing limitations in the medical approach (*cf.* Bury, 1997; Livingstone & Lunt, 1994; Kelleher et al., 1994). As Bury writes:

Where doctors once dominated such coverage, in a form which effectively maintained their 'hegemony' over medical information, other voices are now to be heard, including investigatory journalists, dissenting doctors, campaigners, academics (including, sometimes, sociologists), economists and health care managers (1997, p. 103).

Such findings support the idea that health coverage constitutes an institutionally mediated cultural forum within which health concerns, including criticisms of the medical approach emerging since the 1970s, are worked through (*cf.* Ellis, 1999). A range of character depictions are used to add complexity to coverage of various health concerns.

Underlying my discussion in this chapter is the idea that health coverage is an institutionally mediated cultural forum within which health concerns are rendered meaningful. Health coverage is important to the ways in which

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people perceive health and identify various concerns. It is a central part of the social negotiation of the meaning of health and illness because it provides a shared reference point for public discussion. These programmes draw on notions of evidence to present mediated accounts of contemporary health concerns which inform the public. As part of this process evidence is presented in a manner that renders these programmes self-evident. This is achieved through a realist style which constructs a window on society for the public. Yet no exposition is a pure reflection of a concern. Programmes encompass assumptions about what is a relevant concern and how it should be covered and addressed. This is not to propose that no documentary can accurately account for social phenomena but that health documentaries may present perspectives that are overly reliant on medical and lifestyle explanations. However, the shape and scope of coverage may be expanding to include a wider range of explanations and issues.

Health documentaries are presented as metonyms for what is occurring in society and may be judged on the extent to which they provide coverage of key aspects of a concern. These programmes exist within social meaning systems, which influence the focus and shape of coverage and public discussion. Although medicalized, health coverage is contested and does not appear to present a totally coherent agenda. This chapter has explored the role of New Zealand health documentaries in the social negotiation of health and illness. The audience's role in this ongoing process is outlined in the following chapter.

Chapter Four

Theorising the Audience

In attempting to understand the complex role of television in contemporary life researchers have tended to focus at either the programme or reception level. Research focusing on programmes generally investigates how social norms, values, and beliefs are filtered through television to viewers. The discussion of New Zealand health documentary presented in the previous chapter and the analysis of health documentary content presented in Chapter Six fits into this category. Traditions presented in this chapter and the analysis presented in Chapter Nine primarily fit the reception category. The primary focus of contemporary reception research is on audience uses and interpretations of programmes and the ways television influences what people make of the world. This thesis draws on insights from both categories to theorise a socially embedded audience whose accounts of health and illness are influenced by television health coverage.

Although empirical research often does not fit neatly into specific theoretical categories, reception research can be divided into three prototypical traditions: effects, uses and gratifications, and influences. Categorising reception research according to three such traditions is an oversimplification, but it does provide a useful means for introducing competing assumptions that have shaped reception theory and research. Differences between these traditions lie in where the meaning of a programme is said to reside and the general level of audience activity assumed (*cf.* Abercrombie, 1996; Corner, 1995; Morley, 1996). For the effects tradition, meaning primarily lies within the programme and is transmitted to the audience. Within the uses and gratifications tradition,

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meaning primarily lies with the viewer who has the power to select and reject programmes and meanings. For the influences tradition, meaning is the product of the framing of evidence within a programme and the symbolic resources viewers bring with them and draw on when watching a programme. Each tradition of reception research can also be differentiated along a continuum of viewer activity. Extreme variants of effects research generally assume a somewhat passive audience at one end and uses and gratifications research assumes a very active and autonomous viewer at the other. The contemporary emphasis on influences research provides a moderate tradition (Livingstone, 1993). Many contemporary reception researchers, particularly within cultural and media studies, emphasise programme and audience influences to varying degrees and explore the negotiation of meaning between programmes and various 'interpretive communities' (*cf.* Abercrombie, 1996; Corner, 1995; Livingstone, 1999; Morley, 1993).

It is well established in contemporary reception research that viewers are active in constructing a range of interpretations when viewing television programmes (e.g., Liebes & Katz, 1990; Livingstone, 1993, 1998; McQuail, 1994; Tulloch & Lupton, 1997). This thesis starts with the premise that programmes such as health documentaries promote specific perspectives on a topic, but that these perspectives are not simply injected into audiences. Nor is the audience totally autonomous in producing their own interpretations. Interpretations are influenced by how concerns are presented in programmes and viewers' circumstances and experiences. The meaning of a programme is negotiated in the interaction between viewers and programmes which occurs as part of everyday life.

Placing emphasis on the influence of programmes and the active role of viewers is not new. Such thinking has been evident in empirical studies since the formative years of mass communication research (Curran, 1990). For

instance, Katz and Lazarsfeld (1955) proposed that the influence of the media was mediated through social relations, with personal influence factors playing a considerable role. Although it was recognised in research conducted during the 1940s and 1950s that radio, film, and later television audiences actively interpreted mass media messages (Katz & Lazarsfeld, 1955; Smythe, 1954), reception research since then has tended to reflect variants of the effects and uses and gratifications traditions.

The aim of this chapter is to present key ideas that have shaped reception research and to situate this thesis within the wider field of study. By necessity this chapter does not explore all aspects of or points of contention within such a heterogeneous conceptual field. Audience research is an inherently untidy academic domain, with various intersecting models being used dynamically to explore various elements of the mass communication process (*cf.* Abercombie, 1996; Corner, 1999b; Livingstone, 1998; McQuail, 1994; Morley, 1992; Silverstone, 1994; Van Zoon, 1994). What is provided here is an overview encompassing key points of concern to my research. The effects and uses and gratifications traditions are briefly outlined in the following section as a means for setting the context for influences research, which draws on insights from both traditions. Although informed by effects and uses and gratifications traditions, this thesis is primarily situated within the influences school of thought. In outlining these three traditions the aim is to complement the discussion of health documentary presented in the last chapter and establish the theoretical foundations for my exploration of both health coverage and reception, which is theorised more fully in Chapter Five. Therefore, in the second section of this chapter attention is given to seminal influences models from which my own study primarily derives.

4.1 Effects and Uses and Gratifications Research

As stated above effects and uses and gratifications research are situated in opposing schools of thought. Effects research assumes that the

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meanings communicated during television viewing are predominantly determined by the programme and sets out to explore the process of social domination through television. Conversely, uses and gratifications research assumes that these meanings are primarily determined by the individual viewer and focuses on individual agency and the functions or uses television serves for people. There are various points of contention between these two traditions as well as studies that draw on insights from both. This section does not review all of these complexities. Rather, it provides a brief introduction to the effects and then the uses and gratifications traditions.

Early conceptualisations of the television audience have been associated with the Frankfurt School's pessimistic mass society thesis, a cultural critique often referred to as the hypodermic model of media effects (*cf.* Morley, 1992). According to this Marxist-inspired tradition, television injects ideology into an undifferentiated mass audience (Adorno & Horkheimer, 1979). Viewers are seen as targets for persuasive messages to which they react in a uniform manner. According to this extreme stance, television content is generated from dominant ideology, against which the mass audience is powerless. It is through watching television that the mass audience is tricked into false consciousness. This effects model reflects the assumption that television content has a direct effect on a predominantly passive audience. Messages are thought to be transmitted in the interests of elite, wealthy, and powerful forces as a form of social control (McQuail, 1994). Television's role in preserving existing social power relations is the chief concern. Correspondingly, primary attention is given to the impact of dominant cultural belief systems, which are mediated through television to indoctrinate the audience (Morley, 1992). Primary concern is given to how social structures shape who people become, what they want, and how they behave (Abercrombie, 1996).

Although somewhat less overtly concerned with ideology than research conducted in disciplines such as sociology, effects research has dominated psychological studies of television (Comstock, Chaffee, Katzman, McCombs & Roberts, 1978). This is particularly evident in research which draws on a social learning framework to explore media violence. One such model used to explore the impact of television coverage on the socialisation of peoples' opinions and attitudes is cultivation analysis (Gerbner, 1997; Gerbner, Gross, Morgan & Signorielli, 1986; Signorielli, Gerbner & Morgan, 1995). Television is seen as a powerful force shaping contemporary society. Gerbner and colleagues (1986) propose that television is instrumental in making connections between social events and designating right from wrong. Television is attributed the role of cultivating a selective view of society and shaping the beliefs and values of the audience. This tradition places emphasis on how cultural beliefs are mediated through television to colonise the perceptions of individual viewers and direct their actions. A central premise is that television content cultivates antisocial perceptions over time. Therefore, heavy viewers of television adopt a distorted view of the world which reflects the programmes they interact with.

Cultivation analysis presents a more complex model of effects in which the focus is on the long-term changes in cognitions that are caused by television coverage. Such research raises the interesting idea that the meanings circulated via programmes can shape peoples' views over time. However, the influence of television may be less direct and powerful than cultivation researchers assume. According to the cultivation model the viewer is a victim of television coverage. Attention is not given to the ways that viewers actively engage with what is made available through coverage and construct his or her own interpretations (Liebes & Katz, 1990). Such work is theoretically and methodologically limited. No adequate explanation of the range of interpretations produced by viewers or the impact of

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people's material circumstances on their perceptions is provided (*cf.* Ang, 1988; Fiske, 1987; McQuail, 1994; Morley, 1981). Cultivation research also relies on making causal inferences based on weak correlations between the quantitative content analysis of television programmes and viewer opinion surveys. In addition, such research is hampered by the reliance on standardised attitude measures, which have limited application in the investigation of people's views and the complexities involved in their construction.

Exemplifying such trends within the effects tradition, there is a research tradition within public health which explores the effects of health representations on public knowledge and behaviour (*cf.* Atkin, 1981; Parrott, 1996; Wallack, 1990). Television is conceptualised as a battle ground between healthy and unhealthy messages which compete for the consciousness of the masses (e.g., Signorielli, 1990; Strasburger, 1995). Health promoters are concerned about unhealthy messages and the effects they may have on the audience, while using television to promote healthy messages. Also drawing on a social learning framework, such research focuses on how messages can be used to convey knowledge to individuals which will change their attitudes and in turn their behaviour. This is often referred to as the Knowledge-Attitude-Behaviour (KAB) model (RUHBC, 1989). Inherent in this model is a subtle move towards a more complex conceptualisation of the audience who, although potentially swayed by media messages, is less passive. Existing attitudes and beliefs are seen as mediating variables in the process of message transmission (Atkin & Wallack, 1990; NHACHD, 1998; Tulloch & Lupton, 1997).

The effects tradition is socially naïve in assuming that the perceptions and behaviour of audiences generally reflect the messages that they receive (Morley, 1992). It contributes to a situation where television is blamed for a

raft of social problems, including the incidence of criminal offending, low educational performance, and the incidence of preventable ailments among lower SES groups (*cf.* Seiter, 1998). As a result of tracing the process of change from a message to a person's attitudes, beliefs, and eventually behaviour, what is neglected is an adequate explanation of socio-structural issues, such as widening inequalities of access to a range of social resources. It is not surprising that such thinking is often associated with conservative political movements and pressure groups. In light of growing social inequality it seems morally reprehensible to blame television for social ills. When one considers the influence of social circumstances on people's lives the idea that turning off television will solve social problems seems naïve and at best a political diversionary strategy (*cf.* Seiter, 1998).

We do not believe everything other people tell us, so why would we believe everything that we see on television. The uses and gratifications tradition recognises that the meanings produced by audiences are not homogenous across society. This realisation is reflected in a move away from a conceptualisation of a mass audience, made up of manipulatable individuals, to the development of a more plural conceptualisation of individual viewers (*cf.* Abercrombie, 1996; McQuail, 1991). Katz's (1959) often cited statement signaled a shift in focus for some researchers from effects, or what the media do to people, to uses and gratifications, or what people do with the media. Attention within the uses and gratifications tradition is given to what people, who possess various values, opinions, and experiences, do with the programmes they watch (Dayan & Katz, 1992). According to this functionalist tradition, the effects of television are mediated in accordance with the functions programmes serve within an individual's life. Viewers are said to produce differentiated interpretations from and uses for programmes in accordance with their personal needs, interests, and goals (Katz, Blumler & Gurevitch, 1974). This tradition draws on expectancy-value theory, where programme selection and use is

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thought to be conducted in accordance with the expected gratification of personal needs (*cf.* McQuail, 1994). Research primarily explores what people use programmes for (i.e., gaining health information) and what people gain from viewing (i.e., knowledge of heart surgery). Proponents of this psychologically oriented tradition propose that different viewers can use the same message in vastly different ways. As a result research often emphasises the different uses and interpretations of the same programme that viewers create according to their differing life experiences and needs (*cf.* Jensen, 1988; Rubin & Perse, 1987).

The uses and gratifications tradition is problematic because it focuses overtly on the individual and his or her uniqueness and personality to the detriment of socio-structural considerations and material circumstances. This tradition is fundamentally flawed because it overestimates the openness of programmes to varying uses and interpretations. Although it foregrounds a discussion of viewer activity, it also downplays the influence of the programme's framing of concerns and the restraints imposed by social power relations (Elliott, 1974). Viewer uses are explored as the product of individual psychological processes (Morley, 1983). As a result, *this tradition can lead to the view that viewers are not guided by the programme in creating meaning* (Abercrombie, 1996). Although health coverage is shaped by medical explanations, viewers can read such coverage in any way they choose. Despite attention being focused primarily on the uses programmes serve for viewers and the gratification audience members obtain from viewing, there is no reason why the role of the programme could not be included more strongly within this tradition as a means of overcoming such limitations (*cf.* Renckstorf & McQuail, 1996).

The idea that, although programmes serve various functions for viewers, they can also influence people's interpretations is evident in recent public health research, which combines elements of the effects and uses traditions

in an attempt to account for the complexities of health communication. For instance, in a New Zealand study, Wyllie, Holibar, Casswell, Fuamatu, Aiolupatea, Moewaka Barnes and Panapa (1997) analysed young people's responses to television alcohol advertisements and whether these advertisements encouraged drinking. The study demonstrates the concern of health promoters over the effects of unhealthy messages while acknowledging the plurality of possible audience interpretations and uses. It was argued that, because the advertisements offered positive associations between alcohol and fun times, they increased the likelihood that young people would imitate the drinking behaviour depicted. What Wyllie and colleagues demonstrate is a need to account for the influence of health depictions on viewers and the active process of reception where programmes can be used and interpreted in various ways. Although Wyllie and colleague's research reflects a shift towards the centre of our audience-power continuum, public health research remains predominantly locked within the behaviourist-orientated effects tradition exemplified by the KAB model (*cf.* Parrott, 1996; Ratzan, 1998; Tulloch & Lupton, 1997).

In sum, within effects research, where the focus is on historical and social determinants, the person can disappear from view as a manipulated, unthinking, cultural dupe. Theorising along such lines constructs the individual as a product of ideology, which shapes who they become, and what they can know (*cf.* Althusser, 1971). Here the individual is attributed limited agency and is conceptualised as a product of social structures and as being tricked into a false consciousness (*cf.* Bordwell, 1996). Such thinking is associated with a view of society as an unthinking mass of passive individuals manipulated by dominant forces (Billig, 1991). Ready-made messages are transmitted to the audience via television in the interest of powerful groups and restrict not only how people see the world but also who they become. Because the focus is on social influences shaping contemporary existence through television, we are left with a

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history without actors, where ideologies and discourses, not people, possess agency (Bordwell, 1996; Giddens, 1994). Conversely, within uses and gratifications research, influenced by psychological models of cognition, social determinants are downplayed and the individual becomes the primary concern. This tradition can lead to the view that individuals stand and think outside history and are independent of contemporary social life (Billig, 1991). Such thinking results in an overemphasis on individual agency and a neglect of social constraints.

What is needed is further theorising of the middle ground between the effects and uses and gratifications traditions (Liebes & Katz, 1990). The development of the influences tradition, discussed in the following section, is an attempt to combine insights from both effects and uses and gratifications traditions and to theorise the relationship between people, social structures, and television coverage. However, this tradition has not been as prominent within psychology and health communication as it has in media and cultural studies. The majority of psychological and public health research still draws either on the effects or the uses and gratifications traditions (*cf.* Walkerdine, 1996).

4.2 The Influences Tradition

The encoding-decoding model developed by Stuart Hall (1980) represents an influential attempt to theorise the middle ground between the effects and uses and gratifications traditions, while accounting for the social context within which programmes are produced and watched. Hall's model demonstrates the interconnected character of programme and reception research. The focus is shifted from either television or the audience to a semiotic process in which the meaning of a programme is produced. This seminal influences model combines insights from varying fields such as sociology, communications theory, and psychology into a richer conceptualisation of the relationship between television and the audience

(Cruz & Lewis, 1994). Programmes are conceptualised as signifying systems (the outcome of hegemonic thought) whose codes are read by the audience (Lewis, 1991). The encoding (production) and decoding (reception) environments are identified as separate semiotic processes in a manner that theorises television influences while recognising audience activity. The model emphasises both encoding and decoding as parts of a social process in which the meaning of a programme is produced in an interaction between what is encoded into the programme and the sub-cultural context within which a viewer decodes it.

Programmes are conceptualised within the encoding-decoding model as discursive texts which are constructed out of social belief systems. The meanings encoded into these programmes are in turn decoded by socially located viewers who also draw on social belief systems. This separation of encoding and decoding is intended to highlight that production staff encode belief systems in accordance with their social class and professional training. Meanwhile viewers who generally exist in different interpretive communities (sub-cultures) from producers often access different belief systems in decoding the text and thus produce divergent interpretations (Hall, 1994).

This model states that the preferred reading or perspective encoded into a programme is only one of a number of readings that may be decoded from that programme. As a result Hall (1980) draws on the three ideal types of readings developed by Parkin (1971): dominant, negotiated, or oppositional readings. A dominant reading is in accordance with the hegemonic preferred meaning of the programme. Such readings occur when viewers draw on the beliefs and values that dominate society and programmes. In contrast, an oppositional reading is the opposite of the preferred reading. Oppositional readings occur when viewers draw on beliefs and values that contradict those informing dominant readings. A negotiated reading is

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somewhere in between dominant and oppositional readings. Negotiated readings reflect dominant beliefs and values while not accepting them entirely. These readings often involve audience members making programmes fit with their own experiences, interests, and views.

Hall (1980) uses the concept of hegemony to associate the preferred reading of a programme with the dominant values and taken for granted beliefs of powerful forces in society. Television coverage is thought to give primacy to the definitions and ideas of powerful groups such as the medical profession, which viewers can accept, oppose, or negotiate. The key insight is the recognition that the meanings encoded by producers in constructing an exposition are not necessarily those which are taken up by viewers. As a result, the encoding-decoding model has sparked empirical research which explores the different readings viewers produce when drawing on the conceptual resources available in their interpretive communities (McQuail, 1994; Nightingale, 1996). What is explored in such research are the ways interpretations differ in accordance with audience characteristics, such as SES, ethnicity, and gender.

In what is generally considered to be the first such study, Morley (1980) investigated the types of readings of a current affairs programme made by different groups such as bank managers, students, and union representatives. This study followed on from a detailed analysis of the programme (Brunsdon & Morley, 1978) and was designed to elaborate the programme's encoding and then explore various decodings (*cf.* Seiter, 1998). Morley (1980) found that everyday interpretations of programmes were collectively constructed within social interactions between members of various sub-cultural groups and that various groups made different readings of the same programme based on their unique belief systems. This early application of the encoding-decoding model served to challenge stereotypes about the passive, uneducated couch potato by showing that

viewers were capable of producing sophisticated readings by drawing on various discourses available within their sub-cultural groups (*cf.* Morley, 1983). What Morley's analysis also showed was the fluid and contradictory interpretations that emerged within sub-cultural groups where respondents drew on both conservative and radical political views, depending on the issue being discussed (*cf.* Nightingale, 1996). This complexity was not adequately investigated in this early study. However, it did contribute to Morley concluding that a more complex understanding was required to explore the ways demographic factors predisposed certain readings while also allowing for variance within groups. Subsequently, the encoding-decoding model has been refined and applied in ethnographic studies, often within the domestic context (*cf.* Lull, 1990), which have demonstrated that television viewing is influenced by a range of social relationships, institutions, and rituals as part of the flux of everyday life (*cf.* Nightingale, 1996; Seiter, 1998).

Despite establishing the need to look at television influences and the role of social circumstances in determining what people make of programmes, the encoding-decoding model has limitations (Hall, 1994; Morley, 1991). Although the three-way segmentation of readings was intended as a taxonomy to initiate research with various sub-cultural groups, it has proved to be overly restrictive and to overlook the complexities of reception. For instance, this model has made it difficult to differentiate between various oppositional readings. Placing a diverse array of interpretations under the heading 'Oppositional Reading' can lead to the disregard of differences that exist between such readings (*cf.* Richardson & Corner, 1986). Viewers from the same sub-culture may make oppositional readings which contradict each other. Two such viewers may oppose a programme for quite different and perhaps opposing reasons. Furthermore, another viewer may produce a negotiated reading that does not lie between a dominant and oppositional reading but between two oppositional readings. There is also an assumption

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that the three types of reading are roughly equal. Empirical research shows that most readings are negotiated and do not fit neatly into the three categories (Fiske, 1987; Morley, 1992).

Another important limitation in the encoding-decoding model is the lingering assumption that programmes reflect the dominant social norms of a consumerist society. As a result programmes are often conceptualised as forces of social domination and audiences as accepting, partially accepting, or opposing domination. Television may serve such ideological functions, but this is not the whole picture and may have been overstated to the detriment of analysis of the socially challenging aspects of television coverage. Coverage does not always support the views of dominant groups and can reflect the contradictory and contested meaning systems of society, including the views of subordinated groups (*cf.* Abercrombie, 1996; Corner, 1995; Curran, 1996). This is not to say that coverage is not influenced by dominant meaning systems such as the medical approach, but that coverage is more complex than was initially theorised in this model. An interesting problem arises when we realise that some programmes actually challenge social norms. As a result, the preferred reading encoded into such programmes may not coincide with the interests of dominant groups in society. In short, the encoding-decoding model, although a valuable development, is overly mechanistic and does not adequately reflect the complex and contradictory character of health coverage or reception. Neglected are the complexities arising from the negotiation of meaning and the ways in which lay thought may also influence the scope and shape of coverage.

Despite its limitations the encoding-decoding model has been highly influential in shaping influences research and the development of additional models (Ang, 1985; Fiske, 1987; Lewis, 1991; Liebes & Katz, 1990; Silverstone, 1994). For instance, the resistive model, associated with the

work of John Fiske (1987), extends the encoding-decoding model towards the uses and gratifications end of the audience activity continuum. Fiske works with the notion of oppositional readings to explore more fully audience resistance to social domination. It is useful to distinguish between resistive and oppositional readings at this point. Both concepts are similar but oppositional reading is narrower. Oppositional reading implies the recognition of a preferred reading within a programme and a dismissal of it in favour of an opposing view that may be based on the values and beliefs held by a viewer. The concept of a resistive reading draws on assumptions inherent in both negotiated and oppositional readings. A resistive reading works with the beliefs and values presented in a programme, exploiting ambiguity idiosyncratically in negotiating a counter-hegemonic interpretation (Morley, 1993).

Essentially, Fiske (1987, 1989, 1993) provides an exploration of audience pleasures in resisting domination through the creation of various resistive readings. The viewer in Fiske's model resists ideological and social domination by reading the symbolic products of a capitalist society, such as television programmes, in a resistive manner that reflects their sub-cultural context and interests (Lembo, 1994). A key element of this tradition is where the text is said to reside. For Hall the text exists within a programme and is read in various ways by viewers. For Fiske the text lies between a programme and a viewer and is socially negotiated during the viewing process. As Fiske writes, "the programme is produced by the industry, a text by its viewers" (1987, p. 14). A programme is said to be polysemic or capable of supporting a range of resistive readings.

Fiske's work also reflects aspects of the ritual model of communication (Carey, 1975), which focuses on the social negotiation of meaning within various interpretive communities. Television is conceptualised as a symbolic resource for the circulation of explanations in society. The

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meanings negotiated in social interactions such as television viewing are not necessarily in the interests of dominant groups, as coverage is subjected to and integrated within the sub-culture of viewers. Fiske has provided a valuable discussion of the counter-hegemonic readings viewers negotiate from programmes and further highlighted the possibility of a dialogical relationship between programmes and various audiences. He has situated television within everyday life as a resource that viewers can draw on to make sense of their world. The idea that programmes can be used as resources is a valuable one because it foregrounds the ways viewers actively relate their own experiences to wider social concerns when interacting with television programmes.

Although the resistive model foregrounds the social negotiation of meaning, it can lead to an overemphasis on symbolic resistance and the ignoring of material restraint. Fiske has been criticised for overemphasising the ability of the audience to read programmes resistively and, in the process, romanticising the audience. Such romanticising can lead to notions of consumer sovereignty and an overjustified level of audience autonomy (Curran, 1996; Morley, 1993, 1996). He also mistakes the availability of a range of resistive readings for a lack of programme influence over the shape of viewer interpretations (Morley, 1991). Fiske's work also highlights that a focus on audience activity in reception research can lead to the neglect of the programme in favour of a preoccupation with audience resistance (*cf.* Nightingale, 1996). Although Fiske (1993, 1996) has acknowledged the political economy of television he chooses to focus on resistance, which can be politically dangerous. If the influence of programmes on the meanings viewers produce is not continually highlighted then how can broadcasters be held accountable for what is broadcast? Furthermore, viewers do not set the agenda of coverage and are active only with what other people decide to broadcast (Ang, 1990; Lewis, 1991; Morley, 1996). It is one thing to be able to negotiate the

meaning of programmes and another to decide what is broadcast and how a topic is framed. This model is also problematic because it assumes the positive or progressive character of resistance to hegemonic domination. However, as Kitzinger writes, “should ‘audience resistance’ be celebrated if people reject the primary message of a mass media campaign to encourage safer sex or discourage violence against women?” (1999, p. 19).

Both the encoding-decoding and the resistive models exemplify how television has been explored as a site of struggle over social domination and resistance. Debates between theories of subjectivity, emphasising social domination (Althusser, 1971), and agency, emphasising subordinated groups coping with domination (Bourdieu, 1984), have shaped contemporary reception research (Fiske, 1993). Effects research, which focuses on ideological domination, has overemphasised the power of television and underemphasised the power of the viewer. Conversely, agency-orientated uses and gratifications research has overemphasised viewer autonomy and underemphasised the influence of television. The value of the encoding-decoding and resistive models is that they highlight the negotiated character of television’s influence and the active role of the socially located viewer. Although influences research has begun to look at the social negotiation of the meaning of programmes, the influence of earlier effects and uses research remains, and the corresponding emphasis on social structures and agency is still evident.

Contemporary influences research conceptualises viewers as active interpreters within social conditions not of their own making (e.g., Silverstone, 1994; Livingstone, 1998). Over a decade of such research has shown that people negotiate interpretations within the material and social restraints imposed by contemporary existence (e.g., Abercorombie, 1996; Ang, 1985; Angus, 1994; Corner, 1995; Kitzinger, 1993; Liebes & Katz,

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1990; Livingstone, 1998; Livingstone & Lunt, 1994; Lull, 1990; Morley, 1986, 1992; Silverstone, 1994). An emphasis on audience activity and diversity of interpretations is a highly prevalent feature of such research. Viewers can step outside a programme's perspective and construct their own interpretations. They have been found to make sense of programmes by negotiating interpretations within the context of their life circumstances, biographies, existing experiences, and the programme's perspective (e.g., Liebes & Katz, 1990; Livingstone, 1998; Philo, 1999; Richardson & Corner, 1986; Tulloch & Lupton, 1997). Such research is adding depth to our understanding of the middle ground between the power of television and the power of the audience. What is being debated among influences researchers is where the balance should lie between television influence and audience activity (*cf.* Abercrombie, 1996; Corner, 1995). Recent influences theory has extended the focus on the social negotiation of meaning and called for further explorations of the ways common knowledge is mediated through television and renegotiated by viewers (e.g. Corner, 1999a; Ellis, 1999; Livingstone, 1999).

At this point it seems appropriate to refer to some studies which have drawn on the influences tradition to explore aspects of the reception of documentary (Corner & Richardson, 1986) and health coverage (Kitzinger, 1993). Such studies illustrate the kinds of insights that can be gained by combining an analysis of television coverage with audience activity. Corner and Richardson (1986) explored the ways various topics were covered in British documentaries and the ways viewers assessed these programmes. They found that the way a programme presents a topic, both visually and verbally, influences viewers' interpretations, but that these influences are subject to critical reflection based on viewers' existing knowledge of the topic. Viewers are aware that programmes are constructed to promote a certain perspective on a topic and can step outside that perspective to judge the adequacy of the coverage provided. Showing similar patterns of viewer

activity to Corner and Richardson (1986), Kitzinger (1993) explored the relationship between audience knowledge of HIV/AIDS and television coverage. This author also found that viewers draw on their own knowledge and experiences to construct critical interpretations of coverage that identified limitations and omissions. Participants in both studies explored coverage as a series of mediated accounts rather than transparent representations of events in society. These findings highlight the need to explore television coverage and audience interpretations simultaneously while accounting for the socio-cultural context within which these interactions occur.

In a recent synthesis of their previous work into the ways representations of HIV/AIDS are constructed within risk culture through the tripartite components of production, programme, and reception, Tulloch and Lupton (1997) employed what they refer to as a cultural studies approach to health communication. Generally supporting the findings of Corner and Richardson (1986) and Kitzinger (1993), they found that, although viewers were active and interpreted coverage in unpredictable ways, the framing of HIV/AIDS and risk within health coverage had a considerable influence that was mediated through personal biographies. They also found that certain health and illness explanations circulating within society at the time of their investigations shaped both health coverage and reception. What emerges from such studies is the need to explore the ways in which health concerns are worked through in relation to health coverage and audience interpretations as part of the social negotiation of health and illness.

Such influences research informs this thesis and provides insights for my exploration of the socially negotiated character of health communication. Arguments raised in this and the previous chapter will be integrated in the next chapter to theorise the relationship between health coverage and lay views. Chapter Five also outlines the philosophical stance taken in this

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thesis to explore the social construction of health and illness within health documentary coverage and lay accounts.

Chapter Five

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Owing to the complex relationship between programmes and the audience, there has recently been considerable academic interest in combining an analysis of television coverage with actual viewer interpretations (e.g., Abercrombie, 1996; Corner, 1995; Livingstone, 1998; Morley, 1992; Silverstone, 1994). The integration of programme analysis and reception research is generally considered to be necessary because programmes and the audience are interdependent in the creation of meaning. An analysis of health documentaries can establish how health is covered on television but not what the audience makes of such coverage. To answer questions about audience interpretations, there is a need to engage with actual viewers. Reception research offers useful tools for engaging with viewers but provides a limited account of what occurs on the screen. Therefore, by combining analysis of health documentaries with analysis of reception, limitations in both programme and reception research may be minimised. This thesis extends previous research to conceptualise a socially embedded audience (New Zealanders of lower SES) whose views on health and illness are renegotiated through interactions with health coverage. In doing so, it investigates the social negotiation of the meaning of health and illness at the programme and the audience levels, while accounting for the social context within which health communication occurs.

This chapter outlines the relationship between health coverage and the audience. No single documentary or reception framework provides an adequate explanation of the diversity of health coverage and audience

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interpretations. As a result, this thesis adopts an eclectic approach (*cf.* Morley, 1998) that emerges from the arguments presented in the previous chapters. It also reflects recent attempts within social psychology to account for the ways in which people make sense of phenomena such as health and illness in everyday social interactions. The first section situates this thesis within recent social psychological writing on the social character of human thought. In the process the philosophical basis for this thesis is established. A second section builds on the first to clarify the focus of this thesis and the relationship between health coverage and people's views on health and illness.

5.1 Taking a Stance

The last three decades have seen an increasingly critical focus in social psychology (Burr, 1995; Farr, 1996; Gergen, 1997). This is reflected in the development of research strategies that are not based on natural science models (often referred to as positivist or objectivist) within which a neutral observer is said to have unmediated access to events in the real world (Guba & Lincoln, 1994; Semin & Gergen, 1990). Alternative strategies have grown out of criticisms of traditional social psychology as an overly individualistic enterprise that often results in inadequate attention being given to the influence of the social context on human thought and action. As a result of what has been termed the crisis in social psychology, involving debates around appropriate methodology (quantitative or qualitative) and epistemological concerns (Parker, 1989), increased attention has been given to accounting for the socially mediated character of human thought and action.

These changes signal the return to more socially oriented theories, such as social interactionism, developed in the pre-behaviourism era of psychology (Farr, 1996; Martin & Thompson, 1997). Renewed efforts are being made to explore the social basis, flexibility, richness, and creativity of human

thought (Billig, 1991; Harré, 1979; Moscovici, 1994; Parker, 1989). Changes in social psychology reflect a move away from the investigation of people's attitudes, opinions, and beliefs, as static manifestations of individual personalities and cognitions, to the social representations and discourses which shape the ways people come to see the world. This involves more than a shift in focus from mental structures to social processes. It involves an exploration of the ways human thought is constructed through social interactions within specific historical epochs (*cf.* Billig, 1991, 1997a; Farr, 1996; Gergen, 1997). The focus is on the ways people make sense of the world rather than on developing causal models from which to measure and predict behaviour. In short, alternative strategies do not separate the individual from the social but focus on the ways social forces shape how people see the world. These shifts generally reflect efforts to put the personal and the social back into social psychology and acknowledge the social interactionist origins of the discipline (Farr, 1996).

It is not my intention to provide a detailed discussion of all these developments and various points of contention. Reviews that recount limitations of earlier paradigms and express the virtues of current academic thinking are readily available in the psychological literature (e.g., Billig, 1991; Farr 1996; Gergen, 1976, 1982, 1985, 1997; Harré, 1979; Parker, 1989, 1997; Sampson, 1983). Nor do I wish to claim to have resolved debates, recently re-emerging within psychology and other social sciences, around the nature of reality (ontology) that have direct implications on what we can know as researchers (epistemology) (*cf.* Farr, 1996; Potter, 1996). When discussing debates at the epistemological level, Becker makes the point:

Epistemological issues, for all the arguing, are never settled, and I think it fruitless to try to settle them, at least in the way the typical debate looks to. If we haven't settled them

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definitively in two thousand years, more or less, we probably aren't ever going to settle them (1993, p. 219).

Researchers need to provide an informed position on these issues without becoming paralysed from conducting research because they cannot resolve long-standing philosophical debates. My primary interest is not with the nature of reality or what we can know, but with the social negotiation of the meaning of health and illness. However, it is necessary for me to highlight some of the assumptions underlying this thesis, particularly those pertaining to the social character of lay views. Therefore, what follows is a brief account of the philosophical stance guiding this thesis: a version of social constructionism that combines a realist ontology with a constructionist epistemology (Crotty, 1998).

Generally, social constructionists postulate that people produce their ideas about the world and social reality within the social belief systems and practices of a given society (Berger & Luckmann, 1967; Crotty, 1998; Gergen, 1985; Harré, 1979; Moscovici, 1994). For many social constructionists research involves an exploration of how people make sense of and explain the world and an attempt to create a rich interpretation of social phenomena (e.g., Lupton, 1994; Radley, 1994, 1999; Stainton Rogers, 1991). A diverse array of stances is encapsulated under the banner of social constructionism, particularly within social psychology. These range from a focus on the social mediation of human understandings of a real world (Moscovici, 1994; Parker, 1992, 1997), to a focus on the construction of meaning through various linguistic discourses, which radically questions the relationship between human understanding and an external reality (Edwards & Potter, 1992; Potter, 1996). The first stance retains the notion of a real world in order to address the negative consequences of social events such as structural inequality. The second is not primarily concerned with such external events and investigates the ways people's accounts are shaped to appear factual and the social functions this serves. Taking this second stance can result in the reduction

of contemporary existence to discursive play, where a concern for material issues such as inequality is replaced with a focus on the use of linguistic devices to achieve certain social actions. Owing to the political and material nature of the health issues I wish to explore, this thesis is aligned with the first stance (*cf.* Bhaskar, 1989; Fiske, 1994; Martin & Thompson, 1997; Morley, 1997; Parker, 1992; Yardley, 1997).

Before elaborating this social constructionist stance I will briefly introduce the objectivist and subjectivist positions between which it is located (Crotty, 1998). According to the objectivist position a real world exists independent of human consciousness. Things exist in the world as meaningful entities with their own properties which can be discovered through careful investigation by neutral observers. This is the position generally adopted in traditional empirical psychology. Conversely, according to the subjectivist position human thought is a creative enterprise independent of and unrestrained by what people take to be real things. What is true and taken to be the property of things is relative to the conceptual scheme employed and the meanings people impose on these things. Reality is the product of, and therefore relative to, a given conceptual scheme (*cf.* Martin & Thompson, 1997).

Social constructionism in psychology is often associated with the subjectivist position and is presented as an extreme alternative to objectivism or traditional empirical psychology. The realisation that totally objective or neutral observations of things in the real world are problematic has led some psychologists to the other extreme of assuming that knowledge is totally subjective and relative to one's theory or conceptual framework. This is reflected in the appropriation of post-structuralist theory, particularly in the area of discourse analysis (e.g., Burr, 1995; Edwards & Potter, 1992; Gergen, 1997; Potter, 1996; Stainton Rogers, 1996). However, even if some psychological constructs, such as attitudes, are

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socially constructed and reified (Potter & Wetherell, 1987), this does not mean that all psychological phenomenon is totally relative to our theoretical frameworks (Martin & Thompson, 1997; Abraham & Hampson, 1996). In exploring such issues, other social psychologists have highlighted the need for a balance between objectivism and subjectivism (e.g., Harper, 1996; Harré, 1997; Martin & Thompson, 1997; Parker, 1992, 1997). Some notion of a real world independent of human consciousness is necessary, particularly when investigating topics such as illness, which are embodied and inherently physical as well as psychological and social events (*cf.* Yardley, 1997, 1999).

Such a stance is adopted in this thesis because it provides a response to the objectivism of traditional empirical psychology and the subjectivism of post-structuralist informed psychology. From this stance things can exist in the real world but the meaning of these things does not exist independently of our knowledge of them. Crotty writes, “according to Constructionism, we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and objects in the world” (1998, p. 44). The things we interpret generally do not exist within our conceptual frameworks alone, nor do they simply exist outside these frameworks. Things can exist in the world independent of human consciousness but are assigned meaning in the interaction between the properties of these things and human consciousness (Sayer, 1992).

Our interpretations are social constructions produced in specific historical epochs. However, they generally do relate to the real world and tell us something about, rather than simply construct, the things we investigate. It is possible to recognise the constructed character of our research without having to assume that the subject matter of our studies exists only within the conceptual frameworks we employ. Although we know our participants through the frameworks we use to design and conduct research, these

participants still exist outside these frameworks. Briefly, what is required is a focus on the social construction of health and illness which also acknowledges the material basis of such constructions. From the stance adopted in this thesis a realist ontology is compatible with a constructionist epistemology (*cf.* Crotty, 1998).

The social constructionist stance adopted here provides a position from which to explore the symbolic resources people draw on when making sense of health and illness while still acknowledging that many ailments and health concerns do have a material basis (*cf.* Parker, 1997; Yardley, 1997, 1999). As Lupton writes:

The social constructionist approach does not necessarily call into question the reality of disease or illness states or bodily experiences, it merely emphasises that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis (1994, p. 11).

From this stance pain, suffering, and limited life chances really do exist even though people's experiences of these things are socially constructed (*cf.* Bhaskar, 1989; Martin & Thompson, 1997; Parker, 1992). Such a stance enables me to talk about real events, such as health inequities while accepting that knowledge of such things is produced in a social context.

From this stance it is also possible to acknowledge that social constructions such as inequality can have material or physical implications. For instance, the uneven distribution of resources or social inequality can be manifested physically in lighter bone density and shorter height for people of lower SES (Yardley, 1999). Such implications exemplify how social power relations influence the shape and scope of social constructions and that these constructions have ramifications for people's health (*cf.* Parker, 1997). Taking this stance enables attention to be paid to

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the implications of the ways we make sense of health and illness and whose interests are served in the process (*cf.* Bhaskar, 1989; Parker, 1992, 1997). For instance, the medical approach remains dominant at this time and presents biological explanations for disease which often overlook social and political influences. Thus illness is often treated on an individual basis while various social structures that can cause illness are left in place. As a result inequities, resulting from the present socio-economic system, are not addressed.

According to the social constructionist stance adopted in this thesis the person and the social are so intertwined that they need to be studied together, particularly because people's views are not something they produce in isolation but are constructed through interactions within the social world (*cf.* Billig, 1991). Correspondingly, the focus of this research is not on the individual minds of people, but rather the conceptual resources available in society for people to make sense of health and illness and their personal place in the world (*cf.* Billig, 1997a). This focus is appropriate according to Crotty:

It is clearly not the case that individuals encounter phenomena in the world and make sense of them one by one. Instead, we are all born into a world of meaning. We enter a social milieu in which a 'system of intelligibility' prevails... For each of us, when we first see the world in meaningful fashion, we are inevitably viewing it through lenses bestowed upon us by our culture (1998, p. 54).

According to this stance, people's views are not just their own but are derived from various ready-made frameworks. People's access to the material and social world is mediated through what other researchers have referred to as common sense beliefs (Campbell, 1991), social representations (Farr, 1995) or discourses (Parker, 1992). It is not my intention to delve into the various points of contradiction and debate between these various traditions. Generally, each term has been used, within different theoretical traditions, to refer to the socio-cultural

explanations people use to make sense of the world (Fiske, 1994; Moscovici, 1994). Socio-cultural explanations can be described as shared ways of defining, categorising, and understanding health and illness that are evident in the language, images, music, behaviours, and everyday practices of a given society (*cf.* Farr, 1995; Parker, 1992).

As a reflection of developments discussed above, health psychologists have recently become interested in the social origins of the views voiced by lay people, which have traditionally been investigated by anthropologists and sociologists (*cf.* Bury, 1997; Farr & Markova, 1995; Radley, 1994; Stainton Rogers, 1991; Williams & Calnan, 1996). This thesis draws on such social constructionist research to explore the ways people weave together various socio-cultural explanations to make sense of contemporary health concerns. In doing so it is proposed that these explanations provide the foundations for people's views, but are not simply reproduced (Bhaskar, 1989; Giddens, 1991). We construct our views out of ready-made explanations, which we interpret in various ways. Each of us produces idiosyncratic versions of the social stock of common explanations in order to deal with the complex situations in which we find ourselves. We possess the capacity to reflect on various communal ways of understanding events and to construct our own views (Bhasker, 1989; Giddens, 1991). In line with such reasoning, there is an emphasis in recent psychological writing on people as creative weavers of socio-cultural explanations (*cf.* Billig, 1991, 1997b; Farr, 1995; Harper, 1996; Parker, 1992; Smith, 1996; Stainton Rogers, 1991). This literature proposes that although our thoughts are shaped by various socio-cultural explanations, we are not passive cultural dupes. The social mediation of human experience is both the result of existing social meaning systems and the innovations made by people as thinking beings (Giddens, 1991; Harré, 1997). However, this does not mean that social power relations do not influence the scope and shape of people's views. For instance, the

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influence of the medical profession on the provision of health care and lay thought is well documented (*cf.* Williams & Calnan, 1996). Yet people do not simply accept medical explanations and often seek alternative solutions to health problems (*cf.* Saks, 1994). In sum, there is a dialogical relationship between people's creative use of socio-cultural explanations and the restraints or potentialities contained within these explanations (*cf.* Billig, 1997a; Parker, 1992, 1997).

Various debates, complexities, and contradictions surrounding the ontological status of people's views have emerged with the focus on the social origins of human thought within social constructionist theory and research (*cf.* Abraham & Hampson, 1996; Billig, 1991, 1997a; Coffey & Atkinson, 1996; Crawford, 1984; Harper, 1996; Radley & Billig, 1996; Williams, 1990; Williams & Calnan, 1996). What is becoming clear is that people's opinions, beliefs, or views are socially produced and are more complex and contextually variable than has been traditionally assumed. Stating that people draw on multiple socio-cultural explanations to construct their views is a plausible alternative to simply assuming that our attitudes or opinions are manifestations of either individual personalities or social structures. What is being proposed here is that people's views are 'dilemmatic', encompassing various contradictory themes which are negotiated by people in everyday interactions across the course of their lives. In constructing these views people accept some explanations, reject others, and create their own views as a means of making sense of complex events in their lives such as when they or a friend become ill (*cf.* Radley, 1996).

Within contemporary society, many of the explanations from which people forge these views are derived from sources other than face-to-face interactions. As an institutionally mediated cultural forum, television health coverage helps set the agenda for what people discuss in everyday

conversations and the explanations which are seen as pertinent to such discussions (*cf.* Farr, 1995). Television viewing is an important means through which health explanations are circulated in society, taken up by audience members, and used as resources for making sense of health and illness. Therefore, an exploration of health coverage and audience interpretations can contribute to research into the social character of people's views of health and illness.

5.2 Health Documentary and the Audience

Traditions in programme and reception research, outlined in previous chapters, inform the stance developed in this chapter. Critical and effects research has emphasised the impact of powerful forces in society, such as the medical profession, in shaping the agenda of health coverage and people's views. Pluralist and uses and gratifications research has emphasised the progressive aspects of television coverage and the various ways audience members use television programmes to serve a range of functions. Between these extremes the influences tradition can be used to emphasise both the importance of television as an institutionally mediated cultural forum that circulates certain socio-cultural explanations and the importance of viewer's interpretations, which are constructed within socially located interactions. An active viewer who constructs various interpretations of programmes, within the context of restraints imposed by the programme and his or her life circumstances and biographies, is a central assumption to this research.

When reviewing television research, a number of writers (e.g., Corner, 1995; Lewis, 1991; Livingstone, 1998; McQuail, 1994; Silverstone, 1994) have commented on the often unspecified nature of the term audience activity. The concept of audience activity originated within the uses and gratifications tradition as a response to the passive cultural dupe stereotype evident in the effects tradition. As a result, even when employed

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within the influences tradition, audience activity is predominantly utilised to highlight divergence in audience interpretations (McQuail, 1994; Silverstone, 1994). This can lead to the assumption that when viewers make the same or salient interpretations, which correspond with the perspective of a programme, they are being passive. Such an assumption is questionable. Viewers are active when making both salient and divergent interpretations. Salient interpretations can be explained by the reliance of programmes and viewers on a shared set of socio-cultural explanations, while divergent interpretations can be explained by viewers' drawing on different explanations from those promoted in a specific programme. Within this thesis the term audience activity refers more generally to a person's ability to interpret a programme and critically reflect on its perspective.

The conceptualisation of viewers as interpreters who actively negotiate meanings when viewing programmes is particularly evident in the work of Sonia Livingstone (1990, 1997, 1998, 1999). For instance, Livingstone (1998) provides a rich exploration of the ways viewers employ their social knowledge to make sense of soap opera characters. In doing so, she emphasises the need for socially orientated research as an alternative to research that reduces television viewing and audience activity to cognitive processing (e.g., Biocca, 1991; Harris, 1994; Ross, 1997). Livingstone conceptualises viewers not as simply information processors but as socially located interpreters of programmes. She investigates the interactive processes through which people negotiate meanings out of the structure of the programme and their existing knowledge. As Livingstone writes, "social knowledge and text structure are both determinants of viewers' representations, and each serves to modify or buffer the influence of the other. The resultant representation depends on the input of each and of the nature of the negotiation between the two" (1998, p. 149).

Stating that people are active interpreters of programmes need not lead to the assumption that viewers are totally aware, self-directed beings who are autonomous in all their interpretations. To propose that people actively interpret programmes does not imply that programmes have no influence on audience interpretations. Rather, it reflects the realisation that television viewing is a complex socially negotiated process involving both programme and viewer influences. Research into audience reception of news and current affairs has shown that often viewers obtain explanations from both programmes and the viewing context (e.g., Corner, 1995; Lewis, 1991; Morley, 1983). Despite viewers' expressing cynicism about aspects of television coverage, quite often the overall perspective of a programme is accepted. Therefore, ignoring either the influence of the programme or the creativity of viewers would be a mistake. Research needs to account for both the influence of health coverage and the active role of the audience in negotiating interpretations.

The emphasis on audience activity and the importance of the structure of programmes points to the need to differentiate between what appears on the screen and viewers' interpretations. Such a distinction can be derived from recent media theory. For instance, within the neoformalist tradition of film and television analysis, a distinction is made between the plot (syuzhet) and the story (fabula) (*cf.* Bordwell, 1989; Chisholm, 1991). The plot is the structured set of causal events which appear on the screen. The primary role of the plot is to present the content of the programme in the form of an exposition. The story is the interpretation of the plot that is constructed by the viewer. The story includes elements that do not appear on the screen but are derived from other sources, such as a person's biography. Such distinctions reflect the realisation that the meaning of a programme is negotiated between programmes and viewers. This links back to the idea that a programme is produced by the broadcasting industry and that the story (text) is the viewer's interpretation of that programme (*cf.* Fiske, 1987).

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These interpretations are social constructions that are forged by people from various explanations made available to them by the programme being watched and their sub-cultural contexts and personal biographies.

This relationship between health coverage and the audience is complex. People's biographies are shaped not only through face-to-face interactions but also through previous interactions with health coverage. The influence of previous viewing is evident when people refer to examples derived from previous interactions with health coverage to raise criticisms of a given programme. At one level they are being critical of coverage and at another their views are clearly influenced by previous viewing (*cf.* Kitzinger, 1999). In other words, the explanations people draw on when interpreting programmes are often derived from programmes that they have previously viewed. This process reflects the socially located character of audience interactions with health coverage, which occurs within the ongoing negotiation of people's views.

When watching television people relate their experiences to what appears on the screen as part of an ongoing process of formulating, solidifying, or transforming their views. Audience members use health coverage to interpret their experiences and use their experiences to interpret health coverage. Over time, their experiences and ideas generated when watching television become part of the context within which they interpret subsequent programmes and other events in their lives. An ongoing filtering activity occurs, where aspects of a health documentary are integrated as part of a person's view. These views subsequently influence people's interpretations of not only other health documentaries but the experiences of friends and family, and their own encounters with health professionals. Briefly, health coverage functions as a resource which people use to help order and assign meaning to health and illness.

Exploring such processes involves acknowledging the function of health coverage in presenting new ideas and the ritualistic processes involved in the appropriation, interpretation, and social negotiation of such symbolic resources within everyday life (*cf.* Livingstone, 1999). Television viewing is not an isolated event. The emphasis placed on the social character of human thought in the previous section provides a useful basis for exploring television reception as a form of social interaction between the perspectives provided by health documentaries and the audience as active interpreters. This thesis explores the relationship between health documentary coverage and viewer interpretations as a site for the social negotiation of people's views on health and illness. Building upon points raised so far, the remainder of this chapter provides a brief synopsis of why I elected to investigate health as a subject area, television as a medium, documentary as a form, people of lower SES as a group, and take the stance I do.

In an era of increased individual responsibility and uncertainty, health is a source of concern for many (Blaxter, 1997; Crawford, 1994; Fox, 1993; Glassner, 1989; Lupton, 1995; Peterson & Lupton, 1996). Large numbers of people are concerned to behave in ways that will preserve their health and allow them to live a long and healthy life. Such concerns are representative of current trends in the Western world of heightened health consciousness, where health status is often used as an indicator of a person's status in life and self-worth. In light of the considerable public interest in health and illness and the corresponding media attention, research into the scope and shape of health coverage and its influence on people's views is timely.

Although health stories appear regularly in newspapers and on the radio no medium is as central to contemporary life as television. Television circulates a range of health explanations which are drawn on by people

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when making sense of various health concerns. Viewing television is a primary leisure activity where the concerns of life are played out and where meaning is assigned to material existence. Television is a source of shared experience, through which we can relate our experiences to wider social concerns. However, as yet researchers know little about what health coverage tells people about the causes of and possible remedies for health concerns.

There is a diverse array of television programmes providing explanations of various health concerns. Likewise, there is a range of audiences making sense of these programmes. A single thesis could not possibly cover this diversity in programmes and audiences in adequate depth and do justice to the complexities involved. Therefore, this thesis explores the ways people of lower SES actively draw on their existing views when interpreting New Zealand health documentaries. The continued focus on health concerns and the legitimacy attached to documentaries as in-depth news sources makes health documentary an appropriate form to explore. Health documentary is also one of the few television forms persistently produced in this country which presents in-depth accounts of health concerns in an attempt to inform the public. Lower SES groups were selected as an audience because this audience is one whose views are both under valued and under represented in health research, and who face persistent inequalities in health. Furthermore, since the beginning of television there have been concerns over what effects it might have, particularly on this audience. Although it is necessary to acknowledge that this audience obtains a significant proportion of their health information from television, this does not imply that one has to accept that this is a passive process that can be written off as pure escapism, requiring little or no thought (*cf.* Chisholm, 1991). This thesis will highlight some of the ways this audience actively engages with programmes rather than simply receives messages in a uniform manner.

Although important to illustrate that this is so, it is not my intention to merely demonstrate that the audience actively interprets health documentaries. My primary focus is on the shape and scope of health coverage and people's views and what this reveals about the social construction of health and illness. This investigation is guided by the following four notions: firstly, that the ways programmes cover health concerns influences the interpretations that viewers construct over time; secondly, that the audience constructs rather than simply receives meanings; thirdly, that health documentaries are open to various interpretations as part of the process by which people construct their views; and fourthly, that interactions between health coverage and viewers are central to the working through of health concerns.

In accord with the social constructionist stance adopted in this thesis, both health documentaries and participants' accounts are conceptualised as social constructions that are forged from various socio-cultural explanations in order to account for various events in society (*cf.* Billig, 1997a). This stance enables me to conceptualise people's views as being both socially and individually determined. To explore the social origins of people's views, this thesis focuses on the socio-cultural explanations drawn on in the construction of both health coverage and people's views. As Billig writes, "social psychology should reach out from the study of the individual, in order to see how wider patterns of society and of history are being reflected in the thinking of individuals" (1991, p. 2). In terms of the present study, this involves an investigation of the ways audience members actively interpret health documentaries and renegotiate their views on material health concerns by creatively weaving together aspects of various socio-cultural explanations. The method utilised to conduct this investigation is presented in the following chapter.

Chapter Six

Method

Given the stance outlined in the previous chapter, a qualitative approach was used to explore the social construction of health and illness. Various qualitative approaches have been developed over the last two decades to try and systematise and render explicit the complexities of designing and conducting qualitative research (Berg, 1995; Crotty, 1998; Miles & Huberman, 1994). However, qualitative research is a creative process and it is impossible to establish a simple step-by-step guide that will fit every research project. The steps taken must fit the questions asked and the data sources used in the research. Although a researcher may follow certain commonly accepted avenues of investigation and use particular interview and programme analysis techniques, these avenues should be seen only as guidelines that are adapted to the aims of the research (*cf.* Smith, Jarman & Osborn, 1999). Increasingly, researchers advocate developing an approach that is compatible with the purposes of a particular study and the philosophical stance taken (*cf.* Berg, 1995; Billig, 1997b; Bordwell, 1996; Coffey & Atkinson, 1996; Corner, 1997; Parker, 1992, 1997; Stainton Rogers, 1991).

Social constructionism provides a stance to investigate the processes through which people's views on health and illness are produced within social interactions, including television viewing and face-to-face conversations. Given the way that the health communication process was conceptualised in the previous chapters, an approach was developed to provide a means for creating an interpretation of health coverage, the explanations people draw on in constructing their views, and the ways

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these views are renegotiated as people interact with health coverage and each other. Three primary data sources, health documentaries, individual interviews, and focus group discussions were utilised, in a mutually supportive manner, to provide information pertinent to specific aspects of the health communication process. Essentially, this approach involved four research groups, each made up of five participants. In each instance, a health documentary was selected for a specific group of participants to watch. Members of each group took part in an individual interview prior to watching the programme and participating in a focus group discussion. The analysis of data derived from these sources provided a means of investigating the complexities of health coverage, the richness of participants' views, and the processes through which participants draw on aspects of health coverage and other people's accounts to reconstruct their views on contemporary health concerns. This approach provided a means of exploring the social origins of people's views.

An analysis of four New Zealand health documentaries was used to investigate the ways health concerns are constructed on television and to identify the underlying assumptions about health and illness that are evident within health coverage. Such programme analysis is appropriate given the social constructionist proposition that people draw on shared socio-cultural explanations in order to make sense of health and illness. Television is a primary vehicle for the circulation and renegotiation of such explanations within society. In particular, health documentaries provide ready-made perspectives on various health concerns. Therefore, an analysis of these programmes provides an indication of the types of explanations commonly circulated within society and what implications these explanations have for the scope and shape of health and illness constructions.

Although health coverage contributes to the public agenda, its influence is not all-powerful or direct. Owing to the emphasis this thesis places on people as active interpreters of the world, who draw on various sources to make sense of health concerns, there was a need to gain access to participants' existing views. Semi-structured individual interviews were used as a forum within which the types of assumptions that participants' draw on when constructing their accounts of health and illness could be identified. Such interviews are perhaps the most commonly used qualitative research technique for gaining "...a detailed picture of a respondent's beliefs about, or perceptions or accounts, of a particular topic" (Smith, 1995). These interviews provided a forum for exploring the ways each participant makes sense of specific health concerns. In short, twenty semi-structured individual interviews were used to gain in-depth information on participants' views and media use prior to their viewing and discussing one of the four programmes.

If the meaning of health and illness is socially negotiated in interactions occurring, for example, when people watch television, then this process should be apparent when people discuss a programme as a group. Focus group discussions have often been used in television research to simulate interactions which occur in everyday life when people discuss events or issues they have watched on television (Livingstone & Lunt, 1994). In providing a forum within which participants could interact relatively spontaneously with each other, four focus group discussions were used to gain information on participants' interpretations of the health documentaries and the processes by which their views are socially negotiated. These groups were used to explore the ways participants draw on their existing ideas about a topic to make sense of health coverage within the context of other participants' accounts. They also provided data on the ways participants work together to integrate elements of programmes into their shared understandings of various health issues (*cf.* Livingstone & Lunt,

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1994; Morgan, 1997; Wilkinson, 1998). In short, these discussions provided a forum within which participants could relate their views to health coverage and to the views of others, and from which insights into the social character of human thought could be gained.

6.1 Accessing Health Documentaries

A range of archives (Department of Political Studies at the University of Auckland, New Zealand Film Archive, Television New Zealand Archives, the National Archive, and TV3 Network Services) were accessed to gain an overview of the scope, form, and focus of New Zealand health documentary. The systematic archiving of broadcast material is a relatively recent phenomenon in this country. No one archive possessed a complete set of records. For instance, Television New Zealand records were sporadic before 1985, at which point they began a more systematic attempt to archive material. In spite of incomplete records, archival information demonstrated the long history of New Zealand health documentary and range of concerns covered. The material garnered from the archival work over a two-month period was used primarily to inform the discussion presented in Chapter Two and facilitated a more informed selection of the programmes which provided the focus of this thesis.

Owing to the amount of material broadcast it was not practical to analyse every health documentary. Therefore, four programmes were selected from all available New Zealand programmes broadcast from 1995 to 1997. There may well be examples of health documentaries dealing with more prototypical health concerns such as specific diseases. However, it was decided to explore the ways health and illness are constructed through coverage of wider concerns. These had the potential to highlight the social construction of general health concerns, illustrate the use of different approaches to health, and exemplify trends in the representation of health and illness in health documentary.

To ensure that current health concerns could be explored, programmes broadcast within the same year the individual interviews and focus group discussions were conducted were selected. Two documentaries providing coverage of health care reform were selected because issues around the provision of health care have direct implications for lower SES groups. Furthermore, issues around health care reform overshadowed health coverage in New Zealand in the mid-1990s. A documentary on aging was selected because aging is commonly associated with physical changes including reduced organ function, bodily decline, and a range of ailments which are exacerbated by relative deprivation. The elderly also consume a large amount of health care resources and there has been much debate over the impact of an aging population on health care services. A programme on men's health was selected because increased emphasis has been given to men's health issues in health initiatives and coverage in recent years. The programme on men's health also exemplified trends in the construction of specific ailments such as cancer within health coverage.

The first programme, *The Great Kiwi Health Lottery* (TGKHL, Assignment, 20 July 1995) covered the health reforms. The second, *Health and Wealth* (H&W, Assignment, 12 September 1996), investigated the increased use of private medical services. The third, *Golden Oldies* (GO, Assignment, 10 October 1996), dealt with issues relating to the aging population and health in old age. In the fourth, *The Thing from the Black Lagoon* (TTFTBL, *The Problem with Men, Part 2*; Tuesday Documentary, 24 June 1997), attention was given to raising concerns about men's health. (See Appendix A for a summary synopsis of each programme. The development of these synopses is discussed further in the analysis section of this chapter.) These programmes range in broadcast time from 30 minutes to one hour and were selected from Television New Zealand broadcasts on Network One. This network was selected because of its long history in broadcasting

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health documentaries, its nation-wide signal coverage, and its consistently high ratings as compared to other free-to-air and pay-per-view networks.

6.2 Accessing Participants' Accounts

Participants were recruited between February 1996 and July 1997 from several provincial centres in the North Island of New Zealand: Palmerston North, Hamilton, Hastings, and Huntly. A community group whose membership comprised lower SES people was approached in each city or town for a group of participants. A donation of \$150 was given to each community group in return for their assistance. In each instance, a community coordinator acted as a go-between and telephoned the participants asking if they were interested in participating in the research. If so, the community worker arranged a time for potential participants to meet with me and for informed consent to be gained. (Appendix B and C provide examples of the information and consent forms used.) Potential participants were told the purpose of the study, that the information they provided was completely confidential, that a report of the general findings would be made available to them at the completion of the study, and that they could contact me both during and after the research in order to discuss any queries they might have. Those participants who took part agreed to participate in an individual interview, a screening of one of the health documentaries, and a focus group discussion about that programme. All interviews and group discussions were audiotaped, transcribed, and labelled using pseudonyms to protect the identity of participants. In accordance with the conditions of ethical approval for this research, audiotapes and transcripts will be destroyed at the completion of the research.

People of low SES were recruited for this research because of persistent inequalities in health and the limited amount of research that explores such people's views (*cf.* Chamberlain, 1997). Focusing on people from this sector of society also enabled me to interact with people from a similar

social background to myself. My experiences of life as a lower socio-economic member of society impacted on the sharing of experiences and concerns with participants. In a sociological sense I belonged to this class, spoke the language, had worked in the same types of jobs as many of the participants, and had been unemployed. In short, the focus of this research has been shaped by my own experiences as a working class man who is concerned about the ramifications of recent social reforms on my own family, friends, and wider community.

Participants were on low incomes and included the unemployed, single parents, part-time community workers, truck drivers, labourers, and gardeners. There were ten female and ten male participants, whose ages ranged from 20 to 60 years. Participants made up four research groups, one from each city or town. There were two mixed gender groups, one female group and one male group. (The focus group section of this chapter provides further demographic information for each group.) A minimum of four participants was required for each research group, as the ideal number of participants for a focus group is between four and twelve (*cf.* Morgan, 1995). Five or six participants were recruited in each centre as it was anticipated that a participant might drop out during the research process. Generally, all participants recruited completed individual interviews and attended the focus group sessions. The reason why two participants did not take part in the focus groups was an inability to arrange a time where people could be in the same place simultaneously to view the health documentary. Only information from those participants who attended a focus group was analysed. The small number of participants in these groups had the advantage of providing participants with the opportunity to voice ideas more frequently and in more detail, but it also had the disadvantage of restricting the possible pool of ideas (Krueger, 1988).

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6.2.1 Conducting Individual Interviews

Before the individual interviews were conducted a general semi-structured interview protocol was developed to guide the proceedings. Developing this protocol required several stages, including the identification of key issues across the health documentaries, engagement with the literature on lay views of health and illness, and casual conversations with people of lower SES. This general protocol was then piloted with friends until it seemed to adequately cover relevant issues (*cf.* Berg, 1995; Mathieson, 1999; Smith, 1995). The general protocol contained prompts designed to elicit discussion about broad issues relating to health and illness. This general protocol was then revised for use with each research group. Specific issues were added which related to the programme each research group would watch. As a result four specific versions of the general protocol were developed, each being used with one of the research groups. The identification of specific issues to be explored with each research group was necessary in order to elicit talk about the health concern covered in the relevant programme for each group. (Appendix D contains an example of an individual interview protocol used with one of the research groups.)

Individual interviews ranged in duration from 30 to 90 minutes were conducted with the twenty participants either in a private room within a community centre or in their homes. These interviews took place over the week prior to the documentary viewing and focus group discussion, and also provided access to various personal experiences and background information on each participant, including their television viewing patterns.

During each interview I adopted a facilitative role by introducing issues, monitoring responses, and encouraging elaboration. Not all the issues contained in the interview protocols were used in every interview and additional issues were explored in relation to the participants' statements.

Such a semi-structured technique was used so that I could encourage participants to voice their views on health and illness in general and the health concerns covered in the documentary they would later watch. It allowed me to cover core issues while also allowing me to clarify points and follow up new lines of inquiry raised by the participants (*cf.* Smith, 1995). These interviews provided insights into people's views on health and illness and the ways in which health concerns were conceptualised prior to the focus group discussions.

6.2.2 Conducting Focus Groups

Prior to the focus groups discussions, many of the steps taken to produce a general individual interview guide were repeated. The general focus group guide contained prompts designed to elicit discussion about health coverage and prominent issues explored in the individual interviews. This general guide was tailored for use with each research group. The development of specific prompts for each research group was necessary in order to elicit discussion of issues pertaining directly to the health concern covered in the programme that group watched, and so that each focus group discussion could be compared to the accounts constructed in the individual interviews. (Appendix E contains an example of the focus group guides used.)

Each focus group discussion took about one hour and 30 minutes and was conducted either in the home of one of the participants or a private room in a community centre. Participants were asked to come for afternoon tea and a relaxed group environment was developed in order to encourage people to speak candidly. Once everyone was comfortable, the documentary was screened and any visible or verbal reactions noted. After the screening there was a break for refreshments to promote a relaxed atmosphere prior to the focus group discussion. During the discussion I acted as a facilitator, moderating the discussion but letting the conversation flow. A set of guidelines that were designed to help the conversation flow

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was discussed with participants at the beginning of each focus group discussion. (These guidelines are contained in Appendix E.)

The first two focus groups discussed programmes dealing primarily with the restructuring of the public provision of health care. Group one, consisting of two women and three men ranging in age from 43 to 60 years, watched TGKHL. Group two, consisting of three women and two men ranging in age from 42 to 53 years, watched H&W. These middle-aged groups were selected because people at this point in life were likely to have experiences of the implications of the health reforms to draw on.

The third and fourth focus groups were conducted with same gender young adults. These groups were specifically targeted in relation to issues presented in the documentary screened. The third focus group discussed the programme about health in old age, GO. Women outnumber men in the elderly population, are predominantly involved in care for the elderly, generally have fewer economic resources in society, and are specifically addressed in many segments of GO. Therefore, five women ranging in age from 20 to 40 years, who were enrolled in a Care in the Community course, attended the third focus group. The fourth focus group discussed men's health issues covered in TTFTBL. This programme was constructed as a public health intervention aimed at educating men. Therefore, the fourth focus group was made up of five men ranging in age from 20 to 37 years.

6.3 Overview of the Analysis

In outlining the analysis process an important consideration is how 300 pages of transcripts and notes, several hours of television, and a mass of literature is condensed into a 300-page thesis. The answer is through the systematic process of transformation, selection, and interpretation inherent in qualitative research (*cf.* Berg, 1994; Billig, 1997b; Morse, 1994). The development of an interpretation of the ways health and illness is

constructed in the health documentaries, individual interviews, and focus group discussions was fundamental to my analysis. The general steps used to produce this analysis involved moving from repeated interactions with the data, initial coding, and the establishment of themes, to the development of an argument that represented happenings in the data and provided a more general interpretation (*cf.* Billig, 1997b; Smith et al., 1999). Drawing on insights garnered from the theory and research discussed in the previous chapters, I conducted what might be best referred to as a thematic interpretation of the symbolic resources used to construct health and illness (*cf.* Billig, 1997b; Harré, 1997).

The initial analysis explored the health documentaries through repeated screenings and note-taking, which resulted in the writing of a plot synopsis to highlight the overall focus and pattern of each programme. These synopses detailed each sequence from the programmes in sequential order and were used to identify key sequences for further analysis. Once identified these sequences were then storyboarded to establish the ways various stylistic techniques were used to privilege a specific perspective on a given health concern. Media studies research was then used to enrich the overview of health documentary form presented in Chapter Two. Consideration of the ways the programmes constructed a perspective through the ordering and presentation of evidence also informed the subsequent analysis of the content of each programme (*cf.* Bordwell & Thompson, 1997; Corner, 1995; Plantinga, 1996). As Corner states, programme analysis involves “looking closely at examples of ‘content’ as well as of ‘form’ and seeing the interplay between the different kinds of things which television shows and the different ways in which it can show things” (1995, p. 3). From these detailed synopses, summary synopses were produced to capture the essence of the programmes’ expositions and perspectives. (See Appendix A for the summary synopsis of each programme.) The development of these synopses contributed to the

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systematic analysis of the programmes and ensured the preservation of the expositional context for sequences being used to illustrate general trends in the construction of health and illness within the programmes.

In producing the analysis for presentation within this thesis it became apparent that it was impractical to present a full analysis of each programme because this would result in considerable repetition and redundancy, due to overlaps in the ways health and illness are constructed across programmes. The analysis was subsequently refined to explore the influence of the medical, lifestyle, and socio-structural approaches on the focus and scope of the coverage provided in the four programmes. This focus emerged as a way of dealing with the complex and contradictory nature of coverage and reducing the level of redundancy and repetition in the analysis. It also provided a focus for relating the programme analysis to the existing literature as well as the individual interviews and focus group discussions. In short, the programme analysis explored the ways aspects of these three approaches to health are combined to construct complex expositions that raise a range of health issues for public discussion.

The individual interviews were handled somewhat differently to the programmes. Analysis of these interviews effectively started during the interviewing process, with notes being made directly after each interview. Next, each interview was listened to repeatedly and transcribed for further analysis. The issues contained in the interview protocols and patterns identified in notes taken during the interviewing and transcription stages were used to form the basis of an initial coding framework that was further developed throughout the analysis process. This framework provided a means of systematically organising extracts from the interviews into thematic units (*cf.* Boyatzis, 1998) using the indexing facilities of the qualitative analysis programme Q.S.R NUD*IST (Qualitative Solutions & Research, 1994).

Throughout the analysis of the individual interviews it was necessary to refer back to the audiotapes and transcripts in order to check emerging themes (*cf.* Billig, 1997b). In this way the analysis was conducted on line using Q.S.R NUD*IST to manage the mass of data in a systematic fashion. This on-line analysis was complemented with an off-line analysis where the audiotapes and printed transcripts were used in order to ensure that the context of specific extracts was preserved as much as possible. It was also necessary to refer back to the programme analysis in order to explore similarities and differences in the ways that certain issues were constructed in the individual interviews and health documentaries. In order to facilitate the exploration of similarities and differences between the ways programmes and participants constructed health and illness, the analysis of these interviews was increasingly focused on the ways aspects of the three approaches to health were drawn on. Such comparison enabled the integration of the programme and interview analysis, and the establishment of a comparative basis for the focus group analysis.

The focus groups were then analysed. Owing to the interactive and complex character of the focus group discussions, preparing the audiotapes of these for analysis was a lengthy and often frustrating task. To produce these transcripts it was necessary to identify specific statements with each participant so that the views they had voiced in the individual interviews could be compared with the views they voiced during these discussions. This information was gained through repeated interactions with the focus group and individual interview audiotapes.

Initially, the analysis of the focus group discussions repeated many of the steps taken for the individual interviews, to produce a coding framework that encapsulated various themes or topics of conversation. As well as exploring the ways the three approaches to health were drawn on, part of this

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framework was developed so that participants' interpretations of the programmes could be categorised according to various types of readings: dominant, oppositional, negotiated, resistive, critical, and referential. Subdividing viewer responses into such specific types of readings proved to be overly mechanistic and did not adequately account for the fluid, complex, shifting, and co-constructed character of the participants' interpretations. Many interpretations did not fit any one category and were often constructed between participants over the course of the discussion (*cf.* Billig, 1997b; Catterall & Maclaran, 1997). Subsequently, an additional coding process was developed to explore the co-constructed character of various interpretations as well as shifts in the participants' views over the course of the discussions.

As the analysis progressed complexities and contradictions stemming from the integrated and socially negotiated character of these discussions became even more apparent. Each participant's contribution reflected their personal experiences, previous interactions with health coverage, elements of the programmes watched, and the accounts of other group members. In an attempt to encapsulate some of these complexities the analysis focused on the ways that participants drew on aspects of the programmes to make sense of specific issues. The major goal became producing an interpretation of the ways participants navigated between various television-mediated and interpersonal sources of information when making sense of health, illness, and their place in the world. Owing to the complexities involved, it proved impractical to present a full analysis of each focus group discussion. Therefore, one prominent issue from each focus group discussion was used to exemplify the ways aspects of health coverage were integrated into participants' views on health and illness.

It needs to be noted that qualitative research of this kind is always provisional and never complete (Billig, 1997b). The data could have been

explored with a raft of other considerations in mind and interpreted quite differently (Becker, 1993). From the overview provided above it should be apparent that, as the research progressed, the ways the three approaches to health were drawn on became a key focus. Such a focus represents one way through the complexities involved in the health communication process and provides a means of developing an interpretation of how issues relating to the biological, agentive, and structural dimensions of health and illness are constructed. Although there are other explanations functioning within the data, an analysis of the ways aspects of these three approaches contribute to the construction of health concerns is sufficient to highlight key aspects of the general processes involved in the social construction of health and illness. This focus is also useful in demonstrating that various explanations are drawn on in the social construction of health and illness and that such constructions are complex and changing.

Overall, the analysis was conducted through repeated interactions with the three data sets and relevant literature. In the initial stages thematic analysis was central to the process of merging together information from the synopses, transcripts, notes, and research literature to produce an interpretation of the ways health and illness is constructed in health documentaries, individual interviews, and focus group discussions. Next, patterns across each data set were explored as a basis for developing an interpretation of the relationship between the stories circulated by way of television and peoples' views. Throughout the research my interactions with the data were top down, in the sense of being informed by the existing literature, which was used to identify a topic and refine a research framework. These interactions were also bottom up, in the sense of generating ideas from the data, seeking literature to inform an overall interpretation of them, and then revising the research framework to better encapsulate subsequent findings. This analysis did not just occur at the completion of the data collection, but was a cyclical process occurring

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throughout the research (*cf.* Berg, 1995; Morse, 1994). The focus of the research became clearer as data was collected, ideas were generated, analysis was developed, and the writing of the thesis progressed. Billig (1997b) writes, “The analysis is achieved through writing. One does not do the analysis, and *then* write-up the results. Instead, one begins writing, and tries to arrange the material through writing” (1997b, p. 48; italics in the original). This is what happened here.

Chapter Seven

An Analysis of Health Documentary

As has been argued in previous chapters, health coverage circulates stories about a raft of health concerns. Yet, what does this coverage tell people about these concerns? What is presented as being necessary to ensure one's health? And what actions are presented as being necessary in order to overcome an illness? This chapter explores such questions, relating to the construction of health and illness on television, through an analysis of health documentary coverage of the health reforms, the privatisation of health care, the health of an aging population, and men's health. It is not an attempt to provide definitive answers to such questions, because no analysis can capture all the processes and contradictions involved in the construction of health and illness on television.

To explore such questions, the development of a full analysis of each programme would be ideal, because every sequence within a programme is tightly edited to contribute to the production of a perspective on the given health concern investigated. However, this would have resulted in considerable repetition, and redundancy due to overlaps in the ways that health and illness are constructed across the programmes. As much as possible the expositional context of each sequence drawn on in this analysis is preserved. However, owing to practical constraints such as space and the need to produce an interpretation that spans the programmes, this analysis is not structured according to the development of each programme's perspective. What is provided is an exploration of the influence of aspects of the medical, lifestyle, and socio-structural

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approaches on the focus and scope of the coverage provided across the four programmes.

This analysis develops through four sections. First, it offers an exploration of the use of the medical approach. Second, the ways these programmes integrate elements from the lifestyle approach is explored. Third, the ways aspects of the socio-structural approach function to place the provision of medical care within a wider socio-political context are investigated. Fourth, complexities surrounding the changing nature of medicalization, resulting from the interweaving of aspects from the three approaches, are explored. Following this strategy of producing a composite analysis of the four programmes reduces the level of redundancy in each section and allows for the exploration of the ways key assumptions shape the construction of health and illness on television. This chapter is completed with a discussion that links this general interpretation to the existing literature.

Each programme reflects aspects of the medical, lifestyle, and socio-structural approaches. However, some programmes are more dependent on a specific approach than others. Although all four programmes are medicalized, there are differences particularly in the extent to which each programme draws on lifestyle and socio-structural approaches. As a result, the first section draws on extracts from all four programmes while the second and third sections draw on the two programmes that best illustrate the use of the lifestyle and the socio-structural approaches respectively. The lifestyle section provides an analysis of extracts from GO and TTFTBL because both these programmes place considerable emphasis on the benefits of a healthy lifestyle and the ramifications of unhealthy behaviour. For instance, GO proposes that the elderly now live longer and more active lives owing to lifestyle changes. In a similar vein, TTFTBL emphasises the role of unhealthy living on the incidence of men's health problems. The socio-structural section provides an analysis of extracts from TGKHL and

H&W because both these programmes exemplify the ways that socio-structural explanations are drawn on to introduce inequalities in the provision of medical care. For instance, TGKHL proposes that the health reforms are failing and consequently having a negative impact on the provision of medical care to patients of lower SES. Issues around inequality in access to care, associated with the increased privatisation of health care, are explored further in H & W.

7.1 The Medicalization of Health Coverage

As discussed in Chapter Two the medical approach is orientated around germ theory and focuses on the treatment of disease. This approach has undergone some revisions in recent years. However the focus on biological causes of disease and the development of medical technologies for curing a range of ailments remains the key focus. As discussed in Chapter Three, this approach has also been associated with the medicalization of health coverage through the reliance on medical knowledge and practice in television's construction of health and illness.

Across the four programmes the medical approach is relied upon most. This is evident in the continued use of hospital settings and reliance on the expert testimony of medical professionals to legitimate a programme's investigation and to provide the wider context for events depicted. The medical approach is also reflected in the emphasis given to devastating diseases, biological explanations of bodily functions, progress in medical research, and the prolonging of life through medical intervention. Disease is presented as a deviation from a normal healthy state, which can be detected and remedied through the actions of caring medical professionals. This is exemplified in medicalized plot lines that follow patients through their diagnosis, treatment, and recovery. In such cases the recovered individual sings the praises of medical interventions, which are presented as the means of restoring normality to people's lives. Depictions of lay

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people as needy and grateful patients are used to personify a range of ailments and further legitimate the programme's investigation.

Each of the four health documentaries draws on medical assumptions and applies them in framing the health concerns investigated. For instance, in TTFTBL viewers are told they should be ever-vigilant for the signs of disease. The need for the early detection of disease is extended to self-examination as an aid to early diagnosis and medical testing. If a health problem is detected early enough it can be treated with minimal side effects. GO exemplifies the medicalization of old age. Aging is presented as a deviation from the normally youthful and correctly functioning body. In many respects aging is presented in a similar manner to a disease or something that should be prevented or cured through advances in medical research and knowledge. TGKHL and H&W deal with socio-structural considerations, such as problems in the public provision of medical care and the rise of private initiatives within a medicalized framework. Emphasis is placed on the need for everyone to have access to the wonders of modern medicine. Individuals denied access to medical intervention are presented as being denied life. In this way the legitimacy of the medical approach is preserved.

Throughout the programmes the hospital is presented as the primary location within which professional care is administered. By relying on this setting health documentaries are able to display an abundance of images symbolising high-tech medical science as the means of restoring normality to one's life. Such technological depictions are an extension of the authority and knowledge of the medical profession, which has traditionally been represented by white coats and stethoscopes. Images exemplify the ability to reach into the body, accurately diagnose a condition and provide effective treatment (*cf.* Turow, 1989), and are generally used to associate a sense of

seriousness, authority, and competence with the medical profession. This can be seen in an image of a surgical procedure from H&W (see Figure 1).



Figure 1. An Image of Medical Technology.

Expensive medical technology is presented as the answer to the perils of modern life. The human body is presented as an object to be probed, scanned, and scrutinised. The camera depicts patients connected to elaborate machines which automate bodily functions (*cf.* Lupton, 1994). Such depictions draw on machine metaphors and accordingly disease is dealt with in a mechanistic fashion with malfunctioning parts being repaired or replaced.

Throughout the programmes the combined effort of doctors and patients is presented as the means for the ill to regain some control over their lives, make sense of their illness, and ultimately restore normality. In the process medical procedures are exemplified and the virtues of professional care are presented as self-evident. The programmes present a range of individuals suffering from a range of complaints and the gallant efforts of caring medical professionals to render assistance and restore normality. For instance,

doctors are presented as skilled professionals with the wonders of medical science at their disposal. They provide the last line of defence against disease and an important source of expert commentary.

The influence of the medical approach is exemplified in the way that doctors are called upon to provide authoritative comments on the issues that a programme is investigating. Such authoritative testimonies are not restricted to the technicalities of medical treatment. For instance, GO's investigation of trends, including people taking dietary supplements and hormones such as melatonin in order to slow the aging process and to revitalise themselves, includes a doctor's commentary. The depiction of Dr Bassett, who the presenter describes as an "*expert on aging*", is used to provide legitimacy for the programme's investigation of these trends, which are becoming widespread enough to warrant medical research. Dr Bassett states that he is about to conduct a scientific study with older men to establish whether the practice of taking melatonin is beneficial or harmful. He also states:

There are hypothetical reasons why melatonin may be helpful in good quality aging, but there is no scientific evidence at all. And the problem with taking melatonin is that by taking it you absorb very high amounts compared with what our bodies secrete and we just don't know whether that is a good or a bad thing.

Here people's practice of taking dietary supplements is subjected to medical scrutiny. The depiction of Dr Bassett functions to establish the medical profession and science as the legitimate authority on such matters. Medical expertise is necessary to establish the facts and educate the public about the virtues of such practices and the possible implications. Overwhelmingly, the medical approach is supported by the positive depiction of doctors and the authenticity given to their accounts, which are often used to provide insights into events and as catalysts for a programme's investigation of specific issues.

Accompanying such positive depictions of doctors are depictions of people as actual or potential hospital patients, which further exemplifies the influence of the medical approach over the framing of health coverage. Such depictions often include before and after shots, contrasting a person before an illness and after treatment. A patient's recovery is attributed to the efforts of diligent doctors and the effectiveness of medical treatments (*cf.* Kitzinger, 1995). For instance, at key points throughout TGKHL, a heart patient, Rawinia Caddy, is depicted being admitted to hospital, undergoing surgery, and recovering in bed (see Figure 2).



Figure 2. Images Showing a Patient's Progression Through the Medical Plot Line.

The need for medical intervention is established through a depiction of Rawinia as she is being admitted to hospital. During this sequence she explains that she has been so sick that she could not get out of bed to see her grandchildren. Despite having to wait for access to the wonders of modern medicine in the public system, Rawinia has held on long enough to get her operation. This operation is subsequently shown to remedy her ailment and to return her life to normal.

Programmes use depictions of such patients as they journey through the medical process and recount their experiences to render conditions, treatments, and the health system meaningful. By drawing on the experiences and testimony of patients, complex health issues are simplified and rendered palatable to the general public. These patients provide concrete examples of what is involved in medical care. Through the presentation of successful patients, who are happy now that their problems have been solved and their lives are returning to normal, the benefits of medical care are rendered self-evident. In the process medical explanations of disease, as a disruption to normal bodily functioning that can be repaired by skilled surgeons, are taken for granted and legitimated. Such legitimation is constructed through the tracking of selected individuals' journeys from being a needy to a grateful patient. The depiction of such individuals is a key indicator of a programme's perspective. For instance, in TGKHL it is proposed that medical care is necessary, but that patients of lower SES are having to wait for such care owing to inefficiencies in the public health system.

Although patients are often presented as passive objects subjected to medical examination and intervention, such depictions do not encapsulate the scope of lay depictions. Depictions of patients encompass complementary roles such as the passive patient and the active consumer (*cf.* Lupton, 1997). People are presented not only as passive patients suffering from afflictions or undergoing medical treatment but also as actively accepting the benefits of medical care. When presented discussing their situation patients draw on medical concepts and often reiterate points previously made by doctors about the stages of their disease, how people may be symptom-free while harbouring a hidden intruder, and the treatments that are available (*cf.* Radley, 1996). Programmes present extracts from patient's lives where they draw on medical advice in an attempt to render the illness situation meaningful and to present themselves as well-informed

consumers. For instance, TTFTBL depicts Fraser exercising in a swimming pool as he explains the biological process of the testicular cancer he experienced:

Testicular cancer of the type that I had is basically a kind of cancer that cancerous cells that have gone wild, breeding wildly. Start off in one or other of the testicles, migrate around the body's lymph system and if you're unlucky spread to other parts of the body.

This extract draws on medical advice that is reappropriated and presented in a rather colloquial manner. In the process the biological view of cancer is presented as self-evident. War metaphors, often associated with medical explanations (*cf.* Martin, 1994; Sontag, 1978), are used to construct a malfunctioning body that is out of control as cancerous insurgents (cells) go on the rampage, potentially rendering the body uninhabitable. Fraser's account of the out-of-control cells is used within TTFTBL to emphasize the benefits of medical treatments that can bring order to the body and enable the patient to regain control. In short, through the presentation of such testimonies, programmes translate abstract medical knowledge into lay terminology and justify often drastic medical interventions as being necessary for the restoration of normality.

It is not just depictions of patients that are used to provide such user-friendly translations of medical knowledge in health documentary. Doctors and presenters also provide such translations which complement and add context to the patients' accounts and exemplify the way depictions of doctors and patients give meaning to each other in the framing of health issues. These translations function as an aid to the communication of medical knowledge particularly when doctors are depicted explaining medical events in lay terms (*cf.* Farr & Markova, 1995). Such translations are overtly evident in consultative sequences where the biological situation is explained to patients. These sequences also exemplify the complexities of the medical approach's influence on lay thought.

As a response to criticisms of the medical profession, recent emphasis has been placed on a consultative model, where ailments and interventions are explained to patients and their informed consent elicited. These developments are reflected in health coverage which depicts doctors informing their patients, and by default the audience, about test results, diagnosis, and prognosis. For instance, in a sequence from TGKHL, Evelyn Marshal's doctor informs her of her predicament, as the camera cuts between mid-shots of the consultation and close-ups of the distressed look on Evelyn's face:

What I know is that your kidneys over the past 78 years have slowly scarred up to very little function; they've got very little reserve. And what I also know is that at a guess, a pretty good guess but an educated guess, I think that you've probably got about 6 months left in those kidneys that you've got. I think that in the next 6 months they will do a final bit of scarring up and you'll have very few little filters left, not enough to keep you alive.

Terms like little filters are used here to convey ideas about complex biological functioning in a way that Evelyn and viewers are likely to grasp. The doctor informs Evelyn about what is happening within her body in a manner that, among other things, disassociates her as a person from her disease. Through such interactions a biological explanation of disease and a separation of mind and body are reproduced as a means of justifying a medical course of action and preserving the integrity of the patient's identity. The separation of person and ailment enables the doctor to speak candidly about Evelyn's prognosis and enables the programme to represent the medical profession as caring professionals who, through such consultative processes, are doing their best for their patients.

The remainder of this section draws on extracts from TTFTBL to demonstrate the ways the medical approach is drawn on to shape health coverage and construct a programme's perspective. This programme was selected because it typifies points raised above and also illustrates the

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ways in which health education initiatives are often assimilated within medical knowledge. The programme draws on the notion that doctors are caring professionals who have the skills and technology to intervene in an individual's biological destiny when all else fails or when, despite living a healthy lifestyle, an individual develops a health problem. In this way TTFTBL demonstrates the mutually supportive integration of medical and lifestyle explanations. Emphasis is placed on both the importance of a healthy lifestyle to ensure one's health and the use of medical resources to restore normality. Although primary attention is given to the influence of the medical approach in shaping the exposition in this section, the analysis presented here also provides a useful transition to a discussion of lifestyle dimensions in health coverage.

Considerable emphasis in TTFTBL is placed on the need to detect an ailment early in order for medical treatment to be maximally effective. This is a recurring theme in coverage of men's health issues. For instance, in an analysis of print media in the USA, Clarke and Robinson (1999) found that emphasis was placed on the need for early detection and medical treatment. Health coverage emphasises the idea that men deny the existence of health problems and that it is this denial that leads to further complications. In this way men are presented as being responsible for their ailments if they do not access a timely diagnosis. Within such framing traditional masculine stereotypes are reproduced (*cf.* Clarke & Robinson, 1999). Health coverage of men's issues is constructed to persuade men to change their ways and attend medical examinations.

In TTFTBL one sequence in particular illustrates the way an emphasis on early detection is manifested in coverage. The presenter extends Fraser's explanation of testicular cancer by outlining the incidence of this disease and the probability of a cure, and raising the importance of self-examination:

Cancer of the testicles is one of the big dangers for young men. But of course in terms of treatment it's one of the great success stories of cancer because in 95 % of cases it is curable. But you have to know what you are looking for. Cancer is basically a slightly abnormal growth of cells. So what you are looking for is what you and I would call a lump.

The sequence within which this statement is presented is used to establish the importance of early detection in a manner that does not confront viewers. While providing important information, such as the impact of this disease on young men, the presenter points out that this ailment is a serious issue that can be successfully dealt with if one knows the early signs and is vigilant. To demonstrate this and shift the focus from the abstract to the personal level, Peter is depicted recounting his experience of finding that one of his testicles had hardened. As a result he went to his GP and was informed that he had an aggressive form of testicular cancer. He had one of his testicles removed a week later. Peter's account is combined with images of him enjoying normal family life (see Figure 3) and the presenter's voice-over stating that, *"this was followed by a course of radiotherapy and Peter was off work for about 5 months"*.



Figure 3. An Image of a Man Enjoying Family Life.

This depiction supports the idea that medical treatment is effective in successfully treating this disease. Peter's life is back to normal thanks to his prompt action once he detected a problem and to the successful actions of his doctors. Peter's cancer is represented as having been fairly advanced when he was first diagnosed. If he had known what to look for and had attended regular medical examinations the cancer would have been discovered earlier and he would not have undergone the same level of treatment, would not have had to have so much time away from work, and may have kept his testicle. Supporting this proposition, Peter states that men need to be educated about the symptoms of testicular cancer so that it can be detected earlier and they can avoid drastic surgery and prolonged radiotherapy. Peter states, *"If you get it early your chances of recovery are still extremely good and basically everyone who dies from testicular cancer is just because they don't get it early enough"*.

This sequence reflects the idea that one needs to detect an abnormality and have it treated promptly by a doctor. Further supporting the need for early detection and the idea that doctors have much to offer, a doctor provides a practical demonstration of how to carry out a self-examination. In this way the accounts of patients, doctors, and the presenter are combined to present a tightly edited exposition that spreads the gospel of the medical approach. Even though Peter's cancer was advanced, thanks to the skill of his doctor, his life is now back to normal.

Throughout TTFTBL the testimony of patients and medical experts is used to normalise the diagnosis and treatment process. Men's avoidance of medical examinations is presented as irrational and potentially dangerous to their health. The target audience is presented with men who have gone through the examination and treatment process and can now speak about the benefits of medical care. Such medicalization of men's health focuses attention onto the need for men to take responsibility and seek care. TTFTBL

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attributes the severity of illness to the unwilling of men to access medical services. Such reluctance is in turn attributed to irrational anxieties, masculine attitudes, and a fear of showing weakness. As a result, if a disease is allowed to progress any serious ramifications, including the side-effects of treatment, can be attributed to the failure of an individual to act early enough and not to limitations in medical technology (*cf.* Kirkwood & Brown, 1995). Doctors can do only so much and require the co-operation of their patients. Because TTFTBL develops the perspective that what is important to men's health is personal responsibility and regular medical examinations, issues concerning links between SES, illness and death are not adequately explored.

For men to conduct self-examinations and undergo medical examinations their anxiety must be raised to a level which provides the maximum motivation to act, but does not result in their engaging in avoidance behaviour, by switching off or changing the channel. For instance, TTFTBL points out that a man can be symptom-free while harbouring potentially lethal diseases such as cancer. Like the men depicted viewers have nothing to fear from regular medical examinations or treatment. What they have to fear is the hidden intruder or disease they may be harbouring and the subsequent ramifications of ignoring such an ailment and failing to seek medical attention. The anxiety potentially provoked by such propositions is restricted by the way the programme frames ailments. As a result of the need to motivate viewers without making them overly anxious, the programme takes them on a kind of melodramatic roller-coaster ride. An ailment and its ramifications, when not detected and treated early, are presented to raise anxiety. Then the benefits of medical interventions and access to skilled practitioners are espoused to reassure viewers. The medical examination and availability of effective treatments becomes a means of putting one's mind at rest. This process is repeated for several conditions in TTFTBL and functions to foreground the programme's perspective that men need to take

responsibility for their health. Modern medical treatments are presented as the means of restoring normality with minimal chances of side effects, particularly if the problem is detected and dealt with early.

The focus on the need for individual vigilance and action can invoke anxieties in people about how they might have contributed to causing their ailment. Coverage cannot afford to assign sole responsibility for illness to the individual. There is a requirement for individuals suffering from ailments to be depicted as deserving patients, in order to justify their treatment and encourage viewers in a potentially similar situation to seek medical assistance. Therefore, the patient depictions used to exemplify various ailments present men as victims of biological forces that, although in some instances are exacerbated by the men's lifestyles, are generally outside their control (*cf.* Kirkwood & Brown, 1995).

One prominent strategy used in TTFTBL to restrict anxieties about how men might have contributed to their ailments is to provide biological explanations of disease (Kirkwood & Brown, 1995). Such a strategy is less confronting than solely focusing on an individual's avoidance behaviour, which assumes a level of individual responsibility that audiences may shy away from. For instance, accompanying a series of graphic illustrations (see Figure 4), the presenter's voice-over provides one such account of impotence:

Now this is how the process of sexual arousal works. When the old fella gets the message from the control tower that it might nearly be time for take-off its natural instinct is to puff its chest out a fair bit, show off disgracefully and sometimes behave in a very unruly manner. The reason for this is that when the message comes beating down the spinal column that a policy decision has been made it is relatively all go. The heart pumps blood down into the muscle tissue in the affected area, filling the old John Thomas to the point where it stands to immediate attention and remains on full alert, until either the command is given to fire at will or that management discovers that there's actually been a double booking or the whole things

been postponed due to a filing error or inclement weather or something. Now a lot of people used to think that any sort of systems failure in this area was all psychological but of course it can be caused by physical things, by muscular things; other medication for other things, can do it. Diabetes can exacerbate it and of course these days there are a lot of options about how to fix it.

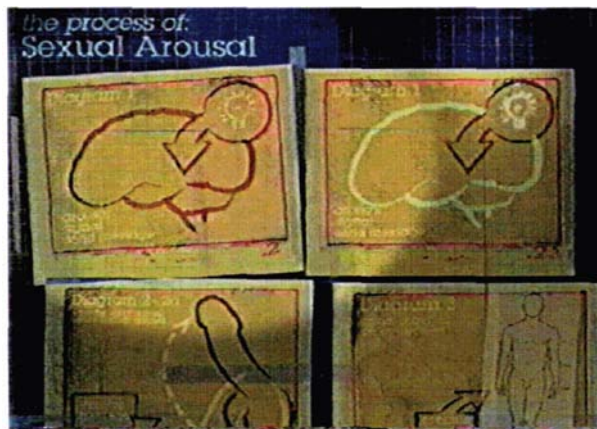


Figure 4. Images Depicting the Biological Process of Male Impotence.

Such a sequence invokes a multitude of medicalized ideas, such as disease being a bodily malfunction, in order to render this ailment generic and thus allow a shift in focus from the person to bodily processes. Humour and indirect references to the penis are also used in an attempt to reduce the tension involved in men discussing impotence. In this way factual medical information can be provided in a non-confrontational manner. Such explanations describe normal bodily processes, the abnormal process of disease, and possible causes and treatments. In doing so they justify a medically oriented course of action to restore normality by repairing a bodily malfunction. By combining such explanations of bodily processes with testimony from grateful patients who have been successfully treated the programme emphasises the need for viewers to take responsibility to seek

care. At the same time attention is diverted away from the individual as being solely responsible for his ailment because there are wider biological forces at work.

In sum, the influence of the medical approach is apparent in the use of plot lines that follow the medical process of diagnosis, treatment, and recovery. Tracking cases through this process provides continuity to the exposition and normalises the medical approach by combining medical practice with lay experience. Many patients are depicted as veterans who now have a second chance in life, thanks to prompt medical intervention. Programmes emphasise the benefits of medical diagnosis and medical technology in restoring normality. They also present patients as informed participants in the healing process and correspondingly pay attention to the psychological dimensions of illness in a manner compatible with biological explanations of illness. In the process the jurisdiction of the medical approach over the person is extended to encompass self-diagnosis and a healthy lifestyle as aids to ensuring health and recovering from illness. As the following section will show, the extension of medical jurisdiction is reflected in the presentation of lifestyle dimensions and in particular preventative strategies as being compatible with medical technology and cures. However, the emphasis on individual responsibility and biological disease processes can result in the individualisation of health and illness, while wider socio-structural influences are given less prominence than is warranted.

7.2 Adding a Lifestyle Dimension

As was highlighted in Chapter Two, the development of the lifestyle approach brings a wider array of human life under professional jurisdiction. This approach emphasises the influence of healthy behaviour patterns, as a means of enhancing health, and the detrimental influence of unhealthy behaviours, as a cause of illness. The emphasis is on the benefits of engaging in a range of health-enhancing rituals, such as eating a good diet

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and participating in regular exercise, and minimising involvement in unhealthy behaviours, such as excessive alcohol consumption and smoking. Such thinking is overtly evident within TTFTBL and GO, but is somewhat less evident within H&W and TGKHL. In TTFTBL and GO considerable emphasis is placed on the need for a healthy lifestyle as a means of maintaining one's health and preventing disease. The key to health is presented as a controlled lifestyle that includes self-discipline and individual responsibility. People are presented as health consumers who have the ability to control their health. They are assigned responsibility for taking care of themselves by choosing to live a healthy lifestyle and if necessary accessing medical care. Coverage provided in these programmes also reflects the health promotion preoccupation with educating the public about what are unhealthy behaviours as well as what they should do to prevent illness and restore health. In the process both the virtues of healthy living and the consequences of an unhealthy lifestyle are emphasised (*cf.* Lupton, 1995). The lifestyle approach is manifested in a range of settings, including fitness centres and health food shops, the emphasis given to people's experiences, and the depiction of various experts, such as 'vitamin gurus', fitness instructors, and health food proprietors.

A focus on prevention results in programmes' presenting expositions that unfold in a wider range of settings than have traditionally been evident in health coverage. As noted above, coverage in programmes such as GO moves away from the hospital and into lifestyle arenas (see Figure 5). Such settings reflect the additional aspects of life that are now of concern to health professionals and enable programmes to show people benefiting from a healthy lifestyle.



Figure 5. A Lifestyle Image of People Working Out in a Gym.

These settings reflect assumptions about the health-enhancing benefits of regular exercise and a healthy diet and exemplify an extension of professional jurisdiction from curative treatment to preventative self-discipline. Although disease is still presented as a deviation from the norm in health coverage, self-discipline and healthy behaviour patterns are emphasised as the primary means for preserving one's health and preventing a range of ailments.

Aspects of the medical and lifestyle approaches are intertwined in the programmes in order to construct a more extensive account of health and illness than would be provided if the medical approach alone was used. The working through of a wider range of aspects of health and illness is evident in the construction of medical treatment as a catalyst for a change in lifestyle, particularly for those who have successfully undergone treatment. Illness provides patients with a warning that they need to take responsibility and action to ensure no other ailments occur. The benefits of exercise are linked to a person's determination to recover and regain

control after medical intervention. As a result, the sterile surgical process is rendered meaningful within the context of patients' lifeworlds, and the role of medical intervention in restoring normality and providing people with a second chance for health is rendered self-evident. For instance, in one variant of such trends, TTFTBL personifies the benefits of exercise as an aid to recovery from prostate cancer, through the depiction of General Norman Schwarzhopf. During this sequence General Schwarzhopf states:

...I asked a lot of people, friends who had been through it, and they convinced me that the key to this whole thing was exercise... So when I went home, the first night at home, there was a loop in front of our house that was about a half a mile... and I walked the half-mile loop... And I started walking every single day and by the time I went back to hospital two weeks later to have the catheter taken out I was walking five miles a day.

Norman continues to outline how such exercise sped up his recovery and allowed his life to return to normal. This depiction also highlights the way that recovery is linked to the reassertion of one's masculinity and regaining control over one's body and life (cf. Clarke & Robinson, 1999). Later in this sequence Norman proposes that he has no side-effects from his surgery because of his exercise and as a result prostate cancer "*was a temporary inconvenience*". Here exercise is presented as part of one's treatment or a means of hastening recovery and ensuring future health. This depiction also exemplifies the way attention is given to a person's experience of illness in a manner that is compatible with, and extends information provided by, bio-medical explanations of various bodily functions. Such depictions reflect a shift in the understanding of health problems from disease to illness, where health consumers are depicted talking about their experiences and how they maintain or restore their health, aided by medical expertise and intervention.

Such sequences are used to highlight the benefits of healthy behaviour as an aid to medical care. There is also a corresponding emphasis on the

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negative effects of unhealthy behaviour within health coverage. Once diagnosed with a disease, patients are often depicted recounting how they have led an unhealthy lifestyle that contributed to their ailment. These accounts often have a confessional style. An overt example occurs in TTFTBL when one man talks about his unhealthy behaviour leading to his impotence. The sequence begins with a shot of Tim preparing for his radio show, as the presenter introduces him as a *“tough and manly”* radio host who is *“...a fully qualified sports nut and the brewery’s working nights to try and get ahead of his social life”*. The way Tim is introduced is important to the progression of the programme’s exposition. It further establishes the proposition that masculine attitudes can lead to an unhealthy lifestyle, which contributes to health problems. It also highlights two elements of Tim’s unhealthy lifestyle. Firstly, although participation in sport is commonly considered part of a healthy lifestyle, Tim takes part in sport as an armchair critic and is overweight due to his sedentary existence. Secondly, Tim is depicted drinking wine while he prepares for his show, which functions to highlight his overindulgent and therefore unhealthy lifestyle.

Links between an unhealthy lifestyle and illness is further established in a subsequent interview in which Tim confesses, *“I just thought that with my impotence, that it was just a natural progression of getting old and leading a bad lifestyle. Too much booze, not enough exercise, and stuff like that”*. Tim attributes his ailment to his transgressions, for which he is being punished (*cf.* Hezlich & Pierret, 1987). He has taken responsibility for his ailment and admits being irresponsible by living an unhealthy lifestyle, which has affected his health.

The association of illness with an unhealthy lifestyle and the assignment of responsibility to the individual raises a potential contradiction with the medical approach which assigns responsibility for illness to germs and bodily malfunctions that are often outside the individual’s control. However,

this contradiction is resolved by the way individual behaviours are presented as only one contributing influence that may cause a bodily malfunction. As a result of combining medical and lifestyle explanations, health coverage shares attention between multiple causes of illness from germs and bodily malfunctions to unhealthy behaviours and attitudes. An unhealthy lifestyle is presented as a contributing factor rather than a sole cause within the context of the programmes. Often the cause of illness is left uncertain (*cf.* Clarke, 1991). Such uncertainty has recently been presented as a defining aspect of television coverage, where issues are aired but no firm conclusions are reached (*cf.* Ellis, 1999; Newcomb & Hirsch, 1984). Uncertainty is evident in TTFTBL when the presenter provides the translation of the biological processes of impotence, outlined in the previous section of this chapter. This translation functions to provide viewers with a means of alleviating any undue anxiety that may have arisen from the previous emphasis on masculine attitudes.

TTFTBL's depiction of Tim also exemplifies the continued reliance on the medical approach, even in light of the attention given to lifestyle factors. Despite admitting being irresponsible in the past, Tim is presented as having not changed his lifestyle. At one level this positions him as being responsible for his ailment and any additional problems. However, instead of emphasising this dimension, the programme outlines how Tim has opted for a curative course of action by seeking medical assistance. Tim is depicted outlining how he experienced the stigma of impotence and initially hid the problem from his partner. The hiding of his problem led to relationship problems. He is depicted recounting how he saw an advertisement for a medical treatment in the newspaper and called the number seven times before having the courage to make an appointment. This depiction supports the idea that to admit a problem and seek medical assistance is an act of courage. As a result of taking responsibility by

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accessing care, Tim now treats his impotence by injecting a substance into his penis and is reasonably happy with the results.

Health coverage carries the assumption that health problems can be avoided if individuals take care of themselves, but if all else fails medical science can provide a range of treatment options. In this guise, lifestyle explanations are used in a manner complementary to medical explanations (*cf.* Karpf, 1988). Lifestyle behaviours are important in preventing disease and in the rehabilitation process, but if a problem develops medical interventions are still effective.

The sequence depicting Tim foregrounds a tension between the medical and lifestyle approaches which exists within health coverage. The medical approach emphasises curative solutions while the lifestyle approach emphasises individual behaviour change as a preventative strategy and aid to recovery. In the current era of consumer choice and individual ideology, and within a medium that works through the uncertainties of life (*cf.* Clarke, 1991; Ellis, 1999), Tim is exercising his consumer rights by choosing a medical course of action over a lifestyle course of action. Depictions of various courses of action reflect fractures in health coverage that allow programmes to cater to a more diverse audience. The course of action is left open to audience members who must decide whether to prevent such ailments from occurring by acting now, whether to change their lifestyles in order to alleviate an existing condition, or whether to seek medical treatment. In a Griersonian-inspired manner, health coverage presents the audience with options for action, but it is up to viewers to act.

The remainder of this section explores the ways aspects of the lifestyle approach are drawn on in GO. This programme was selected because it provides rich illustrations of the functions of the lifestyle approach and the ramifications of its influence on the scope and shape of health coverage. It

also illustrates the way that the use of lifestyle explanations, although raising some contradictions, often functions to support medical hegemony. Because GO deals with issues around the aging of the New Zealand population, it also provides a useful transition to an exploration of the programme's use of the socio-structural approach in the following section.

The prolonging of youthfulness and physical vitality has attracted academic and public attention for thousands of years (Busse, 1989). Ancient searches for the fountain of youth persist in New Zealand health coverage, and the construction of programmes such as GO. In fact GO's exposition emphasises the search for answers to the "*aging problem*" (presenter's voice-over) and how health and vitality can be extended. It is the efforts of the elderly and changes in expectations and lifestyle, in addition to breakthroughs in medical science, that are presented as keys to the fountain of youth. GO draws on the idea that the secret to preventing aging lies in a good diet and regular exercise. This explanation is not new: it also appeared in early manuals on how to live a vibrant, healthy, and long life such as Gabriele Zerbi's *Gerontocomia*, which was published in 1482 (Zeman, 1967). Such explanations are manifested in GO in the presentation of aged people's bodies as worn machines in need of regular maintenance and care. Aging is constructed as a biological process that can be controlled or prevented through lifestyle change and medical intervention.

Previous research indicates that the elderly have traditionally been represented in a stereotypical manner as ill, incapacitated, senile, and unproductive individuals, and that such representations reflect the media's reliance on explanations that construct the elderly as passive objects of medical scrutiny (*cf.* Davis & Davis, 1985; Novak, 1997). However, as the population in the western world ages, and the sheer number of aged persons increases, there may be less tolerance for such stereotypes and

increased commercial interest in this demographic group. It may be that broadcasters can no longer afford to stereotype this increasingly economically and socially powerful group in this traditional manner (*cf.* Davis & Davis, 1985). These developments combined with the emphasis given to lifestyle explanations in society at large may explain the wider range of depictions of the elderly now evident in health coverage (*cf.* Novak, 1997).

GO presents a more vibrant and active elderly who are juxtaposed with depictions of the traditional, inactive elderly. For instance, when outlining recent extensions in people's life expectancies and vitality, GO presents old newsreel footage of the elderly sitting on park benches or looking out windows and passively watching the world go by. Simultaneously, the presenter's voice-over provides an account of how things have changed: *"It's different now. Consciousness about exercise and nutrition and heightened expectations have seen older people undergo a revolution"*. This change is represented by images of aged people enjoying themselves in fitness classes (see Figure 6).



Figure 6. Images Representing the Change in Activity Levels and Vitality Among the Elderly.

Reflecting such shifts, the presenter describes the active elderly as “*a bunch of old folks who refuse to act their age*”. A range of aged persons are depicted exercising as the presenter outlines how this is now normal behaviour for aged persons who, as a result, can expect to live a longer and healthier life. People’s life expectancy and vitality is associated with their behaviour patterns and willingness to live a healthy and controlled lifestyle, which includes a good diet and regular exercise. Accompanying images of the active elderly the presenter states: “*Its clear that with better nutritional advice, wise medical advice, and a sensible exercise programme, the elderly have years more active life in them than many had believed*”. This assertion is supported by the presentation of an interview with a geriatric specialist: “*The message for old people is to ‘use it or lose it’. That means to keep your faculties, your physical faculties and your mental faculties by using them and by, in this case, exercise...*”.

Depictions of the elderly in health coverage reflect the shift from the passive patient to the active health consumer and can be interpreted as a positive step in addressing the traditional inactive elderly stereotype. However, such depictions may simply constitute the construction of the reverse stereotype of the exceptionally active and autonomous elderly (*cf.* Davis & Davis, 1985). Such depictions of the active elderly reflect notions of individual responsibility and support the idea that it is up to individuals to partake in healthy activities as a means of preserving their health and slowing the aging process. If increased emphasis is placed on the benefits of diet and exercise as healthy choices for individuals to make, those who do not engage in such rituals may be held more responsible for their aging and any illness which may arise. The lifestyle approach is thus used to place increased emphasis on the elderly health consumer, who is free to choose a healthy lifestyle, while wider considerations including financial barriers to their adopting a healthy lifestyle are not adequately explored.

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This approach is evident in GO's framing of lifestyle rituals as being central to the prevention of aging.

The programme's emphasis on the benefits of a healthy diet and regular exercise is reflected in repeated depictions of people taking supplements to ensure an equilibrium in their dietary intake and the necessary sustenance for them to engage in regular exercise. Such practices are depicted as strategies which people can use to prevent aging and preserve youthfulness. In one sequence in particular, aging is pathologised and reduced to an individual, biological level as a preventable ailment. This sequence overtly makes connections between the prevention and cure of aging. It exemplifies the implications of the combination of medical and lifestyle explanations in health coverage and how this combination can lead to victim blaming.

GO links the benefits of dietary supplements and regular exercise to the legitimacy of medical science through depictions of Miller Quarles (a wealthy retired US oil prospector) and various medical scientists. Miller is introduced as a fit and healthy 81 year-old who desires to live past 150 years of age. Miller is depicted living a healthy lifestyle, including taking supplements and exercising as a means of preventing illness and extending his life while he waits for the cure to old age. Depicted exercising, Miller states *"the minute you get the 'cure' you won't get any older and then as time goes on you'll start getting younger..."*. Through this sequence the programme constructs aging as a biological process that, like other diseases, is socially decontextualised and can be physically slowed and eventually cured. It is revealed that Miller has invested in an aging research company that has produced some breakthroughs in scientific knowledge of the biological basis of aging. Miller is asked if he thinks researchers will find the cure before he dies. He replies that he does and that he has posted a *"\$100,000 reward for the person who finds the genetic cure for old age by the year 2000"*. When

asked how long he wants to live Miller says he wants to live forever by repeatedly taking the cure. He is presented as a health consumer who is willing to invest in medical research, take a range of elixirs, and generally pay for the dream of eternal youth.

The depiction of medical scientists is a convenient way of legitimating the search for “*a cure to old age*” (presenter’s voice-over). Through the presentation of images of medical scientists working studiously in sterile environments a sense of objectivity and seriousness is associated with the quest for eternal youth (see Figure 7). Accompanying such images of medical scientists and laboratories is the presenter’s proposition that researchers are optimistic about the discovery of vital clues to understanding the aging process.



Figure 7. An Image of Medical Scientists at Work.

As a result of these clues, researchers are working towards genetic interventions aimed at slowing or halting the aging process. The programme foregrounds how research with fruit flies and rats has shown that it is possible to prolong the life span of these creatures, and work has begun on

applying these findings to humans. During this sequence one researcher is depicted as he states:

We can accelerate the rate of aging, we can prolong life spans, we can do that by selection, we can do that by genetic intervention, we can do that by nutritional intervention. Aging has become something we can control.

Such sequences present medical science as a neutral pursuit of knowledge with potentially revolutionary outcomes which justify the investment of resources. These scientists are presented as tireless investigators working in sterile laboratories to discover the secrets of aging and to develop a cure (*cf.* Desbarats, 1994). In the process investment and faith in medical science and a healthy lifestyle is justified.

In order to promote the impression of a balanced account and to normalise aspects of such sequences, the presenter constructs some critical distance from the preoccupation with finding the fountain of youth. This distance is established when the presenter raises questions about whether people should be focusing on extending life expectancies when issues such as famine, child mortality, and age-related ailments remain unresolved. Such questions are raised to establish a wider context for the focus on biology and individual behaviour that has dominated previous sequences, such as the one depicting Miller. They present a potential challenge but are not given any serious attention. They simply function as a device that the presenter uses to construct the impression of a balanced exposition that is exploring all the issues. In conjunction with the depiction of extracts from interviews with a vitamin guru (Dr Michael Colgan) and medical scientists, such questions are used rhetorically to legitimate the search for a cure to old age. For instance, the depiction of Dr Colgan is used to implicate unhealthy lifestyles as a cause of the social problems raised by the presenter and to some degree individualise famine and disease. During this sequence Michael states:

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I believe that a lot of the destructive emotion which produces the war and the pestilence and the famine, I mean famine only occurs because we are too mean to distribute the food. Our emotions are so screwed because we're not healthy animals. I think the more you make people healthy, the better our chances for peace on this earth.

An adequate exploration of questions around whether extending life and searching for a cure to old age is appropriate is neutralised through the use of such expert testimony. The neutralisation process is completed in subsequent sequences. For instance, during an exploration of age-related debilitating diseases the search for a cure to old age is further legitimated. The initial focus in the sequence in question is on whether these ailments are abating with the extension of health and vitality among the elderly. It is revealed that rates of age-related diseases remain steady. However, the depiction of another scientist is used to point out that owing to significant advances in aging research, the cure for these ailments is linked to the imminent cure for old age. The introduction of this proposition serves to legitimate healthy living as necessary for extending one's life while the cure to old age is developed.

In short, the use of lifestyle explanations contributes to the development of a perspective that constructs aging as a preventable illness. Bodily decline can be controlled by action at the individual level, assisted of course by advances in medical science. The construction of aging in GO transforms it from a normal part of life into a health concern. Aging is something to be controlled, prevented, and cured. As a ramification of the emphasis given to diet and exercise as preventative strategies, health coverage favours the idea that those who are incapacitated may be so, at least in part, by choice. The aged have somehow contributed to their situation by not engaging in a healthy lifestyle. A good diet and regular exercise can have a positive impact on people's health and longevity. However, a preoccupation with lifestyle rituals and medical cures can limit the scope of

an exposition and an adequate investigation of socio-structural barriers to good health and longevity.

7.3 Linking Patient Needs to Socio-structural Concerns

To this point my analysis has focused on the ways programmes draw on the medical and lifestyle approaches in the construction of health coverage. In this section attention turns to the programmes' use of the socio-structural approach to extend the scope and shape of such coverage.

The socio-structural approach places primary responsibility for health and illness with structural influences, such as the distribution of health care resources, income levels, and general living conditions. Emphasis is placed on the provision of resources to lower SES groups as a means of increasing equity in society and thus reducing health inequalities. Although this approach is evident in three of the programmes (TGKHL, H&W, and GO), it is drawn on in a restricted manner. For instance, the socio-structural approach is used to raise issues relating to the provision of resources to ensure universal access to medical care. A lack of access to medical care is framed as a management problem, where the efficient allocation of resources is presented as the answer to inequality. Only passing reference is made to inequalities in income and living conditions. Such social inequality is not presented as a catalyst for ill health. The overwhelming emphasis is on providing access to the wonders of modern medicine, not the prevention of illness through structural change.

The influence of the socio-structural approach is evident when health coverage explores socio-political issues surrounding the provision of medical care, including health care budgets and inequality in access to services. Coverage of such issues includes depictions of characters such as bureaucrats, politicians and insurance executives, in addition to more

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complex representations of patients and doctors. This section explores the ways that the use of socio-structural explanations contributes to the production of more sophisticated depictions of patients. Depictions of government and private health care representatives will be explored in the next section in order to highlight the changing nature of the medicalization of health coverage, which results from the intermixing of aspects from the three approaches to health.

The influence of the socio-structural approach is clearly evident in the way the provision of health care is dichotomised between the public and private systems. For instance, the introduction to H&W raises questions around whether New Zealand is developing a two-tiered health system, where more affluent members of society can enjoy prompt access to medical care through private provision, while less affluent members of society are assigned to public waiting lists or denied treatment. Unlike the patients depicted in TTFTBL where socio-structural issues are ignored, patients depicted in TGKHL and H&W are categorised according to SES. The use of socio-structural explanations results in the construction of a dichotomy between anxious public patients waiting for care due to inadequacies in the public system and more affluent private patients benefiting from the wonders of modern medicine. As a means of setting the context for such patient depictions, in the introduction to H&W a series of images contrasts the under-resourced public system and the well-resourced private system. By locating the investigation within both private and public medical settings the urgency of the situation in the public system is established. The visual comparison of a run-down public hospital with state of the art private facilities contributes to the justification for an investigation of the implications that increased privatisation has for the publicly funded system and its patients (see Figure 8).



Figure 8. Images Depicting Public and Private Medical Institutions.

The way concerns over the privatisation of health care are handled provides an example of how health coverage can reflect public expectations and also contribute to the scope and shape of public debate. In developing medicalized expositions that provide a perspective on recent changes in the provision of health care, TGKHL and H&W focus on the benefits of prompt access to medical care. Anxiety about getting sick and not being able to afford health care is used to justify the increasing expansion of private health insurance in New Zealand. Private care is presented as necessary if a person wants to increase their chances of returning to health and minimise the disruption to their lives brought on by illness (*cf.* Lupton, 1994). Coverage presents the proposition that health problems need to be dealt with promptly and that the public health system is not providing this service, by juxtaposing depictions of run-down public facilities and needy public patients with well-resourced private facilities and patients who have accessed private care. In the process good health and quality care is linked to commercial interests that will return health to the paying consumer, and the private system is associated with quality care, technological sophistication, and a rapid recovery. Private providers are presented as

being well-resourced and as providing flexible care that is responsive to consumer demands.

Correspondingly, one aspect of social inequality evident in these programmes is the lack of control associated with being at the lower end of the socio-economic stratum. Depictions of public patients personify anxieties about being placed in the helpless situation of being ill and having no control over one's life in an epoch where such control is highly valued (*cf.* Crawford, 1994). Public patients are presented as being at risk because they have been denied prompt access to medical provisions in the public system and do not have the financial resources to pay for access to the private system (*cf.* Lupton, 1995). For instance, when exploring the impact of health care reform and reduced access to publicly funded care, TGKHL presents images of patients receiving dialysis treatment in a crowded ward. The camera cuts to an image of James McKeown lying in a hospital bed (see Figure 9) as the presenter explains how, when his kidneys failed, he ended up in Middlemore Hospital and was told he had six months to live if he did not get treatment.



Figure 9. An Image of a Needy Public Patient.

Owing to budget cuts, a shortage of dialysis machines, and his age, James was refused treatment:

That is when the trouble started. He took his case to the Holmes programme... He told the nation that it was discriminatory and he deserved to live, which is what he had told his doctors. In turn the decision was reversed and he was given treatment, and six months later he is still doing well (presenter's voice-over).

This depiction is used to demonstrate the ramifications of resource restraints in the public system and the lengths some patients have to go to in order to gain access to care. Depicting James as he benefits from dialysis treatment highlights the discriminatory nature of the health reforms and associated criteria for rationing resources. James is presented as a health consumer whose needs were not being met by the public system and who, as a result, fought for his right to access the wonders of modern medicine. Programme makers could not hope for a more deserving individual to demonstrate the dramatic impact of resource allocation decisions and the urgency of the health care situation in New Zealand. When selecting interviewees such as Harry, Nichols states, "priority goes to those individuals who can convey a strong sense of personal expressivity that does not seem to be produced by or conjured for the camera - even if, in fact, it is" (1991, p. 120).

In contrast to needy public patients, private patients are presented as being unhampered by such problems and as being able to gain control over illness by paying for access to private care. Private patients are quickly restored to normality through prompt access to the wonders of modern medicine. They are repeatedly depicted reflecting on the benefits of their decision to exercise consumer choice and access private care. One such sequence in TGKHL combines images of hospital-based high-tech medical procedures with the depiction of a grateful private patient and the image of

a cross on top of a private hospital to invoke notions of salvation as a result of private medical care (see Figure 10).

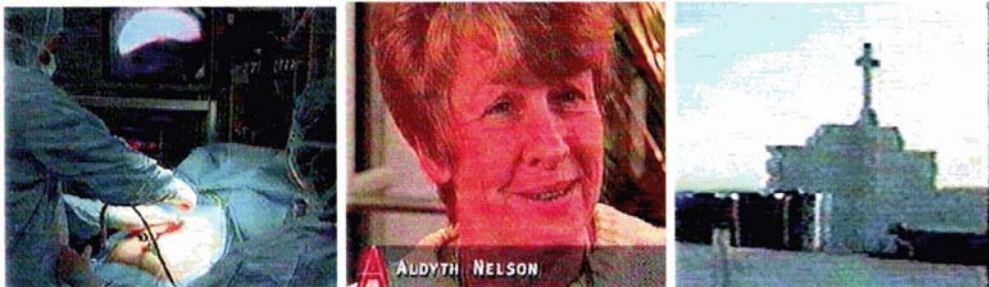


Figure 10. Images Associating Medical Science with Salvation.

The depiction of Aldyth, a private gallstone patient, illustrates *“rationing health according to wealth. It’s rapidly becoming commonplace in New Zealand”* (presenter’s voice-over). The sun is shining as Aldyth, standing outside the hospital, recounts how she did not have to wait for treatment: she was treated *“within two days”* (presenter’s voice-over). In sharp contrast to the depiction of public patients who have difficulty gaining access to care, Aldyth is presented as a grateful patient who describes her experience as *“marvellous”*. Aldyth’s depiction provides the impetus for an exploration of the benefits of private health insurance in a climate of inadequate government funding of the public system. Demonstrating the complex and potentially contradictory nature of health coverage, this depiction also functions to raise the issue of why wealthy patients should be able to gain access to care while less affluent, yet equally deserving, patients such as James have to wait. Accessing private care is presented as a way of *“jumping the queue”* which, as the presenter’s voice-over states, would not need to occur if a *“rational system of rationing was worked out”* (presenter’s voice-over). Emphasis is given to the need to

allocate adequate resources to the public system to ensure universal access to medical care for all New Zealanders. Viewers are left with the proposition that until this is done private care is a patient's best chance, and if the public system remains in disarray then perhaps lower SES patients' access to private provisions should be subsidised by the state.

The raising of socio-structural issues highlights the potential for health documentaries to explore social injustice and stratification. However, this potential is not fully realised, because coverage is restricted to inequality in access to medical care and not extended to wider issues relating to social inequality. In TGKHL, the limited critical scope can be seen in the depiction of a surgeon "*who does the majority of his work in the private system*" (presenter's voice-over). Following the depiction of Aldyth, this surgeon is depicted explaining that patients are better off in the private system and people should get private insurance if they can afford it. Dr Dunn points out that many gallstone patients in the public system are sicker than patients in the private system. Depicted as an authority figure, sitting in a high back chair in his plush office (see Figure 11), he provides an explanation for why this is so.



Figure 11. An Image of a Private Surgeon.

Doctor Dunn states:

Well, one of the big factors with gallstones disease is how quickly you can get the disease treated, namely, how long it takes from the onset of symptoms till they get to the theatre door. Now, in the public system the operations are quite a bit more complicated in that the gall-bladder is often more inflamed so that the operation takes longer, approximately twice as long as in private. A big factor in that, I believe, is getting treatment to these patients.

The camera cuts back to a high-tech gallstone operation and the presenter's voice-over continues, "*John Dunn's message to New Zealanders without private insurance or a spare four and a half thousand dollars is not heartening*". The camera then cuts back to John who states that patients need private insurance to ensure prompt access to such procedures.

It is interesting, in the face of the strong evidence about the relationship between SES and health status (*cf.* Blaxter, 1997; Carroll, Bennett & Smith, 1993; Wilkinson, 1996), that TGKHL favours John's assertion that the difference in health between private and public patients is merely the delay in treatment. Such framing, although highlighting one contributing factor in the length of time between diagnosis and treatment, neglects wider considerations relating to inequalities in life circumstances, such as adverse work environments, limited material resources, and social conflict associated with differences in health across social groupings. The potential for an exploration of the link between economic influences on the onset of illness and recovery rates is not realised. Illness is decontextualised, and the medicalization of coverage functions to restrict the extent to which socio-structural influences on illness are discussed.

To summarise, socio-structural issues are raised to explore political and economic influences that limit the ability of people of more modest means to access medical services. Those on the public waiting lists have received

their test results; they now know the odds of recovery, but are placed in the risky situation of having to wait for treatment. In this way, public patients are presented as victims awaiting divine, or in this case medical, intervention. Conversely, private patients are presented as the picture of health and as receiving all the care they require. Although privileging the need for communal action to ensure access to care for all, health coverage legitimates the actions of individuals who take individual responsibility and access private care in order to avoid problems in the public health system.

7.4 The Changing Nature of Medicalization

The shape and focus of the coverage provided in these programmes is indicative of the intermixing of the medical, lifestyle, and socio-structural approaches. For instance, emphasis is placed on the need for access to medical care, which privileges the medical approach. People are also depicted as health consumers who are increasingly electing to access private care, which reflects the lifestyle approach. The influence of the socio-structural approach is reflected in the raising of issues of inequality of access to services and political influence over the provision of medical care. In short, patients faced with a failing public system that does not allow for prompt access to the wonders of modern medicine can act as health consumers by either taking their business elsewhere or demanding service. Implicit in such framing is the idea that the benefits that come with a publicly-funded system of medical care, such as equity in access, are being undermined by notions of individual responsibility and the privatisation of medical care. As a result there are two competing explanations shaping health coverage. One is that the state should provide universal access to medical care, as it has done since the 1940s, on a medically assessed basis. The second explanation states that health consumers should provide their own access to health care as part of a responsible, controlled, and generally healthy lifestyle. The result is a tension around access to care and resource

restrictions in the public sector that is personified through various character depictions.

Within this section extracts from H&W are used to illustrate some of the ways in which the combination of aspects of the medical, lifestyle, and socio-structural approaches is used to introduce a range of complexities into health coverage. These complexities include the overlaps between public and private systems in New Zealand; issues surrounding the efficient use of resources; and the vested interests of various stakeholders such as government representatives and doctors. This programme illustrates complexities in the changing nature of the medicalization of health coverage that are reflected in the representation of conflict between the medical profession and government over the provision of medical services.

Exemplifying this conflict doctors are depicted stating that the government is deliberately under-resourcing public hospitals in an effort to force patients to enter the private system and pay for their own treatment. Conversely, government representatives are depicted stating that the rising cost of medical care is due to advances in medical technology and the high salaries paid to doctors. Within H&W sympathy is associated with doctors, particularly those working in the under-resourced public system, and negligence is related to government representatives, who are presented as being insulated from, yet juxtaposed with, the harsh reality of their policies. Such framing follows a dramatic tradition of presenting hospital administrators and bureaucrats as unlikable comic characters who obstruct doctors' efforts to provide necessary care to patients (*cf.* Turow, 1989). Politicians and bureaucrats are cast as villains in the unfolding drama and presented as non-medical meddlers who have a hidden agenda. The presenter in H&W proposes that the private system is "*booming*" because the public system is failing to cope and that this may be indicative of the

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government's plan to shift responsibility to consumers by restricting the resources that are available within the public system.

Within an exploration of the possibility that the government is secretly forcing people to access private provisions, H&W depicts the architect of the health reforms, Alan Gibbs. This bureaucrat is presented as a means of foregrounding the link between the health care reforms and the idea that the development of a free market in health care is necessary to encourage individuals to take responsibility and provide for their own access to medical care. In terms of the framing of the programme's exposition, the influence of notions of individual responsibility is restrained by the use of notions of communal responsibility. This is evident when the previous Minister of Health, Simon Upton, who implemented many of Alan's ideas, is depicted proposing that a totally free-market system has not been fully adopted because it would leave many without care and does not reflect public values. At one level these depictions function to invoke questions about the virtues of a total shift to a private system. Yet, at another level they are used to support the proposition that the government has a hidden agenda and are saying that they support notions of universal access to medical care while their policies reflect moves to increase individual responsibility. Statements from politicians such as Simon Upton are likely to seem ironic to the audience because it is common knowledge that these politicians have persistently voiced the virtues of a free market system in other forums (*cf.* Upton, 1991). H&W uses this contradiction to frame politicians as being devious in changing their stance on the virtues of a free-market in health care and saying they support universal access to medical care while the health system functions to restrict such access to a person's ability to pay.

The programme subsequently builds on doubts about the sincerity of politicians' accounts, to foreground the possibility of the Government's

having a hidden agenda. For instance, evidence is presented to support the idea that the government is undermining the public system by restricting funds to public hospitals and subsidising private providers. After outlining the dichotomy between public and private care and linking the shift to private care to government policies and a possible hidden agenda, H&W explores various points of contradiction. Subsequent investigation raises issues about the influence of vested interests on the provision of medical services. In the process images of medical care and of doctors are renegotiated and rendered more complex.

Attention is given to issues around the channelling of government funding to private providers and the establishment of wards in public hospitals to treat private patients. To demonstrate these issues, the programme presents the example of Parkside Hospital in Napier. This private hospital was awarded contracts to provide care for public patients despite its being less cost-effective than other public providers who also tendered for this work. The contract in question is reported to have been awarded on the basis of a private surgeon's letter outlining what would be available. Actual facilities for doing the work had not been built. The tendering of work to an incomplete private facility is presented as an example of the government's "*efforts to prop up the private sector at the expense of the public*" (presenter's voice-over). It is subsequently pointed out that such practices may be inefficient because they lead to duplications in services. The programme proposes that there are already too many surgical facilities in New Zealand and that this leads to greater overall cost, because public facilities are left idle when contracts are awarded to private providers who build their own facilities.

After issues are raised around the use of public money to support private providers, it is pointed out that the reverse is also about to occur. The move to treat private patients in "*unused public facilities*" (presenter's voice-over) is

subsequently introduced as a strategy being proposed by government and private insurance companies to remove the need to build more facilities. The presenter's voice-over accompanies images of hospital wards as he points out that wards that are now unused in public hospitals due to a lack of public funding could soon be full owing to private funding. The possible positive impact of such practices in injecting resources into public facilities is represented visually through images of the current state of public wards and what things would look like if private patients were treated in public hospitals (see Figure 12).



Figure 12. Contrasting Images of Public and Private Medical Wards.

Public hospitals are said to be preparing for the admission of private patients. They are creating separate wards for private “...patients who want to beat the waiting lists, get a better class of care” (presenter's voice-over). Insurance executives and the Minister of Health are then depicted stating that this is the future of health care. However, this is a proposition that is not privileged in H&W.

Notions of communal responsibility and inequality are invoked when the presenter proposes that some public doctors have refused such work

because it will do little for needy public patients. This proposition is legitimated through the depiction of a public doctor, David Guller. Extracts from an interview with this doctor function to introduce the idea that medical specialists can abuse such initiatives. These developments are said to present a conflict of interest for doctors, who are encouraged to prioritise their private patients and tend to do so in order to maximise their own personal gain. Here Dr Guller is presented as the traditional selfless, caring professional who has his patients' best interests at heart and who is willing to expose the vested interests of other more commercially orientated doctors. There are now two primary, but overlapping, images of doctors: the traditional selfless, caring professional and the new medical entrepreneur. Doctors working primarily in public hospitals, such as Dr Guller, are presented as selfless, caring professionals who are hampered by a lack of resources. Conversely, doctors working primarily in private hospitals, such as Dr Dunn, are depicted as caring professionals who are also concerned with personal profit.

The addition of the medical entrepreneur image reflects the programme's exploration of the causes and ramifications of the privatisation of secondary care. By constructing a distinction between the traditional and new entrepreneurial images the programme can raise some criticisms of selected doctors while maintaining faith in the virtues of the medical profession and medical care.

Extracts from interviews with various stakeholders are used to establish the idea that many of the difficulties in the provision of health care and rising costs stem from the actions of medical entrepreneurs. In particular, insurance executives are depicted to introduce the idea that the higher costs involved in providing private medical services are the result of surgeons' high salaries. The programme then juxtaposes depictions of such stakeholders with depictions of private doctors who justify their

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salaries. For instance, an extract from an interview with Dr Dunn is presented as a response to points raised by the executives. This depiction gives voice to the idea that the higher salaries paid to private surgeons reflect the hard work involved in training and risks of private practice. Dr Dunn states, *"I think if you are successful in business people don't tend to point the finger at you, but if you are successful in medicine again they will"*. The presenter then interjects and states, *"I suppose because traditionally it's been seen as a caring role, it's not been seen as a business role"*. Dr Dunn nods and states:

Yes, that's true, but I think you need to join the real world at some stage and realise that unless you're good at business the financial side of your practice will fall over very, very quickly. And so you need to get sophisticated. You need to grow up. That's the way New Zealand is now and it's not at all an unhealthy thing.

This interview is used to invoke the idea that the shift to a privately orientated system is an inevitable development that is linked to New Zealand's becoming less protectionist. Although the programme does depict doctors who are clearly profiting from the shift to increased private care, it does not assign responsibility for the present situation in the public health system to them. Such doctors, although benefiting from the health reforms, do not set the rules and are presented as responding to the market environment created by government policy, like any astute businessperson. The public system does not provide the necessary resources for doctors to adequately treat their patients because of restrictions in resources so they are caring for their patients in private facilities.

What appears to be occurring in such coverage is that the interweaving of aspects from the medical, lifestyle, and socio-structural approaches is resulting in the renegotiation of the image of doctors and medical care. The depiction of doctors as medical entrepreneurs in the pursuit of profit within

the reformed health system adds complexity to traditional depictions of doctors as altruistic, caring professionals whose motivation is purely the health and welfare of patients. The business rhetoric voiced by some of the private doctors highlights a tension between the need to care for others and self-interest. The result is not necessarily a reduction in the influence of the medical profession, because both public and private doctors are presented as skilled professionals whose services warrant investment. The ability of doctors and the effectiveness of medical treatments are not questioned. What are raised are issues around the motivation of some private doctors and the relationship of medical work to socio-economic and political influences. Depicting doctors in a varied light adds substance to health coverage and promotes the impression that programmes provide quality accounts of important social issues.

In sum, health coverage reflects the changing nature of medicalization. Although it contributes to the construction of challenging depictions of private doctors, whose motives and personal gains are aired, the use of aspects of the three approaches does not appear to lead to outright criticism of the medical profession. Coverage emphasises the need for people to gain prompt access to the wonders of modern medicine. If only access to specialists' skills and equipment was more equitable the problems in the health system would be resolved. In this way, although the provision of medical care is placed within a wider socio-political context, the use of socio-structural explanations does not appear to detract from the medicalization of health coverage. What is significant about the continued presentation of a positive image of doctors and associated faith in the medical profession is that responsibility for problems in the public system is assigned to bureaucratic interference.

7.5 Chapter Discussion

The analysis presented in this chapter illustrates the ways that health documentaries constitute barometers of contemporary existence. Health coverage functions as an institutionally mediated cultural forum within which medical, lifestyle, and socio-structural approaches are used to explore health concerns. The use of lifestyle and socio-structural explanations provides a means for the programmes to construct rich and evolving representations of health and illness that invoke a wider range of issues than would be evident if programmes relied solely on medical explanations. Relating this analysis back to the discussion of the three approaches presented in Chapter Two, the interweaving of explanations from these approaches reflects recent shifts towards the development of a fourth approach that focuses on biological, behavioural, and structural aspects of health and illness. These programmes constitute a forum within which aspects of such an approach are socially negotiated and translated into lay terminology.

The programmes comprising the basis of this analysis are thematically complex and encompass a range of explanations stitched into causal narrative structures. The news preference for controversy is highlighted through the juxtapositioning of characters who personify differing points of view. This serves to heighten any emotional potential and to construct the image of the presenter as an arbiter of truth whose investigation renders the evidence open to public scrutiny. The presenter is positioned as the viewer's representative, who mediates between conflicting parties, adopting an advocacy role from which concerns are investigated on the public's behalf and the state bureaucracy can be held accountable.

Health documentaries construct expositions out of the edited accounts of a range of stakeholders including doctors, patients, and government representatives. Ordinary people (patients) become illustrative examples

selected on the basis of perceived representativeness (*cf.* Nichols, 1991). Their experiences become authenticating devices within the exposition. Medicalized events are embodied through personal accounts which viewers may relate to the wider social context. The resulting coverage reflects aspects of both individual and communal responses to health concerns. Considerable emphasis is placed on individual responsibility in health coverage (*cf.* Karpf, 1988; Tulloch & Lupton, 1997). Yet, these programmes also emphasise communal responsibility. Generally, the individual needs to adopt a healthy lifestyle and take responsibility to prevent illness, but, if unsuccessful, society should provide a safety net for those who cannot afford the wonders of private care.

Generally, the four programmes provide a context within which medical and everyday worlds meet. Medicalized perspectives operate to present patient concerns and medical practice as complementary, and to render the benefits of medical services self-evident. Health coverage retains the idea that medical care is effective and that to be denied it is to be denied life. The medicalization of such coverage restricts the scope of health coverage and the ways in which concerns are constructed. For instance, TGKHL, and H&W make reference to people who live with disease and suffer while waiting for treatment. Such depictions support the view that no alternative source of care is available. Prompt medical intervention is the patient's only hope. This framing serves to prevent an investigation of wider issues, such as the control the medical profession has and the challenge the reforms may pose to their virtual monopoly. The health reforms are presented as a conflict between bureaucratic attempts to introduce tighter fiscal controls on the health system and the medical professions fight for self-rule. Public doctors are presented as saints refuting the evil bureaucrats and the rest of us are represented as mere pawns in this high stakes game of chance. People can be saved if the resources are made available. In a well-resourced health system recovery is put down to patient willpower and the

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knowledge and skill of medical professionals. Medical care is naturalised and questioned only in terms of whether we afford to keep providing it on a tax-funded basis. Yet, as pointed out by Wilkinson (1996), only about five years on average of a person's life is attributable to medical interventions. Access to medical care may be less important than social cohesion and general equality in life. Despite this, the primary focus within these programmes continues to be the prolonging of life through medical intervention.

Traditionally, the medical and socio-structural approaches have been developed in an adversarial relationship, with proponents of the socio-structural approach highlighting limitations in the medical approach and in particular the individualist focus, which does not adequately address wider social issues (*cf.* Beaglehole & Bonita, 1997). Such points of contention between approaches are minimised in these programmes by the way evidence is presented within the expositions. For instance, the use of socio-structural explanations does not lead to a displacement of the primacy of the medical approach. Socio-structural explanations do raise issues of inequality, but this is restricted to access to care. Programmes are constructed from a variety of explanations in order to support the proposition that the current medical system needs to be better resourced in order to save lives.

The analysis presented in this chapter is comparable to previous studies of lay views which indicate persistent faith in the medical approach as a whole, despite the existence of localised challenges (Williams & Calnan, 1996). This may be due, in part, to the space given to patients who are intimately involved with the issues covered in these documentaries. Williams and Calnan have argued that the level of criticism of medicine depends on the relation of the person to the issue:

...lay views on the merits of modern medicine are likely to differ according to whether it is being considered in general

or personal terms. Indeed, when viewed at a distance there appears to be considerably more room for scepticism. In contrast, when considered in the context of personal or family illness, the picture is likely to be very different (1996, p. 257).

Health documentaries utilise a personalised approach, where medicine is depicted as a source of hope for those facing serious ailments. With a personal focus of coverage on people undergoing medical treatment or following successful treatment, challenges to medicine may be voiced less frequently.

Accompanying depictions of grateful patients are images of the technological trappings of medical science, which serve to legitimate doctors as skilled carers with a range of treatment options at their disposal. One reason for television's reliance on such images of medical technology has recently been proposed by Chapman and Lupton (1994). These authors argue that health coverage generally conforms to standard broadcasting conventions and in particular the emphasis on compelling visuals. Medical science and practice provides such visuals and they are therefore utilised. Extending such reasoning to a discussion of the ramifications of these conventions, Wallack and Dorfman (1992) propose that such journalistic practices can limit the ways in which health issues are portrayed. These authors point out that the focus on images of medical technology and the plight of individual patients functions to portray health in medical terms and health problems as individual issues. Wallack and Dorfman write:

In general, health stories were presented in terms of individual behaviour or responsibility. Social and economic factors external to the individual were largely ignored whereas biomedical and technological solutions to health problems were emphasised. This contributes to public health problems being understood in isolation from the larger social and political context. In sum, journalistic practices likely contribute to the hegemony of individual-level explanations of

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health issues and so may systematically inhibit a broader public health understanding of health problems (1992, p. 126).

Researchers taking a critical approach persistently argue that television coverage is highly individualised, offering individual solutions to social problems (*cf.* Curran, 1996). There is evidence in my analysis to support such reasoning, but in a qualified manner. Such reasoning does not explain the use of socio-structural explanations that invoke notions of communal responsibility and wider political issues. Health documentaries do present health care issues within a politicised context, particularly when exploring issues around the allocation of resources. Proposed solutions stress both the need for state provisions and individual action. A key qualifying point here is that wider social influences are invoked in relation to the provision of medical services but are not acknowledged as possible causes of illness or health inequalities (*cf.* Clarke, 1991).

My analysis reveals both similarities to and differences from earlier research in the construction of health and illness on television. Coverage does encompass the experiences and social circumstances of patients. Doctors are depicted paying attention to the concerns of patients as a legitimate component of the healing process. Programmes employ depictions to highlight the complex relationship between lay people and the medical profession with depictions of lay people and doctors often being intertwined, each giving meaning to the other. As a mediated social product, health coverage appears to have moved to accommodate shifts in society which have also worked to redraw the traditional boundaries of the medical approach (Elston, 1991). Medicalization has evolved to accommodate an emphasis on prevention, lifestyle, holistic health (*cf.* Crawford, 1980, 1994), and resource allocation. These changing boundaries of medicine have facilitated the neutralisation of challenges to the medical approach as being impersonal, disempowering, and overly treatment-oriented. Recent challenges have resulted in the rise of the

articulate consumer and consequently in doctors' emphasising patient satisfaction, lifestyle factors, and prevention. Challenges around medical competence and the professional regulation of health care have been neutralised through the transference of responsibility to Government bureaucracy. Similar conclusions about the shift of responsibility have been derived from an earlier analysis of television health drama:

The point, well intentioned and based solidly in medical practice, is that doctors to the poor aren't given the chance to heal people that doctors in wealthier hospitals have. Politicians and hospital bureaucrats are blamed for inequities that can be, and ought to be, solved by the re-allocation of funds (Turow, 1989, p. 268).

Similarly, Brown and colleagues (1996) found that Australian news and current affairs programmes portrayed the health system as 'dangerous' for patients owing to bureaucratic bungling. However, contrary to the findings of Brown and colleagues, the health documentaries explored in this thesis do not associate dangers with individual doctors. Public doctors, in particular, are presented as heroes, who are committed to their patients and are willing to fight for resources to save them in a climate of fiscal restraint. Coverage represents such doctors as having the knowledge to solve problems in the health system and represents bureaucrats as having control and hampering doctors' efforts. Consequently, patients' lives are placed at risk. This is contrary to Bury and Gabe's (1994) finding that coverage of changes in health care served to support bureaucrats and question the commitment and competency of doctors. Doctors are depicted as not having control of the health system in the programmes analysed in this chapter. At one level this may be seen as a challenge to medicine but it is used to deflect responsibility for inadequacies in services to bureaucrats. Such coverage demonstrates the way medical care can be placed within a socio-structural context while preserving its legitimacy.

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Government communications managers have commented on the persistent practice within health coverage of assigning responsibility to government bureaucracy. Inkster (1996) proposes that public discontent with the health reforms and perception that the system is failing is a direct result of the persuasive handling of such issues in health coverage, which stimulates public resistance. As he writes:

The mass media, fed information by credible sources [doctors] within the health system, have taken on an advocacy role, raising issues and pressing for the transference of finite resources to particular sectors and causes. The classic case of a renal dialysis patient in his mid 70s being given treatment after making an impassioned plea on a national television show reflects the mass media's ability to take a case to the public court and condemn the health system for failing to provide adequate access to care (Inkster, 1996, p. 15).

It is ironic that this communications manager criticises the media for providing a limited account of such events when his very purpose is to restrict or control the media's access to information (*cf.* Tully, 1996). Inkster's critique further reflects the conflict between government bureaucrats and the medical profession over public understanding of the health reforms.

My analysis generally supports the contention that journalists have developed an adversarial stance against the Government over issues relating to a reduction in health funding and services (*cf.* Corner, 1999a). Often government representatives are held responsible and called upon to justify policy decisions (*cf.* Finlayson, 1996). However, this is not a convention invented by the medical profession to discredit the state bureaucracy. Corner writes:

Television journalism, despite the countervailing forces of public relations, news management and censorship, has in most modern societies been able to exert considerable pressure of accountability upon politicians and government

officials. These have been increasingly required to explain and justify their policies and actions through a communicative convention which has now arguably become the central form of public political knowledge – the interview (1995, p. 45).

Two important considerations are missing from Inkster's criticisms of journalists' efforts to hold government officials accountable. First, coverage does question the actions and motives of some doctors. Second, television does not simply impose perceptions on the public. Coverage also draws on the experiences of members of the disgruntled constituency who have been adversely affected by the reforms.

Throughout this analysis criticisms of the ways health and illness are constructed in these programmes have been raised. However, health coverage can also inform the public and contribute to people's views on contemporary concerns in a positive manner. When writing about television generally, researchers such as Corner (1995), Ellis (1999), and Newcomb and Hirsch (1984) emphasise how television provides a useful forum within which 'the issues of the day' can be explored. Health coverage provides viewers with potential courses of action which can have a positive impact on their health. These programmes do provide information on the prevention of cancer, social reform, and medical procedures that can add to public understanding. However, such potentially positive aspects of health coverage are limited by the continued medicalization of health coverage. Despite positive aspects these programmes are undermined by the omission of an adequate exploration of wider concerns relating to social inequality. Connections between individual health problems and wider social structures are not adequately explored (*cf.* Turow & Coe, 1985). Yet it is important to reiterate that health documentaries do not merely restrict viewers' thoughts by providing limited accounts of selected health concerns. Although the analysis presented in this chapter highlights important communication elements such as the potential influence of the

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framing of issues within health coverage on audience interpretations, it cannot answer questions about what viewers actually do with such coverage. Such questions need to be explored through reception research.

Chapter Eight

Lay Views of Health and Illness

There have been several prominent investigations into lay people's conceptualisations of health and illness (e.g., Blaxter, 1990, 1997; Cornwell, 1984; Crawford, 1980, 1984, 1994; Herzlich & Pierret, 1987; Pierret, 1993; Radley, 1994; Stainton Rogers, 1991). Such studies reflect a shift in health research from approaching lay views as distortions or misunderstandings of medical knowledge to the valuing of these views as legitimate forms of knowledge (*cf.* Bury, 1997; Radley, 1999). An increasingly accepted stance is that:

If research in the field of public health is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, then it must utilise and build on lay knowledge – the meanings health, illness, disability, and risk have for people (Popay & Williams, 1996, p. 760).

Such research has developed from a focus on the role of patient beliefs in the medical treatment process to a broader focus on the functions of lay views on health and illness within everyday life (*cf.* Bury, 1997; Radley, 1994, 1999; Williams & Calnan, 1996). It reflects a shift in focus from whether clients are satisfied with various services to complexities and contradictions in the ways that lay people construct health and illness. A detailed review of research in the burgeoning field of lay views is not provided here. Such reviews already exist in the literature and much of such research lies outside the focus of this thesis (e.g., Blaxter, 1997; Bury, 1997; Radley, 1994; Stainton Rogers, 1991; Williams & Calnan, 1996). What is provided here is a brief introduction to the area of lay views that draws on trends within previous research in order to set the context for the present study.

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A general finding from previous research is that the meaning of health and illness is shaped within the historical epoch and society within which people live. What being healthy or ill means and how these states are produced is inherently caught up in the socio-cultural explanations, moral values, and social institutions which give meaning to everyday life (*cf.* Herzlich, 1973; Herzlich & Pierret, 1987; Radley, 1994; Stainton Rogers, 1991). Health is often constructed as a taken for granted part of life, whereas illness is something that comes along and disrupts life and challenges people's sense of normality (*cf.* Pierret, 1993). As Radley writes, "the point is that 'health' defines the whole dimension, while 'illness' is restricted to being the subordinate opposite of 'health'" (1994, pp. 5-6). Health is a wide-reaching concept, which is used by people to talk about a range of topics including, physical and mental well-being, fitness, exercise, diet, having a job, and social change. When making sense of illness, people think about the implications for their work, and their families, and increasingly whether they can afford access to care. In making sense of situations such as becoming ill, people draw on available socio-cultural explanations from a range of spheres in life to provide structure to their experiences (*cf.* Radley, 1999; Williams, 1990). Radley writes, "...illness is not a stable entity, separable from other aspects of people's lives, but is always known through these other aspects, in terms of which it is acknowledged and encountered" (1999, p. 19). In this way one social realm, illness, is reflected through another, such as work. The key point here is that the meanings people assign to health and illness are not invented anew by each individual. The ways that health and illness are understood reflect wider societal belief systems and values relating to biological processes, treatment strategies, lifestyles, work conditions, and general societal relationships (Herzlich, 1973; Stainton Rogers, 1991; Williams & Calnan, 1996).

What previous research has demonstrated is that analysis of people's views can be used to explore the moral values and communal explanations used to make sense of health and illness (Blaxter, 1997; Farr & Markova, 1995; Herzlich & Pierret, 1987; Radley, 1994; Stainton Rogers, 1991). Although varying in the extent to which people's views are theorised using various psychological or sociological theories, such research has demonstrated that health and illness are central components of people's identities that reflect general ways of engaging with life and presenting oneself as a moral individual. Investigations of the explanations people draw on in constructing their views provide important insights into the complex relationship between individuals and the societies within which they live.

Although findings are still provisional, previous research generally indicates that people tend to draw on multiple explanations of health and illness, but that some explanations are more dominant than others (*cf.* Blaxter, 1990, 1993, 1997; Bury, 1997; Herzlich, 1973; Radley, 1994; Stainton Rogers, 1991; Williams & Calnan, 1996). For instance, Blaxter (1997) drew on findings from the quantitative British Lifestyle Surveys (1986-1987 and 1991-1992) and relevant qualitative literature to explore what lay people think about inequality in health and the cause of illness. In presenting the survey results, Blaxter proposed that there was considerable agreement for the majority of respondents that lifestyle factors, including diet and exercise, and advances in medical science are key determinants of health and illness. Stress resulting from life pressures was also identified as a causal factor for certain diseases, but there was little reference to socio-structural issues and inequality. This type of issue was mentioned by only a minority of participants in relation to health in general, and even less frequently in reference to a person's own health or illness. As Blaxter noted:

Causes of health and illness outside the individual's control –
housing, the environment, personal poverty or prosperity –

were rarely mentioned, for good or ill, as important in one's own life... Rather few specifically mentioned poverty as a cause of ill health in society in general, but those who did were more likely to be in higher income groups (1997, pp. 748-749).

When reviewing the findings of qualitative studies (e.g., Calnan, 1987; Crawford, 1980, 1984; Herzlich, 1973; Pierret, 1993; Pill & Stott, 1985), Blaxter (1997) reported similar trends. Both lower SES and more affluent individuals assigned cause primarily to individual behaviour. People of lower SES, in particular, often refused to accept that more affluent folk were healthier. A moral imperative to be self-disciplined, maintain one's health, and resist illness was a prominent theme. Accordingly, illness was presented as a sign of individual weakness or moral failing that occurred when someone gave in to disease or life pressures (*cf.* Crawford, 1980).

When discussing these trends Blaxter writes:

A corollary of this pervasive "mind-over-matter" philosophy, however, is that "stress" is very commonly offered as a cause of ill health. Stress is seen as more important than "healthy behaviour", and though it is of course associated with structural factors – poverty, unemployment – the *reaction* [italics in the original] to stress is a personal characteristic (1997, p. 752).

Even when respondents talked about stress it was in general terms, as a feature of contemporary existence that places everyone at risk, not just the poor. In this way, although the influence of socio-structural influences was acknowledged, inequality was generally denied. Despite referring to exceptions to this rule, where people do identify socio-structural factors, such as work conditions and poor housing, as a cause of illness (*cf.* Blaxter, 1993; Pill & Stott, 1985), Blaxter (1997) argues strongly that people's accounts of illness are individualised. These are important considerations when conducting research with people facing social and

health inequalities. It implies that these people deny their own subjugation by primarily relying on medical and lifestyle explanations.

As noted previously, research in this area is still provisional and the existing evidence on the shape and focus of people's views is still somewhat contradictory. Although research indicates that people of lower SES attribute illness predominantly to individual behaviour and chance, references to socio-structural influences are evident in the literature. In practice, people have a history of pointing out relationships between socio-structural influences and illness. Popay and Williams propose:

Workers have frequently been the first to identify causal relationships between their working environment and patterns of disease and the trade union movement has a long history of activism around health and safety issues (1996, p. 761).

Despite previous research highlighting the dominance of medical and lifestyle explanations, these explanations appear to be supplemented by socio-structural explanations. Socio-structural explanations are likely to be drawn on more readily as a way for people to make sense of recent health and social reforms that have resulted in more disadvantaged people and reduced access to medical services for many. In particular, people of lower SES are likely to be more willing to articulate their frustrations with structural influences that undermine their health and to develop less individualised views, given the amount of media attention that has recently been given to the ramifications of the health reforms. In fact, there is evidence to support such a shift in people's views in the findings of research into the relationship between lay people and the medical profession.

The relationship between the medical profession and lay people has provided a key focus for research into lay views, primarily because of the dominance of doctors over the provision of health care in the Western world (*cf.* Bury, 1997; Calnan & Williams, 1992; Elston, 1991; Herzlich,

1973; Lupton, 1997; Waitzkin, 1979; Williams & Calnan, 1996; Zola, 1972). Initial studies tended to be rather deterministic and drew on the medicalization thesis to explore the ways that medical thought colonised lay people's lifeworlds (Williams & Calnan, 1996). A general public acceptance of the benefits of an ever-expanding medical approach was assumed (*cf.* Zola, 1972). More recent research paints a somewhat different picture, within which lay people are constructed as social agents who have the ability to question the medical approach (*cf.* Crawford, 1984). This research has shown that people can use medical and various other explanations in complex and novel ways, in order to make sense of events in their lives and to construct their relationship to medical practice (*cf.* Calnan & Williams, 1992; Lupton, 1997; Williams & Calnan, 1996). Such research has revealed that although general faith in the medical profession remains, people now voice criticisms associated with shifts in the levels of acute and chronic conditions, restrictions on health care resources, well-publicised cases of medical misadventure, and the rise of the health consumer (Lupton, 1997; Williams & Calnan, 1996). For instance, in a study of lay perceptions of medical practice, Calnan and Williams (1992) found that medicalization may be undergoing change as reflected in doctors' being subjected to critical evaluation by lay people. Medical practice was evaluated according to whether it enhances or threatens life, creates dependence or restores independence, and whether it is value for money. Respondents also focused on socio-structural issues and criticised the organisation and funding of medical practice and limitations in access to services. A general faith in the benefits of medical care was accompanied by criticisms of the lack of public provisions. Lupton (1997) also found that respondents voiced ambivalent, complex, and varied accounts, within which they shift between expressing support for and criticisms of doctors. It is important to note that criticisms voiced by respondents in these studies are not focused on the dominance of the medical approach over the provision of health care, but on factors such as

the incompetence of some doctors and the restriction of health care resources. In this way both medical and socio-structural explanations are drawn on in a manner that preserves the dominance of the medical profession while raising questions about the allocation of health care resources and the competence of some practitioners.

In exploring such issues as the changing character of people's views, researchers implicate the mass media as a force for preserving general faith in the medical approach while also raising contradictions in medical practice (e.g., Brown et al., 1996; Bury & Gabe, 1994; Calnan & Williams, 1992; Lupton, 1997; Williams & Calnan, 1996). The incidence of people questioning the actions of some doctors and querying problems in the provision of health services is associated with the development of more critical health coverage in recent years. Although it is acknowledged that health coverage continues to present positive depictions of medical practice, the mass media and television in particular is positioned as an amplifier of challenging perspectives. Critical aspects of health coverage may be taken up by the audience and utilised in the reconstruction of people's views on the medical profession.

When exploring the relationship between the changing nature of people's views and television health coverage, it is important to note that people do not act as cultural dupes who simply reproduce shared explanations in a predictable manner (*cf.* Gabe & Bury, 1996; Popay, Williams, Thomas & Gatrell, 1998; Williams, 1995; Williams & Calnan, 1996). People draw on various socio-cultural explanations in often idiosyncratic, as well as common ways, and tailor these explanations for their own purposes. As was emphasised in Chapter Six, people are active interpreters of the world, who combine aspects of various explanations to make sense of health and illness and their own place in the world. However, when emphasising people's ability to construct their views, it is necessary to acknowledge that

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social power relations, such as the dominance of the medical profession, do influence the focus and shape of people's views (*cf.* Giddens, 1991; Williams, 1995). There is a dialectical relationship between human agency and social structures which is particularly relevant when investigating issues such as the social origins of the views expressed by people of lower SES.

This chapter presents an interpretation of participants' views on health, illness, and the four health concerns covered in the health documentaries. Although participants voice a variety of ideas and assumptions, the analysis does not map every explanation used by participants. Rather, it explores the ways that extracts from participants' accounts reflect aspects of the medical, lifestyle, and socio-structural approaches. This focus enables the exploration of the ways participants interweave biological, agentive, and socio-structural dimensions of health and illness when constructing their accounts. A key component of this analysis is a comparison of participants' accounts with the coverage provided in the four health documentaries. This comparison provides an important means of exploring the relationship between the framing of health and illness within the health documentaries and participants' accounts prior to the focus group discussions. Combined with the health documentary analysis, the analysis of the shape and focus of participants' views provides a context for the focus group analysis that explores the ways people draw on aspects of health coverage and other people's accounts when renegotiating their own views.

The first three sections of this chapter provide an exploration of the ways the medical, lifestyle, and socio-structural approaches are drawn on in the participants' accounts. This leads to an exploration of their views on the four topics explored in the health documentaries. Television is recognised as an important source of health information. Therefore, a subsequent section

explores participants' viewing preferences and ideas about the health communication process. As the analysis progresses aspects of previous research findings are used to enrich the interpretation of themes across the participants' accounts. In the chapter discussion a more abstract level of interpretation is developed and many of the points raised in this introduction are revisited.

8.1 The Negotiated Influence of Medical Thought

The analysis presented in this section highlights the ways participants draw on the medical approach when making sense of health and illness. The focus is on the ways participants negotiate a critical view on medical care and doctors whilst still maintaining general faith in and reliance on such care. It is shown that, while taking many medical ideas for granted, people can also present themselves as health consumers who are aware of limitations in the medical approach. The attention given to participants' views on doctors and medical treatment is appropriate given the reliance of health coverage on medical settings and the renegotiation of the public image of doctors outlined in the previous chapter.

In their accounts, participants are well versed in medical concepts, procedures, and explanations (*cf.* Pollock, 1993). Woven throughout their accounts are ideas about correct bodily functioning, symptoms, contagion, and the need for medical treatment. Participants readily express medical ideas about biological processes and the onset and treatment of disease in terms of cause and effect relationships (*cf.* Radley, 1994). They rework medical explanations about aetiology in relation to their own biographies as a means of making sense, not only of disease, but also of wider shifts in the provision of medical care. The medical approach is drawn on to add order and meaning to the experience of illness because it provides a ready-made and socially legitimated framework. Such reliance on the medical approach is evident when participants use medical terminology to

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present themselves as knowledgeable about disease and medical matters and to construct illness, whether psychological or physical, as a bodily malfunction requiring a cure or management. Some of these ideas are reflected in the following extract:

...There's obvious symptoms or clinical symptoms, where they've got a tummy ache or sudden malfunction in the body... I think you've also got to look at their bodily functions and that can sometimes interact with mental functions like schizophrenia, which is a brain malfunction. Things like that just bog you down and stops you from getting on with things... (Alan, a 62 year-old semi-retired salesman).

Implicit in this extract is a psychosomatic explanation (cf. Engles, 1977; Greco, 1993) where biological malfunctions can cause mental illness. Such extracts carry assumptions about the nature of disease and how it is identified, and construct illness as a deviation from a normal healthy state. Reference to clinical symptoms helps Alan present himself as a critical consumer whose account is informed by expert knowledge.

Participants' accounts reflect conceptualisations of the human body as a machine. Such conceptualisations lead to the construction of illness as a malfunction that can be repaired through medical intervention. These accounts feature ideas about the triumph of medical technology over illness and the ability of doctors to repair or replace malfunctioning parts. In a creative use of such machine metaphors, reflecting the interweaving of various spheres of life within lay accounts, Ed (a 41 year-old part-time labourer) uses his own experience in the motor industry to compare the repair of the body to the repair of a motor vehicle:

...Well, it's like any machinery, you just patch it up and carry on. If a part of the body doesn't work you replace it. Technologies allowed us to do that... You know, doctors have a job to do and they specialise in one job and they consider specialised parts. And the point is you can tell a difference between a mechanic and you can tell the

difference between a panelbeater. You never see a mechanic's work. Like a surgeon, you never see his work...

Such metaphors are common throughout the accounts and exemplify the influence of the medical focus on cure and in particular the use of technology as a means of restoring normal bodily functioning. The comparison of doctors' work to that of tradespeople also functions to naturalise a rather dehumanising view of the human body as a machine made up of replicable parts that may malfunction. However, skilled practitioners can replace these malfunctioning parts.

The influence of the medical approach is also reflected in the way that the benefits of medical care are generally accepted. Emphasis is placed on seeking medical assistance as an important part of restoring the ill body to a healthy or normal state. However, this does not mean that participants are not critical of medical care or do not express reservations. Although emphasising the general necessity for medical treatment and presenting the medical profession in a positive manner, participants also refer to instances when things go wrong (*cf.* Lupton, 1997; Williams & Calnan, 1996). These instances are often linked to doctors who are not as competent as they should be. There is an acceptance of medicine as an imperfect science, which employs some practitioners who are not quite up to standard, and whose actions can both cause and complicate illness. As Warren (a 58 year-old semi-retired male) states:

If you have got a problem the doctor will help you with that problem. Things can go wrong but it's cos maybe the doctor isn't as good as he should be. Just gotta be careful who you go to... Once upon a time, years ago, we thought they were Gods. We dwelled on everything they said. Today we know that's not true and we tend to query them more. Myself personally, I always get two opinions from two different doctors... Look at the Wanganui disaster. That's what happens when you get the wrong man for the job...

Warren makes reference to a well-publicised case of medical misadventure in Wanganui where cancer patients were misdiagnosed, leading to those without cancer being treated and those with cancer not being treated because of a doctor's incompetence. As previous research (Brown et al., 1996) and the analysis presented in the last chapter shows, there are now more complex depictions of doctors. The reference to blanket acceptance of doctors' expertise in the past and increased scepticism in recent times reflects the way that examples derived from health coverage can be integrated into public consciousness and used to rework one's relationship with the medical profession. Warren presents himself as both a health consumer and patient (*cf.* Lupton, 1997) when he talks about the need to query doctors and to be active in the consultation process. However, he still reverts to the opinion of another doctor, which reflects continued reliance on the medical profession. For him, careful selection of a practitioner is the key to ensuring quality care.

Participants also talk about evaluating doctors because their faith has been challenged as a result of negative personal experiences. There is a balance in the accounts between good and bad doctors (*cf.* Lupton, 1997). Good doctors are those with the necessary technical skills who also consider the patient's view. Faith in doctors is linked to a consultative model of medical practice. Bad doctors are those who do not have the necessary technical skills and or do not communicate openly with patients.

Mary states:

Well, knowing that there is something physically wrong and when you go to find out what is physically wrong and you get treated as if you don't really know what's wrong with your body by the doctors you go to. They seemed to get the impression, well they are there to be the doctor, you're the patient. You need a doctor who listens and doesn't fob you off. Cos if something's wrong and they don't get it, it can cost you your life... (a 50 year-old home-maker)

This extract exemplifies the importance that participants place on their own understandings of their bodies and their ability to know when something is wrong. Such understanding is presented as an aid to prompt diagnosis. This extract also reflects the way that patients attempt to become actively involved in the construction of a legitimate ailment. They work to have their symptoms legitimated by a doctor as part of the consultation process that enables them to take up the sick role (*cf.* Radley, 1994). However, if their entry into the sick role is not legitimated through prompt diagnosis, they attribute this to a bad doctor and not the absence of illness.

Given the reliance on hospital settings in health coverage and the centrality of this institution to the medical approach, participants were asked to talk about their views on hospitals. They presented themselves as being reluctant to go to hospital, while also being curious about what happens in these institutions just in case they do become ill. When talking about hospitals, many participants draw on medical explanations to raise problems, not only in their obtaining timely diagnosis and access to treatment but also resulting from medical care. Examples of negative outcomes from treatment are taken from participants' own experiences, those of significant others, and from health coverage. These examples include various cases of death or permanent disability resulting from medical treatment. However, participants also commonly gave less dramatic examples of problems stemming from medical treatment. Reflecting the contradictions inherent in their assessments, they accept the benefits of hospital care in addressing a range of ailments but also spontaneously provide examples of problems that can occur. As Ann (a 54 year-old beneficiary) states:

...I think that we all have that fear of hospitals, because of the fear of being told that you have a major problem. It's just that, cos if you go in to have an operation and come out and there are a lot of bugs in the hospital when they come out of hospital and while they are recuperating. And I think there's

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quite a lot of people being put off going to hospital, cause they're going to catch something... If you're really sick, got cancer or something, I don't know where else you would go, but I wouldn't want to go for something not so serious. I'd rather watch it on TV and learn about it that way...

Not wanting to go to hospital is associated with a lack of control and having to face one's mortality. There appears to be some anxiety about hospitals, which historically have been places where people go to die, if not from the ailment they sought treatment for then from something they contract while in hospital (*cf.* Porter, 1985). Notions of contagion are evident throughout the participants' accounts and are often referred to in relation to the possibility of cross-infection as a result of invasive medical procedures. Some of the fascination with hospital settings in health coverage may be a reflection of a general sense of anxiety and curiosity among people about hospitals. The way the hospital is constructed within these accounts reflects the tension between the potential benefits and possible negative outcomes of medical treatment.

Despite readily querying doctors and identifying limitations in diagnosis and treatment, participants still rely on medical intervention. A medicalized plot line of cause, diagnosis, treatment, and outcome is taken for granted in these accounts. An obstruction to someone's progression through this plot line is presented as a threat to people's health. Progression through the medical system is central to having faith in doctors. If doctors' actions do not assist people to successfully resolve this plot line then faith in doctors is diminished. However, these accounts are complex in that participants also invoke wider influences. Faith in doctors is preserved in a similar manner to the manner it is preserved in health coverage, in that problems in the provision of medical care are associated with health care reform. Medicine is constructed as a source of hope that is restricted, owing to wider influences such as recent social reforms in the planning and

administration of medical services. As David (a 45 year-old part-time community worker) states:

Well, some of them [doctors] you have got the faith in. Some shouldn't be there, but then it is more, as I say, it's not so much the doctors, it's the system. Puts people at risk with all these cutbacks and restructurings... Somewhere along the line the system is breaking down... Most doctors do their best but just don't have the backup from Government...

In a similar manner to the strategy health coverage employs, participants such as David assign responsibility for problems in the provision of medical care to the Government. This extract also raises issues about the ways that various explanations, in this case medical and socio-structural, are drawn on in a complementary manner. Such interweaving of explanations will be dealt with in more detail as the analysis progresses.

Overall, the analysis presented in this section supports the idea that the medical approach continues to have a significant influence on the accounts voiced by participants. Medical explanations about appropriate actions to detect and remedy disease are highly salient in these accounts. However, there are various complexities and contradictions in people's views. The benefits of quality medical care are still taken for granted. There is persistent faith in medicine as a whole, despite the existence of localised challenges (*cf.* Lupton, 1997; Williams & Calnan, 1996). From a medicalization perspective, it could be argued that participants have become dependent on the medical approach for making sense of health and treating illness, and that this leads to their neglect of issues pertaining to wider political, social, and economic influences. This would be a restricted interpretation that overlooks the active role of people in constructing their own views on health and illness from a range of explanations. Participants do not just rely upon medical explanations. They complement medical ideas with accounts of the need for healthy living and

adequate provision of care in a manner that is similar in many respects to that used in the health coverage analysed in the previous chapter.

8.2 Accounting for Lifestyle

In a manner complementary to medical explanations, lifestyle explanations are drawn on to conceptualise health maintenance as a means of preventing biological abnormalities or deviations from a normal, healthy state. Health maintenance and the prevention of illness are presented as the result of people refraining from unhealthy activities and engaging in healthy activities. The existence of such ideas among lay people is now a consistent research finding, associated with the medicalization of everyday life (*cf.* Blaxter, 1990, 1997; Crawford, 1980, 1984). People talk about health as something that has to be maintained through health-enhancing rituals, such as a balanced diet and regular exercise. Health requires a balanced and controlled existence. Correspondingly, unhealthiness is equated with a lack of control, which is manifested in over indulgence and activities such as smoking and drinking that damage the body (Blaxter, 1990). Mark (a 36 year-old council worker) talks at length about diet and exercise:

I think it comes down to, you know, healthy exercise and eating well.... I bike to work every day, I work out of town, you know, I still cycle probably 100km a week. I try to stay pretty active and that with the kids, they all play sport and that as well, you know. So I eat probably, you know, have a few beers on a Friday night and things but I wouldn't call me a big drinker. It's usually only like only one day a week we probably indulge in a bit of junk food... We generally eat pretty healthy.

Mark presents himself as controlling his life through a balanced diet and regular exercise. This extract highlights that the lessons of health promotion have been well-learned (*cf.* Blaxter, 1997). Prevention of illness results from refraining from unhealthy activities and from engaging in healthy activities. The commonsense status of such thinking is reflected in

the repeated use of 'you know' statements, which have been shown to be used in order to invoke common conceptual ground between speakers and listeners (Radley & Billig, 1996). This extract also highlights how health, like illness, is understood through other spheres of a person's life (*cf.* Radley, 1999), in this case work and family life.

When participants draw on lifestyle explanations, fitness and health are often used synonymously. Fitness is constructed as a state of bodily preparation, which ensures confidence in overcoming obstacles and coping effectively with challenges. Activities conducted to preserve or improve health imply fitness and vice versa (Glassner, 1989). Self-discipline, diet, and exercise produce a fit, healthy, and moral individual who is in control. In short, by maintaining fitness participants are assured that they are maintaining their health and their ability to fight disease. As Nick (a 35 year-old former mercenary working as a shop assistant) states:

Whether you get sick or not is a matter of, you know, not looking after yourself and building your strength... I don't mind slobbering out on hamburgers and that sort of shit, but at the same time it's got to be combined with healthy food. That gives you the energy to go out and exercise, which then keeps you healthy, but you gotta have the willpower to do it, so to me it's a circle. Without one you're fucked. If you don't have good food then you're not gonna have the required energy to exercise fully... If you're not looking after yourself food-wise, then your mental state is stuffed, but I find that if you're physically fit your mental state goes hand in hand. Fitness is something you do for your health. It keeps you healthy and lets you get on with things to the best of your ability...

This extract also illustrates the way that participants place considerable emphasis on personal fortitude and a healthy attitude as key components to maintaining health and a normal life. Health is constructed as being dependent on a person's ability to take responsibility and to develop their fortitude and strength in dealing with adversity (*cf.* Blaxter, 1997). Health is

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something that requires constant effort and is developed by people keeping themselves fit and active (Blaxter, 1990; Crawford, 1984).

A prominent theme in the participants' accounts is the duty to stay healthy (*cf.* Herzlich & Pierret, 1987) or what has also been termed healthism (Crawford, 1977, 1980). Drawing on the concept of healthism, Pierret states, "although this 'bodyism' lays emphasis on self-development, pleasure and hedonism, it has also come along with a trend that makes individuals responsible for their health and thus cultivates a sense of discipline" (1993, p. 12). Individual agency as the source of both health prevention and illness is associated with personal choices and willpower. One implication of strict adherence to such thinking is that the cause of illness can be assigned to personal weakness and a lack of control (*cf.* Blaxter, 1997; Crawford, 1984). The idea that individuals need to remain motivated and cultivate a positive attitude, which enables them to resist the onset of illness, maintain their health, and cope with a range of risks in life, is evident throughout the participants' accounts. Through demonstrating a strong will participants present themselves as morally responsible and willing to do their bit in the fight against illness and for the maintenance of their health (*cf.* Crawford, 1984; Herzlich, 1973; Pollock, 1993; Williams, 1990). Lisa (a 43 year-old unemployed woman) draws on such lifestyle explanations to identify a lack of mental fortitude as a cause of illness:

...I think mentally and physically has a lot to do with it cos if you are not mentally strong, that's when your body starts to get you crook.

A person's state of mind is presented as having a direct impact on bodily processes. The key to health and means of resisting illness is a person's strength of will. When discussing the implications of such thinking, Blaxter writes:

Moreover, the notion of self-responsibility and self-control, combined with a wide public acceptance of a holistic model of health in which mind and body are inseparable, invites an

assumption of guilt for illness in terms which go beyond behaviour. Illness becomes one's own fault not simply through a carelessly unhealthy lifestyle, but also because of character failings or weakness in will (1997, p. 754).

Such healthist thinking has accompanied the commodification of health, where a range of products from healthy foods to gymnasiums and personal motivation programmes can be purchased in order to ensure one's health and moral integrity (*cf.* Crawford, 1977, 1980, 1984). Health is a commodity that requires considerable personal and financial investment (*cf.* Stainton Rogers, 1991). People are morally obligated to preserve their health and gain control over illness (*cf.* Crawford, 1984).

The lifestyle explanations drawn on by participants invoke moral assumptions about a person's competence and integrity (*cf.* Radley, 1993; Williams, 1993) that have further implications beyond the individual. Within their accounts participants extend individualised notions of moral responsibility from their own duty to be healthy to the duty to not be a threat to others and the duty of society to provide for its members.

In the context of recent changes in the provision of health care, including resource restrictions, those who cause their own ailments through unhealthy living are stigmatised. The idea that a person's unhealthy activities can have consequences for other people results in the presenting of people who do not preserve their health as moral transgressors or the 'unhealthy other' (Crawford, 1994). Participants propose that those who act irresponsibly with their health place other people at risk by squandering limited resources. Several participants proposed that those who have behaved recklessly and have caused their own illness through excessive drinking or smoking should have to wait for care. These people are positioned as undeserving patients. Warren states:

...Because of car accidents and smoking and a whole lot of other things that cause this ongoing drain on resources and

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hospitals, there's just going to have to be some scheme where people get rated. And if you did it to yourself then you are the one on the waiting list. Not those who have been careful and get ill by no fault of their own. People who were foolish, like drinkers and smokers and things like that. They take up hospital beds and should be charged because it's taking up beds that other sick people could have.

In this extract those who engage in unhealthy activities are presented as having behaved immorally and as being frivolous with their health. It is proposed that such people should not be entitled to the same level of care as more responsible folk. Here the duty to be healthy is extended in a manner that invokes moral assumptions as a basis for deciding who should have access to medical care (*cf.* Radley, 1994).

Despite its emphasising people's duty to be healthy and duty not to pose a threat to others, participants' application of moral thought does not stop at the individual level. They also invoke the duty of society to provide the means for people to maintain their health. Although participants accept responsibility to do their bit and emphasise the importance of a healthy attitude and lifestyle, this does not prevent them from referring to factors outside their control that can prevent them from being as healthy as they could be. They voice criticisms of the system which prevents people from engaging in health-enhancing rituals and which wears people down. In other words, even when participants talk about the virtues of diet and exercise, their ability to do these things is recognised as being shaped by their circumstances and the wider socio-cultural context. As Ron (a 28 year-old truck driver) states:

Well, I make sure I get a reasonable amount of exercise. I'm quite conscious of diet intake, probably not perfect in that area, but economics has something to do with that too... People can't afford it cos anything that's healthy is expensive. I mean, a bottle of vitamins is \$15 or \$18 dollars... It's just part of that whole capitalist state, I feel. It's just a whole, you know, I mean the rich, and all that, they get

all health and everything they want... They've got time to diet, they can afford to diet, they can afford it all.

The health-enhancing benefits of diet and exercise are accepted, as is the idea that one can be prevented from benefiting from such rituals owing to social stratification. Participants present themselves in a moral light by emphasising the benefits of a healthy lifestyle and talking about the ways they are prevented from engaging in healthy activities. Because the system prevents people of more modest means from participating in such activities, it is the system and not the person that is immoral and ultimately responsible for illness. People are restricted in their choices owing to an inability to pay for health-enhancing products and services.

In sum, this analysis supports previous studies that have found that people readily voice the idea that health is heavily influenced by individual behaviour, and therefore a considerable amount of responsibility lies with the individual for its maintenance. Favoured explanations place emphasis on the benefits of a healthy lifestyle and the consequences of an unhealthy diet and a lack of exercise. Both medical and lifestyle explanations are not simply used in ways that exclude socio-structural explanations, but in ways that interrelate aspects of all three approaches. Healthy behaviours, such as eating the right foods and regular exercise, can be interpreted as rituals that an individual can do to prevent bodily malfunction and to protect themselves in unhealthy life circumstances. The need for these individual preventative strategies is stated in ways which are compatible with an understanding of inequality; participants explain illness in terms of lifestyle risk factors balanced against considerations such as financial barriers and their situation in life. In short, the moral responsibility to engage in healthy rituals has been extended to include society's moral obligation to provide for its members. Moral dimensions to the participants' accounts contribute to the construction of health as a kind of resource that can be depleted. Health is presented as a product of social provisions and access to necessary resources as well as personal action and fortitude.

8.3 Taking Social Circumstances into Account

Participants draw on many of the same socio-structural explanations as the health documentaries to identify issues surrounding problems in the provision of medical services. However, socio-structural explanations are also used more widely in the participants' accounts, where various contextual influences are identified as impacting on health. These influences include employment, economic hardship, unhealthy environments, and social inequality. Participants recognise the biological basis of illness and links between lifestyle and health, but also highlight the importance of life circumstances.

First of all, there is a clear concern running throughout these accounts that recent social reforms function to restrict people's ability to live a healthy life and to limit their access to care. Access to care is used as a focus for talking about these reforms and expressing anxiety about their impact and disillusionment with ongoing social change. Financial issues are linked to the accessibility of health care and to people's physical condition. Participants present the idea that one's quality of life is being undermined by government policies:

I think it's disgusting. Because, you know, it's blatant by the government, for all the cut backs, that all contributes to our health. I suppose you could say the same with the fire brigade and the police force, that all contributes to our health, and just huge cut backs, and it's just filthy politics, and the people are suffering. People have no confidence in them, they're just running down the whole system, cutting wages and benefits. People are suffering and we've got no options. If you haven't got money your health suffers cos you're trapped, especially with the waiting lists. If you've got money you can go private; you don't have to wait. When there's no money there's no choice. You've gotta wait and some even die waiting. It's just not fair... (Mary)

In such extracts reference is made to cutbacks in the health system and the welfare state in general. Reforms of health care and other social services are presented as contributing to increased inequality and health problems. Researchers have repeatedly shown that people of lower SES often conceptualise illness in functional terms as limiting people's control and preventing them from doing what they want (*cf.* Blaxter, 1990; Bury, 1997; Pollock, 1993; Radley, 1994). In a similar way, participants propose that monetarist policies restrict their control and prevent them from living a healthy life and, if necessary, accessing medical care. The undermining of the welfare state, resulting from these policies, is presented as restricting people's ability to prevent illness, placing them under undue strain, and preventing them from accessing medical care.

When participants were asked to talk about recent changes in the health system they did not just talk about the provision of medical care. They also talk about general living conditions, inequality, and social decline. In expressing their views on such socio-structural issues, participants invoke their personal experience to make sense of social change and the inequalities arising from it. The personal and the structural are interwoven in the construction of these accounts, as is shown in this extract from Jane (a 43 year-old solo parent):

...I had asthma as a teenager and I'd outgrown it. So I didn't have it for twenty years and my children never had it either and we moved into that house. Because it's very damp I started getting asthma again. So I went and applied to Housing Corp [a government housing agency] for transfers and they kept refusing me. And then I went and applied to Income Support [a government agency] for a better heating system and they refused me too. So then when the benefits were cut back I've been sick and now I've been sick for three weeks you know with this hacking cough... It's just the pressure being on the benefit. People with money don't worry cos they got the money to deal with problems. I don't want to spend that money at the doctors. I want food. I just haven't

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gone... But if it's my children that's totally different, that would be the first place I would take them, but because I'm older I know that I can ride it out, which isn't right but that's what I do...

Jane's account uses her personal experience to show how the system removes her control over her environment and places her at risk. This is similar to Pill and Stott's (1985) findings that those living in adverse circumstances assigned cause to factors outside their control, and often referred to personal experiences of financial hardship when explaining the incidence of illness. Jane does not take responsibility for her illness because no one would behave differently in such circumstances (*cf.* Blaxter & Paterson, 1982). Jane's account also highlights the way ideas about an individual's strength of will and fortitude can be drawn on to recount how one copes in such circumstances. In many respects, this aspect of her account resembles those of the women in Blaxter's (1993) study, who reported neglecting their own health for the sake of their families. Presenting oneself as a good mother who has to make sacrifices for her children is an effective means of shifting responsibility to the system and preserving one's moral status.

In many ways the participants' accounts reflect what Pierret (1993) has presented as the distinctly French 'register' of 'health-institutions'. This register emphasises the collective and political character of health as something to be managed by society. Like the middle-class public sector employees in Pierret's (1993) study, these lower SES participants refer to illness as a social problem requiring a collective response. Effort is needed to reduce inequality and to ensure the social provision of resources to provide health for all. Throughout the accounts considerable emphasis is placed on the need for social equity. This is particularly evident when health is presented as something that should not be reduced to economic rationale. Don (a 57 year-old gardener) states:

I would only repeat the fact that I think that health and good health care, affordable health care, should be a fundamental right to any citizen regardless of their age from their birth right through... The problem is with how we share resources in society. Some have too much and others too little. That's whether its health or other issues. It's a very real problem. I think that basically what people need to get during their working life is sufficient income from what they do, to be able to organise a retirement fund and to be able to take care of health problems. I think what's happening is that people are not getting enough income. There's too much of the resources, economically, are going into the pockets of a few greedy people. And that can cause all sorts of stress and health worries for the rest of us.

This extract reflects the ways that participants can interweave multiple explanations. Don's account resembles three ways of speaking identified by Stainton Rogers (1991): the cultural critique, health promotion, and inequality in access explanations. Don uses aspects of the cultural critique when he identifies inequality and disadvantage as a source of illness; it is the economic system that is anti-health because it places the emphasis on profit rather than people. He also draws on aspects of the health promotion explanation when he accepts the benefits of medical care and focuses on health as a fundamental right obstructed by cuts in medical services and the government's focus on monetarist concerns. Aspects of the inequality in access account are also evident, in that illness is presented as a product of social injustice and of an economic system that maintains a gap between rich and poor, particularly in relation to access to health-enhancing resources.

Prominent throughout the accounts is the readiness of participants to draw on explanations that emphasise inequality as a cause of illness. Participants recognise that factors such as income levels, poor employment and housing conditions, and an inability to access services contribute to accidents, illness, and premature death. One pathway through

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which inequality is claimed to exert its influence is via adverse circumstances leading to stress, complicated further by a lack of access to health-enhancing resources. Participants voice what Radley (1994) has referred to as the societal perspective on stress, associating stress with social inequality and the negative features of contemporary life. Stress is conceptualised as the product of adverse material circumstances, which are not faced, to the same degree, by those of more affluent standing. The following extract highlights the use of the stress explanation and how it often evokes many of the themes explored in previous extracts:

...Pressures in life can get to you, make you sick. I think the society we live in is very stressful. That's not healthy. As a matter of fact, that's probably very devastating to a lot of people at the bottom of the heap. When you are struggling to make do, pay the rent, deal with your boss, just to get by in life, things go wrong; the body can give out. And it's often frustrating to get into the health system, for the tests, and there's a lot of waiting for medical help. When you know there's something wrong and you can't get it seen to you just get frustrated and that just adds to the problem. It's not on. Something's gotta be done. There's gotta be a fairer way...
(Don)

In accounting for health and illness, the stressful character of contemporary existence is linked to issues such as employment and access to health services, which may deplete a person's health reserves and render them susceptible to illness. Emphasis is placed on people's efforts to cope and do what they can within conditions not of their own making. The body is under siege and people present themselves as victims of stressful life circumstances, which wear them down and eventually result in illness (Stainton Rogers, 1991). This explanation is highly functional in that it allows participants to identify a specific cause of illness, in life pressure, while retaining some notion of variation in individual responses and fortitude (Radley, 1994): illness is caused by outside pressures, but the person's inner ability to cope also plays a role.

The use of socio-structural explanations to evoke the wider economic context for illness and threats to one's health is particularly evident when participants identify factors such as employment conditions as causes of illness. As is reflected in the following two extracts, people of lower SES can present themselves as having little choice but to make do with poor employment, which they know can have a negative impact on their health. In the first extract, Rose (a 20 year-old beneficiary) talks about a relative who has a hernia that was caused by excessive physical labour. Despite his ailment, this man is still doing physical work because it provides him with a source of necessary income:

People gotta work, gotta pay the bills, even if you're sick. No one is going to do it for you. My cousin's done damage to himself at work, working hard. But he's got to work or else he'd have to go on the dole and he wouldn't get by on that. And it's just like a big balloon on his tummy and if he does any more lifting and that it will pop.

In the second extract Ed voices an awareness of the health consequences of his job, but he continues to work out of financial necessity:

...I think that you have got to force yourself to do certain things that are not healthy... You know, I will hammer. I'm not allowed to actually do any of my trade because I actually did damage to myself, but I will do it, if I need the cash.

Participants repeatedly link health with employment in a way that presents them as being caught in a cycle of needing to work in order to gain an adequate income, but suffering physical consequences in the process. In the current climate of economic uncertainty, participants feel they have little option but to take whatever employment is available. Not having a job and a regular source of income is more threatening than doing a job that one thinks may have negative health consequences.

Throughout these participants' accounts health is constructed as the ability to keep going, even in jobs that can cause illness. Cornwell (1984) identified the duty to keep working and not to seek help until it is no longer

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possible to continue as key components of working-class culture. However, participants in the present research not only voice such ideas, they also reflect on them and propose that such thinking can exacerbate health problems by discouraging people from taking adequate care of themselves.

As Nick states:

...You're, you're own fool if you buy that macho bullshit and don't get things seen to. Yeah, but then that's also the typical kiwi male macho bullshit, as I call it. It's like, you know, if you've got a problem it's like oh shit, you never admit to it, cause otherwise the boys, you know, all the boys give you ribbing... There are some things that you know within yourself you can tough it through... But some times you know you've got to stop an sort it out an get back onto the job. But you've got to know where to go, and sometimes you've got to prioritise. Time off work, that means loss of money. Going to the doctor, that's also going to cost. Then if it's serious you might have to pay even more. The money thing puts a lot of guys off.

Participants emphasised that sometimes one needs to give in to illness in order to be able to recover and continue working in the future. However, the need to seek help is tempered by the realisation that one's situation in life can limit what courses of action are available. In this extract the interweaving of medical notions of the need for access to care, lifestyle notions of individual responsibility, and socio-structural notions of inequality in access is evident. The three approaches are drawn on in a compatible manner to work through issues around the duty to keep working and the complexities involved.

In sum, this analysis supports the idea that people combine various explanations associated with the medical, lifestyle, and socio-structural approaches to construct a complex picture of health and illness. In light of the extracts presented above it would be misleading to propose that the continued influence of the medical approach simply restricts people's accounts to individualised considerations. Medical explanations are often

used within the context of lifestyle and structural explanations that enable people to make sense of illness within the context of everyday life. Stainton Rogers writes:

Whereas the scientific basis of biomedicine expressively decontextualises its explanatory capacity with regard to causes of health and illness, 'lay' explanation for health and illness is deeply and intimately bound within a broader framework of making sense of the world in which 'folk wisdom', the ideologies and values of particular cultures and social groups, personal experiences, religion and ethics all play a part (1991, p. 111).

Participants' views are not decontextualised, but rather reflect people's personal experiences and circumstances. In this way health is linked to wider social issues and not just to biological functioning. In a manner that resembles a multifactorial approach to health, participants weave together biological, lifestyle, and structural issues when making sense of health and illness. They construct accounts that encapsulate the complexities of life by shifting between talking about germs, bodily malfunctions, lifestyles, poor housing, inequality, and their own place in the order of things (*cf.* Blaxter, 1993). Although emphasising the wider socio-structural context of health and illness, participants do not present themselves as merely passive victims who react in a uniform manner. They talk about ways of preserving their health within the context of the material and social restraints of everyday life. By drawing on the willpower explanation of illness (*cf.* Blaxter, 1997; Stainton Rogers, 1991), participants talk about being determined not to give in to illness. Yet things are complicated by circumstances that persistently raise barriers to health which can wear down the most active and hardy of individuals and render them fatigued and vulnerable (*cf.* Stainton Rogers, 1991).

8.4 Negotiated Views on Four Health Concerns

The analysis presented above has focused on explicating some of the prominent themes that emerge when participants make sense of health and illness. This section focuses on the participants' accounts of health reforms, privatisation, aging, and men's health. It provides an analysis of the symbolic resources participants draw on to make sense of these concerns prior to their viewing and discussing the health documentaries. Of key interest are the similarities and differences between the ways these concerns are constructed in the participants' accounts and the health documentaries. Generally, there is a high degree of salience between health coverage and the participants' accounts. Although there are also some key differences, such as participants more readily linking these health concerns to wider social shifts and inequality, these differences reflect an extension of issues emphasised in health coverage rather than totally distinct ideas.

8.4.1 The Health Reforms

A number of issues are prominent in participants' accounts of the health reforms. As was found in the analysis of health coverage, the benefits of medical care are taken for granted. Yet access to such care is presented as being inequitable and restricted by people's inability to pay for private care and government interference in the management of the public health system. However, the focus on wider social issues is more elaborate in the participants' accounts than in health coverage. Issues around health care reform are conceptualised as being indicative of wider social change, increased inequality, and deteriorating employment and housing conditions. In this way the health reforms are comprehended and positioned within the context of adverse life circumstances.

Increased waiting times for treatment and reductions in the availability of services are prominent issues for the participants. These issues are

presented as being the result of bureaucratic interference and incompetence in the management of the health system. Particular emphasis is placed on linking the high salaries of various non-medical managers to reductions in the level of funding that is available to treat needy public patients. As Lisa states:

...I think everybody should have the right to go to a hospital. After all that's what we got public hospitals for and we all paid into a social welfare scheme for. The health changes done by Shipley [then Minister of Health], in charge of the health sector. She was just a manic. She just looked at the rich and she didn't worry about the poor... You have people [bureaucrats] in high areas of the health system and they are getting phenomenal money. Bonuses, now why couldn't that bonus be put to machinery they do need at the hospitals. It's totally wrong... They've got the staff to do operations but they are not doing that because management spent the money on silly things rather than using it for the people not to be on waiting lists. That's what happens when you get people running the health system who are not doctors...

Such extracts reflect debates around whether health care should be administered like other “goods and services” within a “free market” and what implications this has for those who cannot afford to pay for private care. The health system is presented as something that should not be subjected to market forces. Participants use the rhetoric of efficiency, which has been used by the government in order to justify the restructuring of the health system and the purchaser-provider split, to criticise these health reforms. Alan states:

...I'm dead against these so-called changes to the health system because they're supposed to be driven by efficiency and they're trying to treat health like a commodity. The idea is its going to be efficient and people are going to make better use of your dollar or so they say. But the American experience has proven that it's inefficient. It's inevitable if you've got competition in health...it will be expensive and inefficient. Because you've got say, for example, Palmerston North will get a great new heart-lung machine that costs

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untold. So that sets up competition between Central Health and the next Health... So they get a machine to compete. That's why it's inefficient. You get duplication. They've all got to get a new machine...

The health reforms are presented as haphazard and inequitable, as reducing consumer choice, and as being inefficient owing to competition leading to duplications in services. Such extracts present government as obstructing rather than facilitating the efficient provision of medical services. Instead of their being positioned as a catalyst for efficiency, monetarist reforms are positioned as an inappropriate diversion. Participants voice more extensive criticisms of politicians and bureaucrats than are evident in health coverage, which reflects a general cynicism in New Zealand over bureaucratic bungling. Perry writes, "one of the cultural legacies of New Zealand's continually interventionist state has been to make its citizens both effectively dependent upon bureaucratic authority and resentful of it" (1994, p. 55).

Such issues are not presented solely at an abstract level. Like health coverage, participants' accounts of the health reforms are personalised. Participants refer to either their own or other people's experiences of problems with the health system. These examples are provided within medical plot lines, similar to those provided in the health documentaries, which illustrate the consequences of health care reform for those who are left on public waiting lists. Jane states:

The hospital waiting list is pretty abysmal. I went to an unveiling [funeral] last Wednesday and the girl was my friend, she was part of my family, she was a Maori girl, she was happily married with four children, husband working. OK she had a heart problem, she had had a heart problem for nearly two years. For two years she was going to have an operation in March, no put it off. September, no put it off. December, no put it off. OK. She had 16 days to go this time to her date, maybe they were going to put it off again, but it was too late. This little boy went to wake her up, this morning

for school, and she was dead. She was 24 years old and that's, you know, it just makes me so bloody angry, you know...

Participants are very negative about the impact of the health reforms on the lives of those of lower SES who cannot afford private care. Jane provides perhaps the most compelling example of what can go wrong when people's progression through the medical plot line is disrupted and they are placed on a surgical waiting list. Such examples function to highlight the seriousness of bureaucratic bungling and demonstrate the way participants draw on direct experience to warrant their views on the health reforms.

Health coverage promotes the idea that the health reforms were inevitable owing to the escalating costs involved in providing medical care. When discussing the use of similar explanations among her respondents, Stainton Rogers (1991) points out that they are used to construct medicine as a victim of its own success: able to successfully treat so many ailments that there is a significant strain on available resources. As a result problems in health care are reduced to resource allocation discussions and the need to develop an adequate criteria on which to base such decisions. Participants also draw on the idea that advances in medical science contribute to increased costs. However, they do not restrict themselves to such assumptions. Problems in the public health system are also associated with increased need due to social reforms which have increased life pressures that contribute to illness. As Don states:

...I think the society we live in is very stressful now and people are worried about jobs and where they live and if they can feed their families. These pressures can make people sick and that increases demand when there isn't enough resources being put into it [the public health system], and a lack of access to proper tests. So if there is a problem or a suspected problem, you can get it dealt with. Medical sciences having advanced enough, but there isn't a good

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comprehensive system now in place. There use to be, but there doesn't appear to be now. There's just a lack of access to the technology cos the government want to save money and wants us to pay ourselves. I think it's criminal, it's disastrous, it's not fair. There should be an affordable system that exists giving equality for all regardless of whether someone can pay for it. It's a basic right. If it is available in insurance why is it not available in public hospitals...

Participants repeatedly refer to the lack of adequate provision of effective medical services to the needy. Medical care is seen as being beneficial, but access is constructed as being restricted according to social stratification. There is an expectation that everyone should have prompt access to medical care regardless of his or her ability to pay. This extract reflects the strong sense of social justice running through the interviews. Medical and socio-structural explanations are combined when participants talk about the problems of public waiting lists and the deterioration of services, particularly in public hospitals. Yet, unlike health coverage, in the participants' accounts inequality is not restricted to access to medical care. It is associated with adverse life circumstances.

8.4.2 The Privatisation of Health Care

There were similarities between the construction of privatisation in the participants' accounts and health coverage. However, the participants again brought up a wider range of issues. Concerns over the privatisation of health care associated with the health reforms provide a focal point for the participants' feelings about increased social inequality. The accounts contain a general theme of insecurity and uncertainty among New Zealanders of lower SES. This insecurity is linked to increased inequality in life, which is associated with the undermining of people's health as a result of health care and social reforms. Such thinking has potentially serious ramifications for health differentials if, as Wilkinson (1996) proposes, health

inequalities are not just the result of material deprivation, but also result from one's sense of inequity.

The programmes propose that people's anxieties about access to care can be alleviated if they access the private system. Private care is presented in a rather idealised manner as providing unproblematic treatment and a rapid recovery. However, participants in this research are somewhat less certain of the benefits of private care. Although acknowledging that accessing private care is preferable to being trapped on a public waiting list, they point out limitations in private care. The following extract from Mary's account exemplifies these trends:

Well, I think the changes are wrong because having used a private health scheme it would have been nice to have had all my treatments in a public hospital knowing that everybody gets the chance. Whereas at the moment because we were lucky enough to have health insurance through my husband's work, I could jump the queue to be well. If I had to wait in the health system, I would be lucky if I was alive today... It's ridiculous really, because even though I went private, I got an infection and for something serious, they can't handle it. I was sent back to the public hospital to get it sorted out and that's tax-funded. Instead of worrying with tax cuts they [the government] should put more into health. The wages are not sufficient for people to be able to afford private care. They should go back to a proper paid-for public hospital that you could go to so we're all treated equally.

Although her husband's employment package provided them with access to private health care Mary still constructs people's use of such care as being inequitable in many respects. This extract places emphasis on inequality and draws on medical and socio-structural explanations to propose that a communal response is preferable to people having to pay into private schemes in order to access medical care. Uncertainty over the benefits of medical care is also warranted when Mary highlights limitations

of private services and the dependence of people on the public system to remedy any complications.

The privatisation of care is not solely discussed as an issue of government or bureaucratic inadequacies. Private doctors are also implicated in both the participants' accounts and health coverage. One implication of privatisation is that medical practice is constructed as both a business and a caring profession. Participants raise issues relating to conflicts of interest that arise when doctors treat patients in both the public and the private systems. For instance, Jean (a 55 year-old part-time community worker) distinguishes between good and bad doctors when she makes sense of privatisation:

Some of these specialists want to do it in a private hospital. And the thing that really pees me off is the cost of having it done privately. I mean people complain that they have gone up to the hospital and they have been seen by the specialist and the specialist has said you will go on the waiting list. Now you could be a year, but if you have got 11 thousand dollars or 18 thousand dollars, I'll do you tomorrow. Now I mean that's just bloody pathetic. Those specialists should be working for the public hospital, but it just shows that specialists don't really care about patients. They're there for the money. Well most, not all. You're just another client. But some still do good things. Obviously you need them, but I don't have a lot of faith in the others. It's a no-win situation for people on a public waiting list because they can't be insured. Once they are over a certain age or have existing problems, no insurance company will take them. After all, it's all about money.

Like the lower SES respondents in Stainton Rogers' (1991) study, participants in this research refer to the benefits of medical care, but emphasise the focus on profit instead of people as a cause of limited access to care. This extract also reflects awareness that private companies are profit-orientated and that they exclude high-risk groups, such as the elderly, in order to maximise their financial viability. Reflecting the framing

of health coverage, this extract also draws on the notion that there are two types of doctors, those practising medicine for personal financial benefits and those who are trusted professionals doing their best with limited resources. However, issues around profiteering from illness in the private system are more developed in the participants' accounts. For instance, Jean associates problems in health care with insurance companies profiteering and not just greedy doctors or bureaucratic incompetence.

One issue that is prominent in both health coverage and participants' accounts is whether people should be asked to pay for access to private care that is carried out in unused public facilities to enable public hospitals to generate revenue to treat public patients. On this issue there was no clear consensus among participants. One view holds that there is no reason why unused facilities should not be used in this way. Susan (a 42 year-old clerical worker) states:

Look if there is ten empties [beds] there use the fucken things and rent them out, you know. Damn, go for it, I mean if there's spare beds use them. Why not use the empty operating theatres. That's inefficient if they don't... Those operating theatres could be ticking over, being used to make money to get more people through. The private people get preference anyway cos they can pay, so why shouldn't we make some money off it to use for helping people who can't pay.

Susan draws on the rhetoric of efficiency and productivity when voicing this pragmatic view. In the process inequality in access is naturalised and presented as being inevitable. Conversely, the other view states that hospital facilities would not be unused if the necessary resources were put into the public system. As Joy (a 53 year-old home maker) states:

...Cos if you are going to be a private patient, why should you need to go for a public hospital. It comes down to the mighty dollar again. Really because if the private hospitals are going to get the public to do the operations and the private people are taking up public hospital beds, well that's

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putting the waiting list back even further. And no, I don't agree with that, I don't think that should happen. It's to the detriment of those other ones that couldn't afford it. And it would be a case of the haves and the have nots. We'd be better off putting the money into the public hospitals. If people want to pay for private let them get a private hospital.

According to this view, treating private patients in the public system raises issues of inequality and queue jumping. Such practices are constructed as discriminatory and indicative of how financially focused the health system has become. Joy's solution is to provide more public resources rather than encouraging people to bypass the public system by paying for private care.

In sum, privatisation is a key concern for participants, who draw on many of the same explanations as health coverage to make sense of the issues involved. However, more emphasis is placed on inequality in the participants' accounts than in television health coverage. Privatisation is constructed as a symptom of an unhealthy society. A key difference between health coverage and participants' accounts of privatisation is the less idealised view of private care presented in the participant's accounts.

8.4.3 Men's Health

As is the case with the concerns analysed above, when participants talk about men's health they draw on many of the same ideas as are evident in health coverage. In particular, they talk about men's reluctance to admit a health problem and access care. This section draws on the male participants' accounts to explore the ways help-seeking behaviour and men's willingness to discuss health issues are constructed. This focus is appropriate because coverage of men's health emphasises the role of unhealthy attitudes in discouraging men from seeking assistance or dealing adequately with illness (Clarke & Robinson, 1999). As a result responsibility for any health problems can be assigned to the individual. However, as was shown with previous concerns, participants do not simply

accept individual responsibility for illness. Many of the participants voice the possibility that negative consequences can result from masculine attitudes, but minimise the influence of such attitudes. Participants shift responsibility for illness to contextual influences such as societal expectations and financial restraints, which can constitute barriers to their accessing of care.

Within these accounts seeking help is constructed as being dependent on one's assessment of the seriousness of a problem and whether it justifies the inconvenience and money involved in going to the doctor. For instance, in the following extract Paul (a 23 year-old security guard) presents himself as not being concerned about seeking assistance unless he has something that he thinks is serious enough to warrant the cost of medical attention.

Wouldn't bother getting help for a sniffle or a bit of a cough that wasn't going anywhere. Colds and that I haven't worried about, they just run their course. There's nothing a doctor can do for that. If the flu's getting really bad and coughing becomes excessive or what not then I'll go to the doctor, but they can't help you really for that sort of thing. All they can do is make you a little bit more comfortable and relieve you of some of your cash. Just so expensive to get something seen to and you don't really want to have to take the time off work... Now prostate cancer, that's quite a big one that I've heard about lately, but I've never thought about that. Won't worry me until I'm older... But, like if you start getting lumps where you shouldn't have lumps, or, you know, if your glands decide to swell up or whatever, obviously that's gotta get checked out. But if it doesn't happen, you know, you don't really think about it. I think it's just common knowledge that, you know, when something's wrong like that, to get it checked out...

Many of the men refer to ailments such as prostate cancer and cardiovascular disease as threats to their health, but say that these are things to worry about in the future, because cancer is constructed as something that affects only older men. Generally, the accounts support the

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idea that men leave problems until much later, when the disease is advanced and are, therefore, at least in part, responsible for their ailments. Although presenting themselves as being aware of the need to maintain their health and as being willing to have a serious problem examined, participants do voice some reluctance to have a problem made official through diagnosis. In addition to the financial barriers referred to in the previous extract, this reluctance may reflect anxieties about confronting one's own mortality in a society where men are encouraged to be strong, to cope, and not to show weakness. When discussing such issues, participants readily reflect on social expectations which encourage men to delay accessing care. David states:

... You don't want something made official. It's probably a bit of a pride, you know, that we are all meant to be healthy... And I think too a lot of us try to battle on ourselves. Men don't cry is how we have been brought up. You know, we have never seen our fathers cry or rush off when there's something wrong. See, it's like me when I was working. If I was sick, I was really sick. I would always go to work. What we create is that it's all right for women folk but not for men folk. I don't think we are as self-conscious as what women are, particularly about being overweight and that as well, I think that that's a problem. This is what we have got to learn. And if the health system, if the help was there, if you are able to go in and talk to your doctor a bit more about things it would make a big difference.

Participants repeatedly voice the idea that men hide illness to their own detriment, but that things are changing. They critically reflect on masculine attitudes and voice the need for men to seek assistance. By invoking the restraining influence of social expectations and the unavailability of medical care, they shift responsibility for illness from their own avoidance behaviours to social expectations and barriers to care. They claim it is influences outside their control, such as social expectations, the availability of medical services, and financial restraints, that prevent men from accessing care.

Participants also refer to the influence of social expectations when talking about being more willing to discuss health issues with their families and friends than with health professionals. They say it is one thing to talk about these issues in the privacy of your own home, or watch them on television, and another to discuss men's health issues in the formal setting of a medical institution. Throughout the accounts participants propose that men talk to their families and each other in order to get advice on the seriousness of an ailment, to explore what they should do, and to learn about what action should be taken. What is crucial to such conversations is the relationship between the men. For instance, Mark presents himself as being in a legitimate position, as a sports coach, to initiate a discussion of health issues with other men:

You talk in our immediate family about our health, but in terms of like, you know, the guys that I coach and that, I talk to them, you know, regarding nutrition and things like that as well. What they should be eating and the amount of sleep they should be getting and burning the candle at both ends. But it's like, you know, I coach quite a few kids that are sort of 15, 16 as well, and they're primed to be out bloody, you know,...chasing women all night and things. I mean, they've gotta do that to a certain extent, but I mean they've gotta reach a happy medium.

Evident here are lifestyle notions of diet, exercise, and moderation. Under the guise of sports performance health issues can be openly discussed between men. Participants also highlight the benefits of open discussions of men's health issues. Such conversations and health communication initiatives are presented as part of the normalisation process which helps to alleviate any anxiety and makes men's ailments more socially acceptable. As Paul states:

There should be more public discussion about men's things, I suppose, because it takes the fear away by talking about it. Like AIDS was a swear word years ago, now people talk about it. So it wouldn't hurt maybe, that sort of thing. I don't

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know, cancer awareness. They talk about ladies doing breast checks and stuff like that. Actually there was a thing a while back on guys checking their nuts for cancer. But I didn't watch it. Watching a bunch of guys play with their gonads, that'd be a bit much. I'd rather watch how to do the breast one.

This extract reflects a desire to have wider coverage and discussion of men's health issues in order to extend public knowledge and to change social expectations. It is proposed that such coverage needs to be non-confrontational and employ strategies like the use of humour in TTFTBL in order to be effective.

In sum, there is a balance in the accounts of men's health between structural and lifestyle causes of illness and men's failure to seek medical care. Individual responsibility to take action is backgrounded by the association of illness with contextual influences that are outside one's control. Reluctance to seek care is presented not just as matter of individual choice. It is also the product of wider social belief systems about what it means to be a man and how one should behave as a man. What is evident is that these beliefs are beginning to be renegotiated and in the process wider constraints on men's health, such as a lack of time, money, and access to care are being evoked.

8.4.4 Aging

In past epochs aging has been constructed as following a set course: from birth, to maturation, to old age, and eventually to death (Bury, 1997). There has been some shift in these ideas in the present epoch where one can buy products or engage in activities that 'prevent' aging. Today aging is individualised and associated with people's lifestyles and choices. These ideas are evident in both health coverage and the participants' accounts. However, aging is placed more fully within a political and economic context and is associated more directly with communal responsibility in the

participants' accounts. For instance, rather than simply individualising aging, participants present aging as a social process dependent on one's life context before retirement, as well as individual behaviour patterns.

Bodily decline is not simply an accepted element of aging to the same extent as in the past. Active participation in life is no longer restricted to the young. What is important is not the number of years a person has lived, but how a person feels, looks, and acts. The 'use it or lose it' rhetoric evident in GO is also evident in participants' accounts when they talk about the importance of remaining active to aging well. Rose states:

I think that people put a certain time on their life. If you're 65 oh you are meant to retire. You are meant to be slowing down, but it's how you look at your life and what you do to stay young, you know... Some people can stay active longer and want to work longer because they're exercising and living right. But there's other people that can't and get old in their 50s. People should keep active because it keeps their body going, so they don't get old before your time. But for people to keep active they [the government] have to help them, educate people about living right and put things in their reach.

There is overlap between some of the assumptions evident in this extract and the closing sequences of GO, where depictions of aged persons as they continue to work productively beyond retirement age are used to support the proposition that people can remain active much longer than has been assumed. Also evident in the talk here is the idea that people can do things to slow the aging process; therefore, as is the case with illness, to a certain degree aging is an outcome of the choices one makes. The emphasis on living a healthy lifestyle reported for predominantly middle-class groups (*cf.* Crawford, 1980, 1984, 1994; Featherstone, 1987), appears to have reached lower SES groups. Participants voice the virtues of people engaging in health-enhancing rituals. However, they also emphasise the need for the provision of social resources to enable such

activities. This extract reflects the way participants contextualise discussions of healthy living with reference to socio-structural influences. In such explanations, emphasis is placed on the need for people to do their bit. This functions to justify the provision of social resources to people in need so that they can maintain their health, vitality, and youthfulness.

The use of lifestyle explanations in the participants' accounts of aging also raises various socio-structural influences. Health coverage ignores the proposition that people's aging is due to influences beyond their control before retirement, such as work conditions and social inequalities. The participants make this connection. Bodily decline, associated with aging, is attributed to contextual influences such as life pressures. As Don states:

...Health is very important so that you can work and I think that as you get older, you have got a lot less healthy and you have got a lot more health problems and there probably needs to be a bit more said about that so you can recognise what's happening to you... I think that's part of the whole problem with society, if you're not able to keep going nobody wants to know you. It's everyone for themselves and that's pretty sad. It puts a lot of pressure on people and makes them work too hard and get old before their time. When you get older you have more problems from working hard and life's ups and downs. I would like to see, as you get older, the opportunities to have thorough medical tests to detect things like cancer developing, which can sneak up on you. Without access to tests, it's very dangerous...

Such talk reflects a wider conceptualisation of aging that positions it as a social process hastened by hard work and life pressures. Previous research indicates that lower SES groups more readily accept bodily decline as an inevitable part of aging and the wear and tear of life than more affluent groups (*cf.* Featherstone, 1987). Participants in this research contest the inevitability of such bodily decline. They draw on notions of inequality to propose that society should provide people with access to resources so that they can prevent bodily decline and access medical

services in order to ensure problems can be managed. Access to a healthy lifestyle and medical care is positioned as crucial to preventing bodily decline and gaining some control over the effects of aging.

Participants do not just passively reproduce lifestyle explanations that emphasise the need for people to take action or medical notions of bodily decline. Considerable emphasis is given to financial issues, such as the need to save for one's retirement and the uncertainty of current social provisions for the elderly. Various health concerns are integrated when people talk about aging within the context of social reform. Faced with an ageing population likely to further increase demand for health and welfare services, successive governments have attempted to encourage people to provide for themselves rather than rely on the welfare state. Associated restraints on public funding for health and welfare services have been a major issue of public debate throughout the 1990s. Such government policies as means testing for the elderly, which can lead to the liquidation of people's assets as a means of paying for their medical care, have attracted considerable public scrutiny. Participants often referred to such developments. Lisa states:

People worry about the future more as they get older. I mean they [politicians] say save for your retirement, you know, compulsory superannuation. I don't have a problem with that, saving for my retirement. But it's never going to be enough, no matter how hard I save. What with the cost of living and then if something goes wrong having to pay for an operation, it's a joke. I look to my parents. My mother and my father have been hard-working people all their lives and I feel they have been very honest people...but they're not valued. I think the elderly are just walked over... The government have just abuses them... They are getting pushed from pillar to post and they are not being catered for... They should be allowed to get old gracefully and, you know, maybe some of those people have got some money put away, but it's not up to the government to strip them of it. It's just taking their

dignity, their pride of their livelihood. All for the sake of the government putting it back in their coffers. And it's wrong.

In this extract emphasis is placed on discriminatory policies, such as means testing, which discourage people from saving for their retirement. These issues are presented as being representative of the undervaluing of the elderly and are not emphasised to the same extent in GO. Through references to these issues participants link aging to inadequate social provisions, inequality, and a pessimistic view of government policy. By using the example of her parents, Lisa establishes the impact of government policies in a dramatic way and warrants her pessimism about the future: aging and the management of an aged population is no longer an individualised issue; it is something requiring planning, communal provisions, and compassion.

Briefly, there is a similar range of active and inactive elderly representations in the participants' accounts to that provided in health coverage. However, participants place more emphasis on issues faced by the inactive elderly. Aging is linked to inequalities in life, as well as individual behaviours and choices. Participants draw more on notions of communal responsibility than health coverage does, but still invoke notions of individual responsibility through discussions of the links between healthy living and aging. They accept that one has to do one's bit, but propose that people are often prevented from engaging in healthy activities, and as a result responsibility for aging can be attributed elsewhere.

8.5 Using the Media: Television as a Source of Health Information

People readily express ideas about the role of television in society, be it as a corrupting influence on young people or a useful information source. In light of the emphasis placed on the relationship between television health coverage and people's views in this research, it is appropriate to explore how such general ideas about the role of television are applied to health

coverage. This section links the previous analysis of participants' views on health and illness to an exploration of their views on television health coverage and its role in their lives. Such links are important here because participants shift between television-mediated and interpersonal sources of information when negotiating their views on health and illness. They also evaluate programmes, such as the health documentaries screened for this research, within the context of their own experiences, previous interactions with health coverage, and their ideas about the role of such coverage in everyday life. An exploration of participants' viewing preferences and ideas about the health communication process provides useful background information, prior to the focus group discussions.

When exploring television health coverage as an information source, it is necessary to acknowledge that, despite the importance assigned to television, participants also refer to other mass media, such as pamphlets, newspapers, and talkback radio, as sources of health information. In doing so they construct health communication as a taken for granted part of contemporary existence. For instance, when positioning his interactions with various information sources within the work context, Paul states:

...Through work we have a bit to do with one of the local chemists in town and they've got these little pamphlets and cards and things. Occasionally I'll have a read of those if I get a bit bored, things like that. Newspapers are a good one, they might talk about a topic that you might want to go and find out a bit more about. Sitting in a doctor's waiting room is always a good one. Just places like that. An when you go home something is always on the tele, you know. I don't usually seek information as such, it's just if it's there.

This extract reflects the media-saturated nature of contemporary society, where a range of both official health messages and popular cultural forms coexist across a range of contexts.

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Although referring to the availability of health information across a range of media, participants do refer repeatedly to television as the primary source of such information. When doing so participants tend to mention interactions with both fiction and non-fiction television programmes. However, primacy is given to non-fiction forms such as documentary and news, as legitimate sources of health information. Warren states:

...You know, I like most entertainment on TV. I prefer watching things about costs in hospitals and all the changes in this country that have been very rapid in the last five years. I'll watch 20/20 and what's that other programme, 60 Minutes. Some of those have got a bit of American rubbish they use as a bit of a filler, but I like watching the factual programmes. Assignment is another one. Because I like to be up to date with what's happening. Knowledge is power. Though they do sensationalise things it does draw your attention to various diseases and people who haven't been treated right.

The emphasis given to non-fiction programming may reflect the positive connotations often associated with the perceived educative potential of news and documentary. The impression participants project is of informed individuals actively seeking information about the world. As Livingstone and Lunt point out, "it is our duty as responsible citizens to be informed and to have opinions about current affairs" (1994, p. 8). At another level, it is not surprising that participants refer to programmes such as *20/20* and *60 Minutes* given the amount of attention devoted to health concerns in these programmes.

When assessing the adequacy of such television health coverage, participants emphasise its educative potential. In doing so they present themselves as critical viewers who form their own opinions on health concerns. For instance, Susan comments on the focus of health coverage on individual responsibility and medical misadventure:

I think they [television journalists] are actually focusing more and more on responsibility, not just our responsibility to eat

the right things and take care of ourselves. Their [doctors'] responsibility is highlighted by some of these cases of negligence and so on... Like a mechanic, sometimes they forget to do the wheels up and, you know, it's actually negligence. They are dealing with human life and the quality of that life as well, you know, and if they are a little inclined to be casual, for whatever reason, they've gotta be held accountable. It's good that these things are put out there. They are doing a bit of digging on these topics and its good to know about them...

This extract draws on rhetoric about the need for individual responsibility and accountability to construct an assessment of recent health coverage on medical misadventure. Within a climate of individual responsibility doctors are held responsible for their actions and this is constructed as a positive aspect of health coverage. Participants' accounts reflect an awareness of the way notions of accountability shape coverage of contemporary health concerns. Health coverage is associated with public service goals such as informing the public about important events.

It should be noted that, despite acknowledging such positive educational aspects of health coverage, participants are also critical of medicalization. They raised a number of points relating to the reduction in the amount of research being put into programmes. A key criterion participants use to assess the adequacy of coverage is the depth of investigation and whether there are omissions in the stories provided. Participants propose that coverage should be well researched and provide in-depth coverage in order to educate the public and realise public service goals. Joy states:

I think it's probably overdramatised to a large degree, and doesn't cover all the points. They haven't got all the facts. I always believe that you only see the cure side of health. You don't see the prevention side as much, you seem, like this is what's happened, this is how we are gonna fix it, you know. I don't really think that you get the full story... A wider range of health problems from every aspect of life, not just portraying the best in, you know, what technology can do and all their

successes and things. They don't show life as it really is and people as they really are and, you know, that sort of thing. I feel that they should have a variety of remedies... Maybe they even should have a contrast of the doctors who aren't so good, so that people can get an overview and be more educated on who to go to for what. Cos that's what the media is suppose to be, that's what television is suppose to be, it's suppose to be coming to the people to teach the people. So the people can learn. But they've gotta do their homework.

This extract reflects a high degree of sophistication in viewing, where programmes are used to explore wider issues around health care, medicalization, and the role of health coverage. Once again emphasis is placed on the educative potential of health communication, which, in this instance, is presented as not being realised due to a narrow, medicalized focus. This extract highlights the way health coverage can be used as a window on actuality that provides a limited field of view. Participants do not simply accept the accounts provided in television programmes. They propose that health coverage needs to include a wider range of depictions in order to fulfil its public service role of informing the public and revealing something about current events (*cf.* Aron, 1998; Roscoe, in press).

Criticisms of health coverage are linked not just to medical information about specific ailments or the need for more coverage of prevention and lifestyle rituals. Participants link a range of issues from the role of a healthy diet and regular exercise to health care reform to social stratification. Health coverage is also presented as a channel through which powerful social forces, such as the government and big business, can deceive the masses. For instance, Alan draws on a media effects explanation, discussed in Chapter Four, to propose that the health reforms need to be covered more thoroughly and that existing coverage is biased because of the reliance on elite sources:

The down side of the health reforms needs to be discussed more. You see, it's all society these days is driven by

propaganda and people are controlled... There's a continual barrage; you get plenty of information from the government and statements in the media from Jenny Shipley or Bill Birch or from different government ministers, and they create the ethos that things are just great. The Business Round Table and different organisations that have the power, and statements from business people like Doug Myers create an atmosphere where people will start to believe, well, maybe its not so bad. They call it public relations, but if you put an idea across long enough people come to believe it. So somehow you need publicity or you need people who are going to combat a constant barrage of propaganda. You know that this is good for people, that this is good for health. We're getting it right...

Alan's extract contains a number of assumptions about direct media effects and a linear understanding of the health communication process. He presents powerful forces in society as imposing false consciousness on the masses (*cf.* Adorno & Horkheimer, 1979). The media is presented as having the power to impose erroneous beliefs on the unsuspecting public through the restricted exploration of concerns such as the health reforms. In the process, health coverage is presented as a site of struggle over the consciousness of the masses.

Briefly, the above extracts exemplify how, when making sense of the health communication process, participants voice explanations similar to those found in academic research (*cf.* Seiter, 1998). Not only have health promotion messages about responsibility been learned, but health education explanations, which talk about television as a public health tool, are also used. Participants voice ideas about the role of positive health messages in educating people as well as the detrimental impact of institutionally restrained health coverage that is dominated by elite forces. Illness is linked to a lack of knowledge in a similar manner to the KAB model. Effects explanations are drawn on to speculate about the impact of health coverage on other people. Conversely, participants present

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themselves as critical viewers able to see what is really happening and as being able to resist the impact of the same health coverage that fools others (*cf.* Billig, 1997a). Seiter writes, "people always compare their own television viewing to that of the imagined mass audience, one that is more interested, more duped, more entertained, more gullible than they themselves" (1998, p. 131). When referring to their own viewing participants' accounts reflect influences explanations which emphasise the active negotiation of the meaning of health coverage during reception. According to the influences explanation the programme transmits information that is open to interpretation and negotiation between viewers. Don states:

Well, your ideas about something sort of develops. It does come across the TV, but I think as you experience things, any visits with doctors, and what you hear other people are doing your general knowledge sort of develops. They [health coverage] open up something and it becomes more easy to talk about it. The stigma is taken away... You usually hear from word of mouth too. You often hear somebody has seen something on someone having problems with the health system and you talk about that... I think a lot of it does come from the general conversation of people. That's where you flesh out what's going on.

Here Don presents a commentary on the health communication process and the ways health coverage becomes part of a person's repertoire and is integrated into everyday life. He does not pathologise television as an unhealthy influence (*cf.* Seiter, 1998). Rather, the benefits of health coverage, including increasing awareness and encouraging public discussion, are emphasised. Health coverage is constructed as being just another information source which people make sense of as they construct their views within everyday life.

In sum, although participants readily refer to a range of media, when talking about television health coverage, they emphasis documentary and

other non-fictional forms as legitimate information sources. This is interesting in terms of previous media research where it has been proposed that, due to the lack of legitimacy and status of television, people tend to down play the positive role of television and apologise for their viewing 'habits' (Seiter, 1998). People have been found to prefer mentioning newspapers and books because such media are more socially legitimated information sources. Here, participants legitimate their television viewing by emphasising the educational potential of non-fiction programming and presenting themselves as informed consumers who can reflect critically on the adequacy of health coverage. Such self-presentation functions to justify their television viewing and to stave off any potential criticisms: it is other people who are susceptible to media effects.

8.6 Chapter Discussion

This analysis demonstrates that people draw on multiple sources of explanation to make sense of health and illness, and their situation in life. Participants recognise the link between lifestyle and illness and the moral imperative to be healthy. However, they also recognise the link between life circumstances and the moral responsibility of a society to care for all its members. People do not just assign responsibility to the immoral individual, but renegotiate this explanation and extend it by attributing illness to an immoral and inequitable social system. Despite the importance given to structural factors, participants do not present themselves as passive victims of circumstance. They acknowledge the benefits of a good diet and regular exercise, while proposing that these benefits are not equally available to all. Their views are a complex amalgamation of notions of bodily functions, individual behaviour, and social circumstance.

Participants present themselves as healthy individuals, but do not accept responsibility for maintaining their health and preventing illness in a simple way. Invoking socio-structural influences enables them to remove

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responsibility from the person to the social system, reducing but not excluding individual responsibility. Participants conceptualise health as something achieved through choice. However, they also argue that access to the means of health preservation is a matter of social stratification. Health is a state of equilibrium which enables people to do things, but which can be undermined by social positioning. By accepting some responsibility for health and asserting personal agency while acknowledging social restraints, these people can negotiate a position that is safe to their identity as worthy members of society, but that also allows them to question the ramifications of their situation in life. The duty to be healthy is contextualised by the use of explanations that emphasise people's right to access health-enhancing resources that are available to other, more affluent members of society.

A key finding from this analysis is that all three approaches to health provide explanations that people draw upon in making sense of their own health, the health of others, and various contemporary health concerns. In accordance with previous research (e.g., Blaxter, 1993, 1997; Stanton Rogers, 1991), accounting for health and illness was found to be a complex process that is shaped by socially shared explanations, but that also reflects personal life experiences. People do not simply reproduce socially accepted explanations or personal stories, but rework these shared explanations through their own lived experiences in ways that allow them to present themselves as worthy members of society (*cf.* Pierret, 1993; Popay & Williams, 1996; Radley & Billig, 1996). Contrary to the trends reported by Blaxter (1997), participants in this research interweave socio-structural explanations with the personal in order to talk about inequalities in the level of stress people of lower SES have to deal with. Such stress is presented as a cause of illness that is beyond individuals' control. In emphasising the ways that they are subject to stressful lives these people

hold the social system accountable for illness and not just their own lack of fortitude or lack of ability to cope.

The use of socio-structural explanations suggests that these accounts may have been influenced by current concerns in New Zealand society about increased inequality. Previous qualitative evidence on the individualised character of lay views was predominantly collected in the 1980s, at a time when considerable emphasis was given to individual responsibility and when publicly funded provisions were in better shape (*cf.* Blaxter, 1997; Burry, 1997). The accounts analysed in this research were constructed in 1996 and 1997, at a time when aspects of this rhetoric were beginning to be challenged publicly. Part of the reason why socio-structural explanations appear to have greater currency in these participants' accounts may be that monetarist social reforms have received critical media attention in recent years (*cf.* Gabe & Bury, 1996; Stainton Rogers, 1991).

As demonstrated in the previous chapter, health coverage functions as an institutionally mediated cultural forum within which medical, lifestyle, and structural explanations are used to explore various concerns. Considerable emphasis is placed on individual responsibility. Yet emphasis is also given to communal responsibility. Coverage of concerns such as the health reforms focuses on the undermining of communal initiatives such as the public funding of medical care. Such coverage promotes the idea that the individual needs to adopt a healthy lifestyle and take responsibility to prevent illness. Yet, if unsuccessful or illness does occur, society should provide a safety net for those who cannot afford private medical care. The restricted focus on inequality in access to medical care and on lifestyle behaviours as solutions to illness in health coverage does not mean that members of the public cannot use what is made available within health coverage to further work through additional issues and solutions pertaining

to social inequality. Health coverage may not provide the whole picture, but it does provide symbolic resources from which people can construct more socially critical explanations (*cf.* Dearing & Rogers, 1996; Newcomb & Hirsch, 1984). Owing to increased awareness of the negative impact of monetarist policies, lower SES people are able to further develop aspects of health coverage, to associate health care reform with social inequality and to present such inequality as a cause of illness.

From the accounts explored in this chapter there is evidence to support the contention that the explanations circulated via television health coverage are drawn on by people as they construct their views on various health concerns (*cf.* Gabe & Bury, 1996; Lupton, 1997; Williams & Calnan, 1996). The analysis of participants' accounts supports the proposition that such coverage is a central component of everyday life and a key source of health information. Television health coverage reflects, circulates, and helps create communal explanations of health and illness and targets public attention onto specific concerns from specific perspectives (Dearing & Rogers, 1996; Farr, 1995; McCombs & Shaw, 1972; Putnis, 1994). For instance, many of the contradictions surrounding changes in the provision of medical care that are evident in health coverage (*cf.* Brown et al., 1996; Gabe & Bury, 1996) are also evident in the participants' accounts.

In a similar manner to that of the views voiced by respondents in the research of Calnan and Williams (1992) and Lupton (1997), the views expressed by participants in the present study reflect the changing nature of medicalization. Although the need for prompt access to medical care was privileged in participants' accounts, they do voice some ambivalence towards medical care. Their accounts shift between voicing support for and criticisms of the medical profession. The distinction between good and bad doctors that was central to the construction of doctors in the health documentaries is also a central component of the participants' accounts.

Reflecting the accounts of respondents in Lupton (1997), a key factor in participants' assessments of the medical profession is whether doctors take patients' views into account. Faith in such good doctors is preserved by participants' drawing on socio-structural explanations to invoke the mismanagement of the public health system and political interference as a threat to peoples' health (*cf.* Calnan & Williams, 1992). Such a strategy shifts responsibility from doctors to the social system in a similar way to the way these issues were framed within health coverage.

In sum, participants draw on many of the same explanations as health coverage does to work through contemporary health concerns. Their accounts are grounded in a mix of personal, interpersonal, and television-mediated experience. However, the manner in which lifestyle and medical approaches are drawn on does differ from that of health coverage and there is considerably more use of socio-structural explanations in participants' accounts. For instance, invoking notions of social inequality allows participants to maintain their moral worth while questioning restrictions on their ability to live a healthy lifestyle and access medical care. Drawing on explanations that fit with their life experiences enables responsibility to be shared between the individual and the social system. What remains to be seen is how aspects of health coverage are integrated within participants' views. This is the focus of the following chapter.

Chapter Nine

An Analysis of Audience Interpretations

Analysis of the health documentaries and individual interviews presented in the previous two chapters provides a context for the analysis of the focus group discussions presented in this chapter. These previous chapters have provided an exploration of the shape and scope of health coverage and participants' views, which are renegotiated in the audience discussions explored in this chapter. The focus group analysis investigates the ways that participants draw upon their existing views and aspects of the programmes to make sense of key issues concerning the health reforms, the privatisation of medical care, aging, and men's health.

In previous reception research there has been a tendency to assign viewer responses to dominant, oppositional, negotiated, resistive, critical, referential, or other such reading categories (e.g., Morley, 1980; Richardson & Corner, 1986). However, health communication does not involve only the acceptance, partial acceptance, or rejection of programmes. Participants often refer to both positive and negative aspects of coverage at the same time as valuing programmes as discussional resources. As Liebes and Katz write, "for better or for worse, real readers insist on behaving more ambiguously than the roles that theory assigns them" (1990, p. 145). The development of different reading categories has been instrumental in legitimising reception research and developing reception theory. However, the practice of subdividing viewer responses into specific categories is not adopted in this analysis because it does not

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adequately account for the fluid, complex, and shifting character of viewer interpretations (*cf.* Nightingale, 1996). The focus is on what viewers do with aspects of health coverage during focus group discussions, rather than whether such activities fit into preset academic categories.

It would have been ideal to present a full analysis of each focus group in order to capture the entirety of such complexities. However, developing such analyses would be redundant, repetitive, and unwieldy because of the overlaps in the way health and illness is constructed across groups. Although each group watches a different programme, the processes through which participants renegotiate their views are not distinct to each group and can be exemplified in a more succinct manner through a composite analysis that uses aspects of each focus group to highlight various processes. The first section of this analysis draws on several of the focus groups in order to explore the ways participants' rework their views on the role of such coverage in everyday life. Again, drawing on extracts from several groups, the second section provides an analysis of the negotiation of the image of doctors to exemplify how aspects of health coverage are integrated within ongoing public discussions through which people construct health and illness, and their own relationship to the medical profession. This second section also functions as an introduction to four subsections that explore in more detail the ways participants work through various health issues. Within these four subsections one prominent issue from each focus group is used to exemplify the ways aspects of health coverage are integrated into participants' views on a specific health issue. The first draws on focus group one to explore the construction of participants' views on the allocation of health care resources. The second draws on focus group two to explore the ways that participants work through the proposition that the government has a hidden agenda to encourage people to access private medical care. In the third, focus group three is drawn on to investigate the ways participants construct the

implications of extending the life expectancy of the population. The fourth draws on focus group four to explore the ways participants' views on men's reluctance to seek assistance are renegotiated. The chapter culminates in a discussion that revisits key trends and presents some more general theoretical observations.

9.1 Conceptualising the Health Communication Process

Within the discussions, health communication is constructed as an integrated component of everyday life that influences public awareness of health concerns. As in the individual interviews, considerable emphasis is placed on the positive educational potential of health coverage, as well as the negative impact on the unsuspecting public of inadequately researched or biased coverage. Again, it is other less informed viewers who are at risk of being misled by biased or deceptive coverage. Conversely, these participants present themselves as critical viewers actively involved in the negotiation of meaning. This section does not simply reproduce the analysis of participants' views on health communication presented in the previous chapter. Rather, the analysis presented here complements the analysis presented in the previous chapter by exploring the ways participants construct the health communication process within a group context, once they have viewed one of the health documentaries. It provides an interpretation of the ways their views are negotiated among participants.

The participants often talk about health coverage in a manner that positions it as a key element of everyday life. This can be illustrated through an extract from focus group one. In this extract participants discuss the ways in which awareness of health concerns can be developed across media forms. Participants discuss how a topic can be raised in television health coverage and then worked through further in other media such as talkback radio in relation to people's experiences:

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Mary: *Well, they watch these programmes and then they ring up talkback radio and complain what they think is wrong with it. And get others coming back on to give their opinion... There is things that come on the TV and then it is talked on Radio Pacific and it is dealt to and then Radio Pacific go to the politicians and say, hey, hey, hey, such and such.*

[...]

Joy: *...I know there is a lot of negative things said and seen on that programme [H&W], but one positive thing I can see that comes out of something like that is, it makes the general New Zealander more aware of what's going on. It makes them think more and so it makes them act better, I hope... If one person speaks to another person and the next person speaks to another person and so on, you can really make a difference...*

Mary: *And that's why talkback is so good, that one person can speak to a whole lot of others at once... It's good these programmes come out because you watch those and start to think. Then if you end up in a hospital situation then you think, hmm, I'm not just a piece of meat, I'm a person. And then you start to react and you start to say, "if I'm a client here, I want..." As a client, then you start to put demands on for what you want as a client and then when you come out, then you decide hey, this is not right, and you might ring talkback and tell others...*

This extract reflects an interactionist model of health communication that was also voiced in the individual interviews. According to this model, people watch a programme and then work through the issues as a group. Here talkback radio is presented as a medium through which this process occurs on a larger scale. Health communication is presented as an effective means of raising public awareness and bringing public pressure to bear on those in positions of power. The emphasis on public service functions of documentary is a prominent finding in reception research (*cf.* Aron, 1998; Corner, Richardson & Fenton, 1990; Roscoe, in press). A kind of feedback loop is invoked when participants talk about how, through

forums such as talkback radio, the public gain a voice which is taken up by hosts and used to keep those in positions of power accountable. Health documentaries are positioned as resources for stimulating public debate and action. Also reflected here is the way that participants refer to their own critical engagement with coverage at the same time as emphasising positive aspects of coverage.

Participants repeatedly draw on notions of communal responsibility throughout the discussions and present health coverage as contributing to lay thought by raising awareness and setting the discussional agenda (*cf.* Dearing & Rogers, 1996; Farr, 1995). The agenda-setting process is evident in conversations about the ways ideas from health coverage are taken up and used by participants to shape their experiences of and dealings with health providers. Health coverage is presented as a source of information and support. For instance, in the interaction above, Mary presents herself as a health consumer who is willing to fight for quality medical care. Aspects of health coverage, and in particular depictions of the active health consumer or client, are appropriated and used as a basis for reconceptualising her relationship to professional care.

Emphasis on the importance of public awareness is a staple part of public understanding of health promotion campaigns. Reflecting the prevalence of such ideas, Tulloch and Lupton (1997) found that most participants agree that the government should use television to educate the public and raise awareness about health concerns. The emphasis placed on this educational role in all four focus groups conducted for this project reflects public service ideals that have been linked to documentary since the days of John Grierson. Although participants emphasise the educational benefits of health coverage, they do not simply accept or receive messages. In developing a more complex understanding of the technicalities of health communication, participants refer to the constructed character of health

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documentaries and talk about the use of various depictions in order to effectively inform the public. For instance, participants in focus group four talk about the way humour is used in TTFTBL to raise awareness about men's health:

Mark: *I think it's really good having someone like John Clarke, you know.*

Ron: *Yeah he's good.*

Mark: *Cos I mean it gives it, it's a light hearted look at it, but I mean it doesn't, you know it's...*

Nick: *Not too serious.*

Mark: *It's not as serious that it...*

Ron: *Confuses you.*

Interviewer: *So do you think the humour worked?*

Mark: *I think it did. I think it was good. It was a good way of presenting something that's pretty serious.*

Ron: *It can get to the men, eh? You can sort of relate to it.*

Nigel: *If it's a bit dull and boring, real monotone thing, then you sort of switch off, I suppose. But if he cracks a bit of a joke you pay a bit more attention just in case you're missing out on one of the jokes. You know, like, while you're listening to the jokes and crap then you're sucking in all the other stuff as well, aren't you?...*

In talking about the programme's use of humour to raise awareness of men's health issues without provoking undue anxiety, participants are presenting themselves as being knowledgeable about the health communication process and the intentions of broadcasters. They are constructed as critical viewers who demonstrate an understanding of health documentary as a constructed interpretation that is aimed at educating the public. In this extract TTFTBL is positioned as a positive example of what can be achieved if a non-confrontational strategy is used.

Although the discussions emphasise the positive and educational aspects of health coverage, perhaps as a result of the prevalence of health

promotion rhetoric in contemporary society (*cf.* Blaxter, 1997), participants also talk about limitations. Generally, they judge the coverage provided in the health documentaries as being adequate. Yet, they also raise issues around the omission and the distortion of some information (*cf.* Comer et al., 1990; Livingstone & Lunt, 1994) that result in the programmes' not fully meeting the public service ideal of informing the public. Participants are critical of journalistic impartiality and assess programmes according to the extent to which they mesh with their existing views, the adequacy of the evidence presented, the consistency of the argument, the reliability of sources, and the coherence of the exposition (*cf.* Corner & Richardson, 1986; Plantinga, 1996). They often accept a programme's perspective, but qualify their acceptance by pointing out omitted details that would have enriched the coverage provided (*cf.* Corner et al., 1990; Philo, 1999). For instance, in focus group three participants highlight omissions in GO's representation of the elderly. They propose that GO does not pay enough attention to the inactive elderly and to financial barriers to health and longevity:

Lisa: *I think they sort of skip over financial issues and those who are sick.*

Jamie: *Yeah, they just had a little bit there, cos they had to.*

Lisa: *That's right, because it felt good on their part.*

Jamie: *They should show more about financial situations... What about the people who couldn't afford the vitamins or can't save for their retirement?*

[...]

Lisa: *Now what about that guy [a needy public patient depicted in GO] who had to pay 30 thousand in hospital fees. There wasn't much on that, was there? Well not so much him. Look at that guy, I think it was the eighty-year-old... He had renal failure or something like that, within him anyway... Here's this poor guy [James McKeown] and he's denied the right of using the dialysis machine.*

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Participants propose that more attention should be given to financial considerations and people who are not leading such an active lifestyle. The focus on the active elderly is thought to be at the expense of coverage of financial restraints faced by the inactive elderly. Such criticisms are justified through participants providing examples from their own experiences and from previous viewing. For instance, the reference to the case of James McKeown, who was not depicted in GO, is given as a way of legitimating the proposition that this programme provided an inadequate focus on the inactive elderly. Examples of the kinds of problems faced by the inactive elderly are readily available to these participants. Health coverage has given considerable attention to the plight of needy patients such as James McKeown (*cf.* Brown et al., 1996; Inkster, 1996). This extract exemplifies the way that participants can draw on examples from health coverage which they have previously viewed to highlight omissions in a specific programme (Kitzinger, 1999; Lewis, 1991). As a result, the ways health coverage can influence the shape and scope of participants' criticisms of a given programme become evident.

All four groups propose that the programme they watched provides only a partial account of events in society. The constructed character of coverage and limitations in scope and focus are not just discussed in terms of stylistic conventions, such as the use of humour. Participants link limitations in coverage and its construction of concerns to the wider socio-structural context. Programmes are seen as commercial products that are restrained by market assumptions and as a result tend to promote monetarist values. For instance, in focus group two, discussion of H&W's coverage of the benefits of private care and medical technology raises socio-structural influences:

Don: ...*He [the presenter] demonstrated that there was a very big move to private medical care here, for obvious reasons. You don't want to wait. You don't want to take risks for your health.*

Joy: *One interesting thing on that I thought, do you realize that reporters and people like that only say what they are allowed to say? And only concentrate on what they are allowed to concentrate on?...*

[...]

Susan: *Is it not just part of the agenda that's already in place? Assignment, who pays, who actually says, "This is what we are going to put on". Is it the questions you want? These are the issues you want, highlighting.*

Don: *In preparing people for the reality of having to pay for our own medical.*

Susan: *Yeah, inevitably... You flip through the three channels, and you just watch the concepts that they are selling us and, actually, you thought back about the fact that's how New Zealanders are shaped, you know, in our thinking and our understanding.*

Don: *Did you notice one ad in there? It wasn't actually an ad, it was part of the programme, the Southern Cross ad... And then you noticed that obviously the agenda is to identify with private insurance.*

Through this interaction the group develops the idea that the programme is justifying the shift to private care. Participants explore possible links between health coverage and commercial interests and infer that commercial interests have a direct bearing on the scope and shape of health coverage. This extract also reflects aspects of an effects explanation that proposes that powerful forces in society manipulate the unsuspecting public through television coverage.

A comparison of the above extract with the first extract cited in this section, which was also taken from group two, demonstrates the ways participants can shift between explanations in order to make sense of various aspects of the health communication process and its functions within everyday life. In doing so, participants can discuss both positive and negative aspects of health coverage. In the first extract, participants talk about the ways

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aspects of health coverage are used within public discussions as an educational resource that informs people's understandings of health concerns. By drawing primarily upon an interactionist explanation they are able to present themselves as critical viewers who actively seek information and use it to make sense of various issues. In the extract directly above, participants draw on an effects explanation to talk about limitations in the scope and focus of health coverage. Manipulative forces are presented as restricting the quality of coverage and as functioning to impose certain beliefs on an unsuspecting public (*cf.* Roscoe, in press). As in the individual interviews, across both extracts participants present themselves as critical viewers who can reflect on the possible impact of health coverage on public thought (*cf.* Billig, 1997a). Participants voice distrust in health coverage at the same time as accepting that such coverage can influence their thinking and contribute to public awareness (*cf.* Kitzinger, 1999).

Overall, participants are very aware of the complex and constructed character of the health communication process. They voice a flexible view of this process that reflects aspects of interactionist and effects explanations. According to the participants, health coverage may not provide the full picture. However, it does help set the public agenda and provide useful information. Coverage is not taken to be a pure reflection of actuality, but a selective interpretation that is subject to various influences, including economic. Participants are very aware of the constructed character of health documentaries and present programmes as providing selective accounts of events in New Zealand society. Discussions often explore whether a programme is informative and credible in terms of what participants already know about the topic (*cf.* Aron, 1998). In this way, participants position programmes as being realist, fabricated, and selective at the same time as valuing them as news sources. In a manner that

reflects a sceptical faith in television as a tinted window on the world, programmes are positioned as interpretations of events.

9.2 Working Through Health Issues as a Group

In order to demonstrate the ways that health issues are constructed within social interactions, the analysis presented in this section focuses on the working through of prominent issues within the focus groups. It needs to be highlighted that, although each group watches a different programme and uses it to generate a contextually specific discussion, there are overlaps in the issues raised across the four groups. For instance, as shown in the subsequent analysis of each focus group, the discussions repeatedly emphasise financial barriers to health and link these barriers to the restructuring of medical services and, more broadly, to social reform. Throughout the discussions, various social relationships and issues are rendered meaningful in relation to such wider social shifts. Initially, this section will explore one such overlap through an analysis of the ways participants reconstruct the public image of doctors.

Within an epoch of social and health care reform, participants draw on assumptions voiced in the individual interviews and those evident in the programmes they watched to renegotiate the public image of doctors. The construction of doctors both within and across the groups is inherently complex and contradictory. At different points in the discussions both positive and negative images of doctors are presented. What is evident is that the image of doctors is changing as part of the changing nature of medicalization reported by researchers such as Calnan & Williams (1992), Gabe and Bury (1996), and Lupton (1997).

Despite various contradictions and complexities, general tendencies in the construction of doctors appear to be emerging. For instance, faith in the medical profession and medical practice is preserved, despite the voicing

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of various criticisms (*cf.* Calnan & Williams, 1992; Gabe & Bury, 1996). Participants draw on distinctions between good and bad doctors, evident in health coverage and the individual interviews, to make sense of the changing context of medical care. Generally, whether doctors are supported or criticised in the discussions depends on the health care context being referred to and, in particular, whether a specific doctor is depicted working competently in the public or private systems. Competent public doctors are presented in a positive light as caring professionals who have their patients best interests at heart and who are doing their best within an under resourced public system. Generally, the actions of private doctors are subjected to more critical scrutiny than the actions of public doctors. Initially, private doctors tend to be presented as self-interested medical entrepreneurs who are often motivated primarily by personal profit. However, as the discussions progress, the image of such doctors is complicated when sympathy is voiced towards some private doctors. The realisation that not all private doctors are motivated solely by personal financial gain and that some public doctors have been forced to shift their practice to the private system, so that they can gain the necessary resources to treat patients, results in an acceptance of private doctors as skilled professionals who are simply responding to problems in the public health system. The key to preserving the positive image of the medical profession is reference to political interference and management incompetence as causes of problems in the health system (*cf.* Brown et al., 1996; Calnan & Williams, 1992).

Doctors working primarily in the public system are presented as having to be selective about who to treat due to resource restraints resulting from managerial incompetence. These doctors are generally interpreted as being honest and caring professionals who are doing their best in a bad situation. Like public patients, they are positioned as victims of inadequate funding in the public health system. In this way health coverage appears to

contribute to a discussional agenda within which sympathy towards doctors who work in resource-strapped public institutions is the appropriate response:

Warren: *Their [public doctors'] hands were tied. They're doing their best and getting worn out with lots of phone calls cos one or two of them were just like a computer and they didn't want to get too involved and one or two of them have gone private where they've got more control.*

Alan: *I feel you get the same sort of problems in the health system as you get in the education system cause the doctors and nurses are the same as teachers. Their hands are tied. The government makes the decisions and they set in place the health reforms. So doctors in many cases must feel a little bit helpless. Like the one who went in and set up in private practice, he had had enough, you know, by actually going all the time. So he's gone into private practice. An the more that goes on, doctors moving into private practice doing 70 or 80 percent of their work there, and the trouble is it has an adverse effect on the waiting list too... It's like a vicious circle.*

In this extract it is government mismanagement that is presented as the cause of both shortfalls in the public health system and doctors' shifting to the private sector. The comparison of public doctors with computers functions to highlight the strains doctors face in having to deal with resource restraints. Doctors have to suppress their emotions in order to cope. If they can no longer cope, doctors can shift their practices to the private system. The positioning of government representatives as 'non-medical meddlers' reflects TGKHL's perspective and supports the idea that the medical profession are the experts and that they are being obstructed because of political interference. Doctors are not in control of the health system and therefore responsibility for problems can be attributed to 'bureaucratic bungling' (*cf.* Brown et al., 1996). Such extracts reflect both the framing of these issues in health coverage and the ways they are talked about in the individual interviews. There is also evidence here to

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support Gabe and Bury's (1996) contention that health coverage does not just impose certain beliefs upon the audience. Rather, health coverage can amplify existing public concerns through a circuit of communication and provide ready-made stories that participants can draw upon to further explore relevant issues (*cf.* Tulloch & Lupton, 1997).

Despite presenting a generally positive image of doctors, participants also raise criticisms. There has been considerable coverage of medical misadventure over the years preceding these discussions (*cf.* Brown et al., 1996; Tully, 1996). Although misadventure is not explored in the four programmes that these participants watched, as the analysis of the individual interviews demonstrates, it appears to be a key element of their existing views and is invoked when participants make sense of doctors' depictions. References to cases of misadventure exemplify the ways participants can be critical of a specific programme while being influenced by previous viewing (*cf.* Kitzinger, 1999). In these instances the ways in which both personal and mediated experiences are integrated during the renegotiation of the image of doctors becomes evident. For example, in focus group four participants refer to cases of misadventure to further develop the proposition that the treatment they receive when presenting themselves to a doctor is less ideal than that depicted in TTFTBL. These participants link the quality of treatment they receive to their circumstances and to doctors' motivation to be more studious when treating wealthy paying customers who have the power to hold them accountable:

Nigel: *With Selwyn's [a celebrity depicted in TTFTBL] doctor you could bet anything you like he'd give him a real thorough check over, because if he made a balls-up and poor old Selywn dies then the whole world's going to know about it. If you died you won't even make the back page of the newspaper. Just another ball-bag falls through the cracks.*

Nick: *That's it.*

Nigel: *But if a doctor makes a mistake and Selywn dies because he got misdiagnosed then I'll tell you what: the shit will hit the fan big time.*

Ron: *It's just the money status thing.*

Nigel: *But if he cocked up with any other people you'd probably...wouldn't even make the paper. You hear about it so much that it just becomes so so.*

The taken for granted character of cases of medical misadventure reflects a changing image of doctors in the media and an awareness of doctors who do not work to expected professional standards (*cf.* Brown et al., 1996; Lupton, 1997). The voicing of a distinction in the quality of care provided to different segments of the population functions to construct a challenge to the neutrality of some doctors and reflects pessimism among New Zealanders about the quality of health care (*cf.* Paul, 1999). What is interesting about this extract is that doctors' motivations are linked to the circumstances of their patients. When treating private patients, doctors are presented as being more motivated than when treating less affluent patients. This framing is not a key component of health coverage, but is an extension of the distinction made within such coverage between needy public and grateful private patients. When constructing doctors participants extend television depictions using their own life circumstances and experiences.

The image of doctors is also constructed in relation to issues around the commercialisation of care. Participants repeatedly voice the idea that the prevalence of a business ethos in medical practice is a barrier to quality care and a corrupting influence on medical practice. A key area of contention emerges in relation to the involvement of private surgeons in commercial ventures. In working through the image of such doctors, participants invoke both the traditional caring professional image that is still primarily associated with public doctors and a newer medical entrepreneur image. A key to the expression of some support for these private surgeons

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is references to wider influences on medical practice, including government policy and the interests of private companies.

For example, in focus group two, participants propose that it is government policy and commercial interests that are corrupting some private surgeons and encouraging profiteering. Participants initially emphasise how private companies are profiting from the increased use of private services. Contrary to the generally positive depiction of these organisations within the health documentaries, these organisations are presented as being primarily concerned with profit and not people in this discussion. Participants do implicate some private surgeons in the increasing commercialisation of medical care. However, the emphasis placed on the actions of stakeholders such as insurance assessors functions to absolve private surgeons of responsibility:

Ed: *...Soon as you involve insurance companies, soon as you involve private enterprise, they have got no desire for helping people. I think they know the rules and use them to make money.*

Susan: *Yeah, they get the money as long as they do the job.*

Ed: *That's right.*

Susan: *And they [caring public doctors depicted in H&W] had a point about the insurance companies that actually encourage the surgeons. I wonder if many surgeons have got shares in the insurance companies? So what they have done is manipulated the situation to their own benefit, in effect, so that now they can charge whatever sort of money they want for these particular services. And there's nothing to stop them... They abused the system... I can see his [a caring public doctor depicted in H&W questioning the shift to private practice] point though cos this greed and corruption is very apparent across the board. I mean, how many prosecutions of doctors ripping off the system have we had recently? If I mean, they are as guilty as anyone else out there of greed.*

[...]

Susan: *But that specialist there who was earning two million, I was like saying to myself, Look, he's got top quality gear. We haven't heard anything in the news about people wanting to do him for malpractice or anything. If they can earn it and not screw it up for other people, I sort of am inclined to think, well it's only a three thousand dollar operation. He's got to be doing a lot of those to get two million in a year. What's the problem?...*

Ed: *...Lets plug it into, say, the insurance world. Some of these assessors, some of these consultants, you know, they get 500 thousand a year, make doctors look like leamers.*

Susan: *At least the doctors do years of training.*

Joy: *Yeah*

[...]

Ed: *Well they tell you the truth, you know. The credibility of a doctor is actually ranked pretty highly in my books, eh. Just the credibility of them because they will tell you when you're gonna die. You know, an insurance company wouldn't be able to say that to you.*

This extract illustrates the working through of some of the complexities and contradictions of the relationship between the public and private doctors and providers. In a similar way to health coverage, participants rely primarily on the testimony of good public doctors while criticising some bad private doctors. The image of greedy private doctors is juxtaposed with that of the caring public doctor who is depicted in H&W criticising the shift to private care and the motivation of some providers. Such extracts reflect the persistent reliance on the medical profession as a source of expert care and testimony. There is a tension here between the realisation that some private doctors tend to act in self-interest and an acceptance of the need for access to their skills. To contain this tension, participants draw on depictions of private insurance executives to further work through the meaning of depictions of private doctors.

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Briefly, although medical practitioners are still relied upon to address health problems in everyday life and to provide expert commentary in health coverage, medical practice has been subject to increased public scrutiny in recent years (*cf.* Calnan & Williams, 1992; Gabe & Bury, 1996; Lupton, 1997). Such scrutiny appears to be contributing to the renegotiation of the image of doctors, but has not yet detracted from the dominance of the medical profession. A recurring theme in all the groups is that the government's health and social policies are barriers to health. The pessimism expressed towards state institutions and government representatives may reflect television focus on disaster and scandal (*cf.* Morgan, 1989). Reforms in the health system are presented in health coverage as a cause of the increased inequality in access to care for needy patients and of the undue pressure being placed on public doctors. As a result, competent doctors are being forced to relocate to the private system at the expense of the public system and patients of lower SES. Despite the existence of potential challenges to the medical profession, within the programmes and the participants' discussions, it is non-medical stakeholders who are presented as being ultimately responsible for the present situation.

In light of the emphasis participants place on the government as a cause of problems in the public health system, it is understandable that they progress from criticising some doctors to accepting the general benefits of medical care (*cf.* Calnan & Williams, 1992; Lupton, 1997). The image of doctors is worked through in a way that shifts responsibility to the health system. For instance, participants propose that some private doctors might be acting in self-interest, but that in many cases their skill justifies the financial rewards they receive. The financial benefits of medical practice are linked to the years of training doctors undertake and, provided that nothing goes wrong, are generally seen as being justified. So long as private surgeons are depicted as being studious, honest, and willing to do

their utmost for patients, participants construct them in a positive light. Despite raising criticisms of individual doctors, health coverage predominantly presents positive depictions of the medical profession and preserves its expert status (*cf.* Brown et al., 1996). Central to the preservation of the expert status of doctors within television constructions is the continued use of traditional character traits such as empathy, understanding, good will, and studiousness (*cf.* Gripsrud, 1999). Participants appear to draw on such constructions in their discussions and use them as resources for making sense of their relationship with the medical profession.

This analysis has shown that participants work together to explore various ideas and to make sense of health issues that have serious implications. Within this process health coverage is drawn on as a resource that focuses these discussions and extends participants' views on the issues explored. Participants accept elements of coverage such as government incompetence, but also raise additional issues such as the profiteering of private companies. Their relationship to medical treatment is given meaning in light of various contradictions and complexities that are worked through as the discussions progress. These discussions may not provide any definitive answers to the health issues explored, but they do provide a forum within which health and illness is made sense of and where peoples' views are negotiated and linked to wider social shifts and the experiences and views of others.

The salience of common explanations across the focus groups supports the proposition that participants draw on their existing views as well as aspects of the programmes when working through various issues as a group (*cf.* Liebes & Katz, 1990). Each participant's account reflects their personal experiences, their previous interactions with health coverage, elements of the programmes watched, and the accounts of other group

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members. During the discussions participants develop initial interpretations that are renegotiated in the group discussion in light of the views of other group members. As Catterall and Maclaran point out:

Participants change their views and opinions in the course of the discussion once they have had an opportunity to hear and reflect on other opinions, through introspection and retrospection. Indeed it is not unusual for participants to think these changes through out loud. Participants expand later on experiences recounted earlier; adding new information, giving the experience a new and sometimes different interpretation or, simply placing this experience in the context of another participant's experience (1997, p. 6).

Through conversing with each other, participants position programmes as discussional resources that are used to aid the working through of various issues of relevance to their lives. As a result an analysis of these interactions offers insights into the shared lifeworld of the participants (*cf.* Kitzinger, 1999; Wilkinson, 1998). These discussions provide a way of exploring how participants work together to make sense of health and illness and what implications events presented in health coverage might have on their lives. The analysis of such discussions highlights that the meaning of health and illness is neither out there in society nor held solely within the individual (*cf.* Roscoe, Marshall & Gleeson, 1995). It is the product of social interactions in which people explore various issues by drawing on and reworking information from various sources as a discussion progresses.

Building on the analysis presented above, the following subsections further explore the processes through which issues are worked through as participants renegotiate their views. The remainder of this analysis is presented in four subsections, each dealing with one of the focus groups. It begins with an exploration of the ways participants draw on aspects of TGKHL to discuss the allocation of health resources, an issue that is central to the introduction of the health reforms. Attention then turns to how

focus group two constructs the idea of a government that has a hidden agenda to encourage people to shift to private care. Next, attention is given to the ways that focus group three works through both positive and negative implications of extending the life expectancy of the elderly. The fourth section draws on focus group four to explore the way men's reluctance to seek medical care is negotiated in a manner that allows participants to shift responsibility for health problems from men's masculine attitudes to social expectations and a lack of support.

9.2.1 Focus Group One: A Discussion of Resource Allocation (TGKHL)

As participants work through the allocation of health care resources in the public health system, government mismanagement is positioned as a catalyst for shortages in health resources that put people's lives at risk. Participants accept TGKHL's proposition that there is no adequate criterion for guiding decisions on who should be treated in the public system when there are so many patients in need. However, they do not accept the proposition that a workable criterion or adequate resources cannot be found. The discussion is focused around a possible criterion for allocating resources, the consequences of rationing decisions for those who cannot afford private care, and the need to refocus the public health system to serve people rather than profit.

In exploring a possible criterion for allocating resources and making decisions on who will be treated, the Oregon strategy (covered in TGKHL) of making a list that designates which ailments will and will not be treated at the public expense is initially discussed. This early focus exemplifies how selected elements of a programme are drawn upon to stimulate discussion and, as interactions between participants progress, how these aspects are worked through in relation to additional considerations (*cf.* Roscoe et al., 1995). The Oregon strategy for allocating resources is subsequently linked to considerations such as the increasing demand for

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services associated with unhealthy lifestyles. Participants draw on a lifestyle explanation to explore whether treatment decisions could be made according to someone's health-related behaviour patterns, such as smoking and drinking:

Warren: *...Millions of dollars are spent on unhealthy living and it [TGKHL] didn't even touch upon that. It just mentioned we're getting older and it looked at the old person who couldn't get his blood washed. It looked at an old lady of 77 who had a heart problem. It didn't mention...the fact that our hospitals are full of people because of drinking, motor vehicle accidents that cost a billion dollars a year, and other unhealthy things that can be altered. People can eat more healthy foods, cut down on the smoking, cut down on the alcohol. Apparently we're the highest per thousand population in the world...for drinking alcohol...*

Alan: *But don't you think that, what you've just raised, don't you think that raises another issue? That instead of emphasising all these people in hospital and the population getting older and we can't pay for all these dialysis and these heart transplants, but on the other hand they're encouraging an unhealthy lifestyle... Maybe they should be spending more to encourage a healthy lifestyle so that people don't have to go into hospital.*

Warren: *...If I was the chief surgeon at Greenlane Hospital I'd be ruling below the line all those with cirrhosis of the liver for alcoholism, vascular surgery for feet going black because you're a heavy smoker, you know. I'd make the list for those, I wouldn't give surgery to those who self-cause the damage to their own bodies and they didn't explain that that's what the list came out of.*

Here lifestyle explanations of illness are used to propose that prevention in the form of healthy living would reduce the demand for services and free up resources that then could be used to treat patients who are sick through no fault of their own. Warren introduces the idea that people who have caused their own illness should be assigned less priority than more deserving patients. Warren's reference to 'the line' invokes the cut-off point

used in the Oregon strategy to differentiate what treatments are publicly funded and which ones people have to pay for themselves. In this interaction 'the line' is recontextualised to refer to ailments resulting from lifestyle behaviour patterns, where ailments associated with unhealthy living are not publicly funded. Here Warren invokes the 'duty to not be a threat to others', which he also drew on in his individual interview, as a criterion for allocating health care resources (*cf.* Crawford, 1994; Radley, 1993; Williams, 1993).

Identifying lifestyle causes of illness and allocating curative resources accordingly is controversial because it places considerable responsibility for illness on the individual. In a response to Warren that highlights how such views are subjected to critical scrutiny, Jane voices her opposition to a lifestyle-based strategy for allocating resources. Drawing on aspects of TGKHL, Jane proposes that such a strategy is discriminatory. She draws on TGKHL's depiction of the Human Rights Commissioner, which is presented in the programme to raise questions around the legitimacy of government guidelines that restrict services to the elderly. Jane extends the programme's use of this depiction to propose that one cannot discriminate on the basis of lifestyle behaviour either:

Jane: I think with the human rights legislation you wouldn't be allowed to discriminate against those people cause they smoke. And I don't think that's a fair assumption to make, because a lot of people in those circumstances have worked and paid a lot of taxes. So I think they got the right to get help too.

This statement signals a shift in the discussion from a primary focus on individual responsibility to a focus on communal responsibility and the effective management of government funds. This shift is initiated when Jane draws on 'the duty of society to care for its members' in order to question the fairness of allocating resources according to lifestyle behaviours. These extracts exemplify the ways that participants can draw

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on aspects of their existing views to make sense of specific issues. Subsequently, participants propose that tax revenue generated from the sale of alcohol and cigarettes should be used for treating lifestyle-related ailments. These issues are then related back to the Oregon strategy. It is concluded that making a list of funded and non-funded ailments may have some merit in theory, but that it simply increases inequality in access to care because not everyone can afford to pay for the treatment of non-funded ailments in the private system:

Alan: *No I don't think it [the Oregon strategy] would be democratic at all because it sounds all right in theory, but I think it would further entrench the two-tiered system for those who can afford it. And who's going to decide what's going to be above the line and what's going to be below? Depending on who makes the decisions I might get an operation and I might not. If I can afford it I can go straight in and if I can't I have to wait forever.*

Within this interaction, participants work through more than criteria for allocating resources. They construct a balance between notions of individual and of communal responsibility that is developed further throughout the discussion. Alan initially supports Warren's call for individual responsibility, in the form of people living a healthy lifestyle. However, in response to the ensuing discussion, Alan appears to shift his view by emphasising the need for communal responsibility and highlighting some possible negative ramifications of increased self-reliance. Emphasis on communal responsibility is further developed as the participants explore the resource allocation issue and call for the adequate resourcing of the public health system. Such resourcing is presented as a way of ensuring the provision of timely medical services to all, regardless of people's personal circumstances. In the process TGKHL is drawn on as conceptual resource within a discussion of wider socio-structural influences.

As the discussion develops, the exploration of the allocation of health care resources is conducted at the levels of both abstract health policy and

personal consequence. Emphasis is given to the consequences of resource allocation decisions, brought on by the health-care reforms, on the lives of people of lower SES. Reference to specific examples of the problems faced by those on the waiting lists serves to emphasise the seriousness of the situation and to link abstract discussions of criteria for allocating resources to specific implications of such decisions on people's lives. Participants exchange horror stories about problems in the public health system as a way of establishing the extent of the problem and assigning responsibility to the government's mismanagement of the health system. They generally identify with the needy patients depicted in TGKHL and provide additional examples of needy patients from their own lives (*cf.* Livingstone & Lunt, 1994). These examples function to further warrant the participants' pessimistic views of the health reforms and extend the scope of the investigation provided in TGKHL. They allow participants to work through aspects of the programme's exposition within a wider discussion of social change. For instance, during the discussion of possible lifestyle-based criteria for allocating resources, Jane revoices the example of her friend who had died while waiting for surgery. She had voiced this example within her individual interview and uses it during the group discussion to support her view that responsibility should be attributed to the health system rather than sick individuals:

Jane: *I went to an unveiling [funeral] last week of a young lady who was 24 years old and she was waiting for a heart operation and she was put off and put off. And she was happily married with four children, husband working. An finally they give her a date after 2 years for 16 days and her little son goes in to wake her up in the morning to get ready for school and she couldn't make it to the operation because she was dead. An she was 24 years old. That movie [TGKHL] just counted really on elderly people so it's not really just affecting elderly people at all. To tell that girl to go out and get private insurance would just be an impossibility. Because people just, you know, he wasn't in a job that was paid enough money to have any form of insurance anyway.*

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And the way I look at it now is everything that is happening within this government now, irrespective of whether its health or education or anything else, housing, its all from the view of privatisation and never mind you if you don't have the money, too bad for you.

This extract exemplifies the way participants use their existing experiences as a kind of validity check on health coverage. Jane reuses this example from her individual interview to highlight omissions in TGKHL's exposition. The voicing of this example functions to warrant Jane's view that the risks posed by the restriction of health care resources do not affect only elderly patients.

This extract also demonstrates the way in which views voiced in the individual interviews are refined within the group context. In using the above example Jane re-emphasises some propositions from her view on the health reforms which she voiced in the individual interview, but she also raises some additional points. For instance, the graveness and inequity of the waiting lists is emphasised in Jane's statement about the consequences for this woman of having to wait for care and her young son finding her dead. Furthermore, the woman's husband is presented as working and paying taxes in both renderings, which functions to support the idea that treatment was deserved. Within the group discussion, this extract is used as a key component of Jane's resistance to the emphasis being given to individual responsibility. As a result more overt reference is made to the financial barriers to health faced by this family, as a way of shifting responsibility from the individual to the social system. Increased emphasis is placed on constructing the woman as a trapped victim who has limited control over her life and is not able to take responsibility. This is achieved, in part, through the reference to the inadequacy of her husband's wages, which prevented her from accessing treatment in the private system.

In short, such examples are used within this discussion to demonstrate the implications of recent government policies and of the increased emphasis placed on self-reliance for those who cannot afford access to private services. Participants appear to work with the framing of inequality in access to care in TGKHL and extend this framing to talk about wider social inequalities that place people's health at risk and prevent them from managing their health. For example, although used to highlight limitations in coverage, Jane's example also functions to extend TGKHL's perspective. It provides further evidence for the proposition that the lives of people with acute ailments are being put at risk and some people are dying while on the waiting lists. The programme's perspective and the participants' interpretations part ways where participants place more emphasis on the need for communal responsibility to address social inequality. Participants do not simply accept the programme's proposition that increased access to private care is the answer.

As the discussion progresses, participants construct a wider exploration of the political nature of problems in the public health system than is evident in TGKHL. Shortfalls in resourcing are linked further to government policy and mismanagement of public funds. The discussion develops from an exploration of specific criteria for allocating resources to an exploration of additional examples of the ramifications of resource restrictions, to consideration of the wider context of health care and social reform. Inadequate resourcing is linked to the wider issue of public diet and government mismanagement of public moneys. The following extract illustrates the way in which the exploration of resource allocation in the health care system is contextualised within a discussion of wider social shifts:

Warren: *...We've got the money being wasted on frigates and other areas, over long periods of time and other capital expenditure. It's going to have to be shifted back to the people... They're [the government] going to have to sort of*

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spend more money on education and health, otherwise this process is going to blow out. It's bad enough now!...

Jane: *I thought that was what restructuring was supposed to be doing in the first place.*

Warren: *Yeah, and it hasn't worked. They've hocked off 42 billion dollars in private companies in the last ten years and they still can't balance the books and the fact that they balance the books and are giving us a tax rebate is just creative book keeping...*

[...]

Alan: *...I basically agree with you but they need to look at the overall picture. Not just the health, because the tax cuts are political. And if we're so short of money that we can't afford a decent health system how come we can afford all these tax cuts? So, I think that they really need to go back to the drawing board and they need to look at where the money is going. And the trouble with a system that once you start contracting out and privatising things and encouraging people to take out private medical insurance, like Southern Cross and Medic Aid and all the rest of them, they're based around profit so they're not really interested in people. People are being used as objects to make money and so this philosophy comes into it, doesn't it? How are you going to do it? You want a fair system that is not based around profit, that is supposed to be based around people.*

Warren: *You're going to end up with duplication. You're going to end up with Southern Cross hospital and Palmerston North hospital in competition with Wanganui hospital, in this district.... They're all going to have empty surgery theatres because that particular month they won't get any money.*

Participants construct a shared frame of reference by assigning the cause of the problems in the health system to government incompetence and the self-interest of private companies. The welfare state and communal initiatives are presented as being undermined by impersonal private providers, through an exploration of recent health care and economic

policies. Reference to contradictions around the government providing tax-cuts, while proposing that an adequately funded public health system is unaffordable, suggests incompetence and bias. The use of tax revenue to pay for an adequately resourced public system is presented as being preferable to forcing people to pay for private care. Participants propose that a publicly funded system can provide for all more effectively than a private system. It is competition that is presented as leading to inefficiencies and health inequalities (*cf.* Salmond, 1992). This contradicts government rhetoric that proposes that competition and private health care provisions bring inefficiency. Inherent in the participants' discussion is the idea that duplications in services and inefficiencies result from competition and that this leads to increased costs (*cf.* Ashton, 1995). In this way, the health reforms are positioned as the cause rather than the solution to inefficiencies in the health system.

To recap, as the discussion develops participants move beyond the programme's framing to contextualise the rationing of care more fully within everyday life and social reforms. The health reforms are presented as indicative of the demise of the welfare state as a result of government mismanagement. In exploring the rationing of health resources, participants draw upon elements of health coverage that emphasise inequality in access to care. However, they also invoke the wider political context and position inequality in access to care as yet another injustice in an increasingly inequitable society. Emphasis is placed on the need for a change in government policy to ensure health for all. Through the integration of aspects of TGKHL into an ongoing discussion of health and illness, participants further explore issues of moral responsibility that were invoked in the individual interviews and apply these to make sense of the health reforms. In doing so they demonstrate how people can work with multiple explanations and renegotiate their views in relation to health

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coverage and the accounts of other group members. It is through such social interactions that health and illness are constructed.

9.2.2 Focus Group Two: The Government's Hidden Agenda (H&W)

As participants in focus group two explore the privatisation of health care, they draw on H&W's proposition that the Government may have a hidden agenda to increase the shift to private care. It is proposed that, by shifting the cost of treatment to private health care schemes and individual consumers, the Government plans to eventually move out of the business of providing medical services on a tax-funded basis. Early interactions set the stage for a discussion of the influence of wider social shifts and vested interests on the provision of medical services. As the discussion progresses financial restraint and inequalities in access to care are presented as being indicative of the Government's agenda to undermine the welfare state. Society is constructed as being increasingly inequitable, self-centred, and out of kilter, and the increasing gap between rich and poor is presented as inherently unhealthy. Problems in the public health system and social decline are attributed to bureaucratic interference that places people's lives at risk. Briefly, participants accept the possibility of the Government having a hidden agenda and then work through possible implications for the provision of health care. In the process the programme is positioned as a resource for talking about not only the privatisation of medical care but also wider social shifts.

When making initial interpretations of H&W, participants construct a link between increases in inequality and the Government's hidden agenda. They draw on a biomedical plot line, progressing from diagnosis to treatment to recovery, to talk about how such progression is often disrupted for public patients because many cannot afford access to private care:

Joy: *Yeah, they have the haves and have-nots. If you have got a bit of money, you can afford to get private health care, you know. But if you are poor, where do you stand then?*

Susan: *I suppose you are stuck on a list.*

Joy: *And what then? That's not very fair, is it?*

Mary: *You're sure to die.*

[...]

Susan: *...I was just sort of thinking if the wealthy people did actually take the responsibility to care for their own health...*

Don: *If you have an operation privately you are certainly saving the Government money and I believe they know that.*

Joy: *But are they deliberately pushing for the private sector in health care because they want to save money?...*

This extract reflects the combination of a number of taken for granted themes from H&W and the individual interviews. It functions to place responsibility with the government for the consequences of people's having to wait for care. The moral imperative to take responsibility for one's health is drawn on to propose that those who can pay for private schemes, and do so, are acting responsibly and may free up resources for those who cannot pay. Yet the government is presented as secretly trying to avoid responsibility for providing for people who are not self-reliant. Again, the tension between notions of individual and communal responsibility shapes the construction of health and illness.

This discussion exhibits a similar pattern to H&W, when participants initiate an exploration of the evidence for the existence of a hidden government agenda and its implications. However, during their exploration of this issue participants do not simply reproduce the programme's exposition. Rather they supplement it with a more socio-structurally informed framework. The shift to privatisation is presented by the participants as being indicative of an increasingly unhealthy society, in which private providers and Government are ignoring the needs of people of lower SES and are

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reluctant to take responsibility for their actions. Such stakeholders are presented as putting money before people. The following extract exemplifies these trends and the way privileged propositions from H&W, such as the Government's having a hidden agenda and the benefits of private health care, are renegotiated as participants work through the issues. For instance, although making what could be seen as a preferred reading (*cf.* Hall, 1980), by accepting that the Government has a hidden agenda, participants do not simply accept H&W's proposition that access to private care is the answer to problems faced by needy public patients. Participants are critical of the quality of private care and construct a less ideal image of it than is presented in H&W:

Mary: *Another thing, if they [the government] want to push people into private insurance, then they are going to have to push the employers for the Contracts Act for a better standard of living for the ordinary people so they are can afford to buy... And there's another one too. You go to a private hospital and you have the operation. If you get an infection or something goes wrong when you go home, you don't go back to the private hospital for them to pay, for them to fix it, without charging you again. You then go to the public hospital where they clear up the mess.*

Don: *Yeah, they're [private providers] not accepting their responsibility.*

Susan: *Oh, no, that's the thing. Was it guaranteed work? You go to a bloody panel beater or a mechanic, eh. You have got guaranteed work, eh.*

Joy: *That's right.*

Susan: *They do a job and if they don't do it properly, you go back and they damn well do it.*

Don: *That's where the Consumer Guarantees Act probably comes into it.*

[...]

Ed: *...That TV clip in there, when I saw Roger Douglas and all them right early on in 1988, they first introduced a private*

system, the Labour Government. These people need to come up on criminal charges now, because everybody here hasn't got that right now what they had there. And I actually really feel personally that from then on, this whole country is being sold down the tubes, health, education, jobs, the whole lot. It's all being sold down the tubes.

Joy: *And they started it, didn't they?*

Ed: *They started it and they had a secret agenda back then, that this was going to happen. But it's like anything, once a thing is in motion it takes a few years before it catches up and by then it's too late. We slid through, I must say, in the last ten years and we have been chopped, channelled, kicked, demoralised, seven days a week. We've gone back to the 40s, even 50s. We have actually gone back in time.*

Mary draws on her own experience to raise limitations in private care and to question the benefits of the shift from the public health system. She draws upon her own experience of having caught an infection while being treated in a private hospital, which she voiced during her individual interview. This example is used to raise questions about the quality of private care and to voice her opposition to people's being forced to pay for access to such services. She does not elaborate on this experience during the group discussion because she has already talked about it with other group members. Rather, she invokes the experience merely to warrant her scepticism about private providers and whether they can be trusted to accept responsibility for their work, like other professionals.

Subsequently, participants draw on notions of accountability and responsiveness to consumer demands, which have been used to justify the health reforms, to question the integrity of private providers. The comparison of surgery to the motor trade functions to position medical care as a commodity and to raise a potential challenge to its privileged status. In the process, participants present themselves as health consumers whose needs are not being met. The idea that the public system has to address

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problems caused by private providers also foreshadows the group's conclusion that the public system is superior to the private system, but that it needs to be adequately funded rather than purposefully undermined. The construction of government representatives as villains in this extract reflects similar framing in both health coverage and the individual interviews. Through the use of the example of the actions of the fourth Labour Government, participants in this group provide evidence of the ways governments often say one thing and do another.

Although participants accept H&W's proposition that the government has a hidden agenda, they implicate a wider range of stakeholders than H&W did. H&W attributed the hidden agenda to government representatives and presented private providers as simply responding to the health care reforms in a sound business manner. In the participants' discussion, those who profit from the privatisation of health care, including private insurers and some surgeons, are also implicated in the conspiracy to shift the provision of services and responsibility to the private health system and individual consumers:

Mary: *The idiot that wanted it all private [Alan Gibbs] was suspect.*

Susan: *The politicians too.*

Ed: *I think those insurance salesmen had an agenda.*

Susan: *Never believe a word they say.*

Ed: *Southern Cross, the joker that works for Southern Cross, I thought he was a killer. You know, he actually said a few lines that actually showed that, at the end of the day, he was calling the shots...*

[...]

Joy: *...Well, to my mind is private health care necessary? And the other guy [Dr Dunn, a private surgeon depicted in H&W] more or less said it's so important. It is necessary if you, you know, want to stay healthy or get better. Yeah, they*

more or less, to me, it seems like they were brain-washing these minds who were watching them, eh.

Don: *They were justifying the growth in health insurance by reminding us of the problems of the public system.*

Joy: *Yes.*

Ed: *That's right, so it's a market-driven programme.*

Joy: *Yes, it's justifying it.*

Don: *And it, without a doubt, it did support the private company.*

Susan: *I thought it was funded by Southern Cross.*

Within such interactions an inherent distrust in the privatisation of health care emerges. Privatisation is associated with various stakeholders who are presented as acting in self-interest by manipulating the increased use of private services in order to secure personal gains. Perhaps as a result of its failure to question the vested interests of private insurers, participants also implicated the programme in the agenda to encourage the shift to private care. They speculate about possible funders of H&W and propose that the programme is corrupted by commercial interests and as a result provides a biased perspective promoting the benefits of private care. This extract exemplifies the way that participants can accept some aspects of coverage while also criticising other aspects, as they work through the possible causes for and implications of depicted events (*cf.* Lewis, 1991)

The discussion of the hidden agenda also allows participants to work through some controversial issues such as whether people of lower SES should have subsidised access to private facilities because public services are not available. The example (derived from H&W) of a childcare centre that had to pay for private medical care in order to ensure prompt access to treatment for their children is discussed. Reference to this centre functioned to highlight the implications of the government's strategy of restricting resources in the public system in order to force people to access private care. Susan and Mary propose that the government should

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subsidise this sort of initiative. Such interpretations appear to be influenced by H&W's framing of this care. Those involved with this childcare centre are depicted as being willing to take responsibility for gaining treatment for the children, but are being hampered in their efforts due to a lack of funds. Sympathy towards these people and their efforts to ensure prompt access to care for the children is expressed in both H&W and the participants' discussion. However, Don is more cautious about calls for the government to subsidise such lower SES group's access to private care. He proposes that such developments simply reflect the government's agenda to undermine the public system. This case is worked through in relation to the need to treat needy patients such as the children on the one hand and the need to resist government efforts to manipulate the situation and shift responsibility for access to care to consumers on the other:

Don: *But I don't agree with that though, because they did it privately, they can't expect the government to pay.*

Mary: *But they had to do it.*

Susan: *...I liked to hear what the doctor said about these children with glue ear who have 40 or 50 percent hearing loss and how it stunts their development so completely and it really does. The knowledge of the child is gained through its ears, primarily. When they are playing, they might be doing something here but everything that's going in there is creating a picture in their mind. I watch my granddaughter, eh. And for these children to have hearing loss means that for them not to be specially dealt with, so that they can get on with their education, means that they are severely disadvantaged by not being treated. And for these people to have gone in there and take responsibility for the health of their young children is good, it's really good to do and they shouldn't be excluded from the funds that are being spent.*

Don: *Well, you get back to the point that nobody should have to pay for their own health care, except of course through taxes for the public system. It's just the way they [the Government] are getting us to go private. If we give in there's not going to be a public system.*

Mary: *Well I think now that the Kohanga Reo and those doing that sort of thing and the deficit that they have got, the government should pay them and not give the bonus to the management of the hospital boards.*

Susan: *Yeah, you get a quarter of a million-dollar bloody bonuses.*

Mary: *They don't need bonuses. After all, they just run around in suits and clipboards, feeling important.*

Don: *Oh, okay.*

Mary: *And the thing is that money could have gone and helped that group to still be able to go to the doctors and not get in debt. And that would be more important than the management having a bonus.*

Don: *And that's what happens in a lot of businesses where you have administrative costs. And of course that's an area that can be cut down.*

This extract presents an example of how people move in and out of accepting and rejecting aspects of coverage as they work through points of contention and explore various possibilities and courses of action. The discussion moves from the importance of the need for access to care for these children to the immorality of the Government's efforts to use such situations to force people to pay for private schemes. This in turn leads to a discussion of the Government's mismanagement of financial resources and the need to divert funds from administration to treatment in order to solve such problems. Considerable media attention has been given to excessive administrative cost in the various CHE's prior to this discussion (*cf.* Tully, 1996). Participants appear to draw on this previous coverage rhetorically to justify the view that money that could be used to provide treatment is being wasted. This interaction also highlights the way participants' views are derived from a range of sources, including health coverage and personal experience, which are often intertwined (*cf.* Lewis, 1991; Livingstone, 1999; Morley, 1999). Participants such as Susan integrate examples from the

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programmes with their own experiences in complex ways to illustrate the ramifications of the hidden agenda.

In sum, participants appear to accept aspects of H&W's coverage of privatisation. For instance, in a manner similar to how the privatisation of health care is framed within H&W, the participants' discussion is orientated around the idea that the Government has a hidden agenda that is not in the interests of New Zealanders of lower SES. However, participants do not simply reproduce the programme's perspective. Rather, they work with and integrate aspects of H&W within a wider-reaching discussion. Diverging from the focus of H&W, participants do not limit the discussion of privatisation to inequality in access to care. They also draw on various sources to present changes in the health system and the increased emphasis placed on individual responsibility as indicative of wider social shifts and increased social inequality. However, this does not imply that the programme has no bearing on the discussion. In working through possible implications, participants do not just accept the monetarist assumption evident in H&W that there is not enough money for health and education. Participants propose that shortages in resources are due to government mismanagement and the uneven distribution of wealth in society (*cf.* Philo, 1999). Although accepting responsibility for one's own health is presented in this discussion as being desirable, increased individual responsibility for access to medical care is associated with increased social inequality. Participants present increased privatisation as a transgression from communal responsibility that places people's lives at risk.

9.2.3 Focus Group Three: The Implications of Extending Life (GO)

All the participants in focus group three identify the search for the fountain of youth as GO's key focus. However, there is some disagreement among participants as to whether this search is appropriate and what implications it has for individuals and society. This group's discussion provides

illustrations of the ways such divergence is negotiated as participants draw on a programme's perspective, their own biographies, and the interpretations of other group members to enrich their own views. Divergence voiced during this discussion contributes to a more complex exploration of this issue than would have occurred if participants simply agreed. As participants work through the implications of extending life their views are modified to accommodate aspects of the opposing views voiced by other participants.

Early in the discussion participants explore the implications of extending the life expectancy of the elderly and in doing so reproduce the inactive and active stereotypes that shape GO's exposition. The juxtaposing of these two stereotypes in GO appears to have a varied influence on the scope and shape of the participants' constructions of aging. May proposes that people living longer would result in more inactive elderly and increased cost to society for providing geriatric services. She acknowledges the possibility of more active elderly, but does not present this development in a positive light. May proposes that if the active elderly remain in the workforce for longer, then fewer jobs will be available for young people. Conversely, Lisa and Jamie appear to accept the programme's depiction of the active elderly as a positive development and emphasise how these people can become more self-reliant. As the following extract shows, Lisa and Jamie focus on the positive personal gains experienced by the active elderly, while May focuses on the possible negative implications of an aging population:

May: *I don't know whether that [prolonging life] was a good thing or bad thing. I think it's going to be good for us that work in the care industry. But I think it's going to be bad for somebody else.*

Interviewer: *What do you mean?*

May: *Well, it's going to mean they are going to have to build more rest homes and retirement villages. So that's going to*

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be good for us for more work. But in the long run it's going to cost the country more.

Interviewer: *Does anyone want to say anything about that?*

Lisa: *I think just watching that they're looking at ways of cutting down from the rest homes. If you have to go to the rest homes, you are looking to a unhealthy diet, it's prevention, the loss of youth. The fact is your body failure and mentally failure can be preventable. Like they were saying, there is forty thousand Alzheimer's patients. Now if they could slow down these processes like the diseases that are causing, you know, the failure in their health, they might just come up with the right answer where it's not going to get them, affect their mental capacity or the physical capacity of them.*

[...]

Jamie: *I reckon you should just carry on working and enjoying life.*

May: *But then if they don't retire then there's not going to be the jobs for everybody else out there.*

Lisa: *It's not their fault.*

Jamie: *They are talking about not having them giving up...*

May: *And the country's going to grow so much that it's going to end up where you are going to have an overpopulation.*

Lisa: *Yeah, but what do you want, the culling of the elderly? I mean these guys [the active elderly] are trying to improve their health, their mental capabilities, you know. After watching it, you can see they are achieving it. Now it's not their fault that there's going to be a blowout because they're living longer... Good luck to them. If you've got the physical capabilities of doing the job, well let them have it. I bet you anything that they are more regular than the younger lot that are coming up. They are always there on time.*

This extract highlights the way that May's interpretation of GO, which could be construed as an oppositional reading, is resisted by other participants who voice what could be construed as preferred readings (*cf.* Hall, 1980).

For instance, May questions the programme's construction of the positive implications of extending the life expectancy of the elderly population, while Lisa generally accepts the programme's framing of such positive implications and the proposition that aging is preventable. This extract also illustrates some of the ways that interpretations are negotiated among participants as they draw on various socio-cultural explanations. Lisa draws on a lifestyle explanation that places responsibility for aging and illness with people's behaviour. She uses this explanation to respond critically to May's account of the possible implication of an aging population on welfare resources.

Such interactions established a pattern that is replicated and developed throughout the discussion. This pattern invokes a tension between people's right to choose a healthy lifestyle and the impact this might have on social services and other members of society. The discussion alternates between a focus on the individual and on the societal implications of an increasingly elderly population. The issue of extending the life expectancy and vitality of the elderly is explored and rendered meaningful in relation to wider financial considerations. This discussion is indicative of the ways in which lay views on health concerns are not constructed solely within the sphere of health and illness. They are constructed in relation to other spheres of life, such as employment, the family, and religion (*cf.* Radley, 1999). Aspects of a programme are drawn on by these participants and then recontextualised within a discussion of the possible implications of extending life that invokes broader issues relevant to various spheres of life.

The voicing of opposing views within this discussion makes participants reflect on and justify their positions (*cf.* Billig, 1991, 1997a). For instance, Lisa and Jamie's initial emphasis on the possibility of finding a cure for old age and the role of individual choice results in May acknowledging the

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possibility of such a cure. However, May warrants her skepticism about such developments by proposing that a cure is unlikely to benefit everyone. During the working through of such developments and possible implications, May invokes the idea that maintaining one's youthfulness and health is not just a matter of individual choice because financial restraints can restrict people's ability to live a healthy lifestyle:

May: *Oh, some of it [the programme] I agree with, but others I think they are like dreaming slightly. I mean all good and well if they can find something to stop them from aging but, realistically, I don't really think they are going to. And if they are revolving their whole life around it, then that's not good. And not everyone can afford that sort of life... I mean it's just pointless spending millions of dollars and then finding something that they supposedly think is going to make them young so they can live longer.*

Jamie: *Yes, but maybe they want to enjoy life by being young and able to watch their grandkids grow up.*

May: *Realistically, I mean, you have all got to die somehow. So they are all going to die. Why spend thousands of dollars on it? What a waste!*

Jamie: *Yeah, but that's their choice.*

Lisa: *Yeah, but hold on a minute. You see, you're an asthmatic; now you need that pump, don't you?*

May: *Yeah.*

Lisa: *Well, this is it. See, they have prolonged your life. Now here you are saying, they are spending thousands to live longer. Now if it wasn't for that person that designed that pump for all the asthmatics, a lot of them would be dead. That is another way of culling. You can stop finding cures to these diseases. If you want to cull them, well, don't find a cure for it.*

May: *Yeah, but aging is not a disease though. Everyone is going to grow old. Not everyone is going to get asthma.*

Lisa: *Yeah, but good on them. If they want to lengthen their life, go for it.*

Jamie: *Yip.*

Lisa: *They have every right. It's everyone's personal choice.*

May: *Yeah, I wasn't saying that but, realistically, who else out there can afford it, spending all that money. It's not going to be for everyone cos they'd make you pay through the nose for something like that if they did find it.*

As participants work through the likelihood of a cure for old age, they justify their views by either invoking notions of individual choice or social restraint. In doing so this group constructs a tension between the influence of individual choice and barriers to people exercising such choice. Social restraint is implied when May talks about inequality in access to a cure and refers to the commercial orientation of medical science. As a result medical science is constructed as being both potentially beneficial and unevenly distributed. However, May's comments are subjected to critical scrutiny from Lisa who proposes that the extension of life among the elderly is no different from the extension of life at any age. Lisa questions the legitimacy of May's making a distinction between some elderly people choosing to take a cure for aging and May taking treatment for her asthma. By providing a more general context for medical intervention, Lisa naturalises the benefits of medical science and highlights a potential inconsistency in May's acceptance of treatment for her asthma and her criticism of what aging research is attempting to do. However, May further warrants her position by stating that financial barriers will mean that any breakthroughs will not necessarily be available to all. This is a proposition that would be difficult for Lisa and Jamie to refute given the restraints placed on their own and other family members' access to medical services, which they had voiced earlier in the discussion.

Tension around whether aging is a disease and whether medical science should search for a cure for old age is not resolved in these early interactions and is further worked through in the ensuing discussion as participants renegotiate their views in response to each other. An important

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component throughout this discussion is that, by naturalising the search for a cure for old age as just another example of the potential benefits of medical science, Lisa and Jamie construct aging as an illness. This is a prominent proposition within GO that functions to justify the medicalization of aging and to legitimate the need for prevention and cure. However, May maintains a distinction between illness and aging as a way of resisting the medicalization of old age. May further warrants her criticism of the search for the cure for old age on religious grounds:

May: *I have always been brought up though, where in our religion you don't tamper with anything like that. In my opinion if you weren't to grow old and you weren't going to die, then that would have been the way God made things, but he didn't. Not everyone wants to live on this earth forever, you know.*

Lisa: *Yeah, but did he make, did he make the asthma pump? No. It was someone within this world that created it. Did he make renal machines to keep the people alive? No. It was someone within society. Now, they've lengthened life and this is artificial living. Well, fair enough, if it gives someone else a chance to live, or quality of life, go for it.*

Jamie: *And also enjoyment.*

Lisa: *That's it. And enjoyment. It is their personal choice and if it weren't for these people, these pioneers out in the medical field to learn from life, this is it.*

The extension of life expectancy and the possibility of finding the cure for old age is a radical proposition that presents a challenge to May's religious beliefs. As a result the discussion of a cure for aging introduces issues concerning the intersection of science and religion. Within such interactions both May and Lisa warrant their views by appealing to wider considerations and the common-sense status of their thinking. May appeals to God's intentions while Lisa appeals to scientific progress. In the process the discussion reflects a tension between traditional secular notions of God's plan and modernist notions of scientific advance and rational choice. This interaction highlights how, when making sense of topics such as aging and

illness, participants also reconstruct their faith in social institutions such as religion and science.

The above extracts are illustrative of the ways in which the participants negotiate their self-presentations and their relationship to each other (*cf.* Livingstone, 1999). For instance, May presents herself as a good Christian concerned about inequality and scientific interference with nature. Lisa presents herself as a consumer advocate who is supportive of the elderly getting everything they can out of life. These participants may disagree on aspects of the extension of life, but they both present themselves as moral individuals and justify their views in relation to each other's accounts. However, in order to present themselves as reasonable, they do not simply voice the same opinion repeatedly. Rather, they also voice some of the points raised by each other and renegotiate their views as the discussion develops (*cf.* Roscoe et al., 1995). The programme functions as a catalyst for debate within which participants explore one another's views and reconstruct their own positions. Such practices reflect the complex, contradictory, and changing character of lay views (*cf.* Billig, 1991).

During the discussion there is evidence of participants' efforts to accommodate one another's views while working rhetorically to justify their own positions (*cf.* Billig, 1991; Roscoe et al., 1995). The influence of participants' views on one another is evident in the second extract cited in this section when May concedes that scientists might find a cure for old age. However, May maintains her own sceptical view by proposing that such a cure is unlikely and would not be available to everyone due to financial restraints. This concession signals a softening of her initial proposition that such a cure would not be found and allows May to present herself as a reasonable person who is willing to listen to others. May's view also influences the reconstruction of Lisa's view. This is evident in the extract cited previously in the health communication section. In this extract,

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Lisa criticises GO's lack of focus on the financial restraints faced by the inactive elderly. Within another segment at the end of the discussion, Lisa draws on May's proposition that some people may not want to live forever in a manner that reflects a modification of her view. Here she combines May's scepticism about the universal benefits of extending the life expectancy of the elderly with her own emphasis on individual choice:

Lisa: ...*You know, I work at the Little Sisters [Retirement home] and for every resident that I have tended to, they say to me: "Dear, I pray for you that you never get as old as me".*

Interviewer: *Oh, okay.*

Lisa: *And I thought, now this isn't just one person who says this. It is a lot who tell me that they pray for me, that I never get past 60. Now those are the people not on this programme... Now maybe if they spent more time in a rest home, I think they would get a totally different answer to, you know.*

In the context of the wider discussion Lisa maintains the distinction between the inactive elderly who are unhealthy and should be allowed to die with dignity and the active elderly who remain healthy and who should be allowed to choose whether to prevent themselves from becoming ill. She proposes that the views of the inactive elderly are not given enough attention in GO, but does not propose that the active elderly feel the same way as the inactive elderly she works with. This extract highlights the way that participants' views are contingent on the context (*cf.* Billig, 1991).

In sum, much of the discussion in this group revolves around the implications of extending the life expectancy and vitality of the elderly. GO's construction of this issue is both supported and opposed by participants and is positioned within a discussion that invokes various spheres of life. The inevitability of bodily decline is challenged in GO through the depiction of the active elderly and the search for a cure for old age. The integration of such depictions into the participants' views leads to tension within their constructions of senior citizens. Two images are used

within the participants' discussion in order to emphasize both the positive implications of extending life and vitality for the active elderly, and the negative implications for society of extending the lives of the inactive elderly. Participants' orientations towards the active or inactive elderly are influenced by the programme's perspective, their biographies, and the accounts of other group members. In engaging in an ongoing public debate about the implications of an aging population, participants draw upon various ideologies and religious beliefs in a way that reflects how wider fields of knowledge are drawn on within conversations about health and illness (*cf.* Radley, 1999). As participants work through this issue they voice multiple explanations that could be interpreted as contradictory to propositions they voiced earlier in the discussion. However, people's views are never finished and are expanded and enriched through social interactions within which they appropriate elements of others' accounts and integrate multiple explanations (*cf.* Billig, 1991).

9.2.4 Focus Group Four: Men's Reluctance to Seek Care (TTFTBL)

TTFTBL provides coverage of men's health issues that is taken up and further developed within focus group four. During this discussion participants draw on ideas presented in the individual interviews and TTFTBL to further work through a range of issues regarding men's health. The focus of this section is on the participants' working through of men's reluctance to seek assistance, in part, because such reluctance is commonly used in media and academic circles to explain health inequalities faced by men (*cf.* Clarke & Robinson, 1999). This issue is also a central component of the participants' discussion that offers access to the ways responsibility for men's health is negotiated. Men's health problems are related to unhealthy masculine attitudes that prevent men from admitting weakness and seeking care. However, given the reluctance of participants to accept responsibility for illness in the individual interviews,

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participants also shift responsibility to influences outside their control in this discussion.

As participants discuss men's health-seeking behaviour they state the need for early detection. Like the men depicted in TTFTBL, participants emphasise the benefits of having an ailment dealt with promptly. Following the pattern evident in the individual interviews, the importance of early detection and prompt treatment is linked to the need for wider public discussion of men's health issues, in order to increase awareness and encourage men to seek assistance. In the process responsibility for men's failure to seek assistance is shifted from the individual to the lack of interventions targeted at men's health problems:

Ron: *It's about time they put one across, eh. You know, cos no one really gives a shit about men. We don't know about these things, so we don't bother getting them sorted in case it's serious.*

Nick: *I was surprised just how many people actually do die just because of prostate cancer, I never thought it was as big a problem as that. 500, that's a biggie. Shows that you need to get things sorted.*

[...]

Mark: *I think in terms of the health budget too, a lot of it goes into women's problems. I think for health promotion.*

Nick: *Agreed.*

Nigel: *That's about the only programme you ever, or anything, you've ever seen. You see heaps of ads on TV about women and low iron and eat more meat and shit.*

[...]

Paul: *They're [TTFTBL] trying to get awareness of not to be scared of going to get that stuff checked out. The guy's saying, you know, "You're still manly even though you've only got one of your nuts, or it doesn't hurt". Because pain is a big fear for most people that go and get surgery.*

Nick: *There shouldn't be anything more unmanly about it than a woman just having one breast. Or losing their ovaries.*

Nigel: *Yeah, like, I think it probably is a good idea to, if you did have a regular checkup, and get to it early before you are pissing into a plastic bag and all that sort of crap.*

Mark: *For good.*

Ron: *Yeah, but you could leave here and think, oh that was a good discussion and then fuckin' not bother about it again until you got to 45, and you think, you know, you're having a bit of a grope in the shower and uh oh...*

Nick: *By that time it might be too late.*

Nigel: *Yeah, see, if they had more regular, you know, like it's good to have a programme like that every now and then, but if they had a lot of you know, like short ads.*

Nick: *You got to have the follow up.*

Nigel: *Ads on TV all the time then, you know, you get it drummed into you. You know, like they have that women's bloody breast cancer, to tell you what symptoms to look for.*

Participants voice surprise at the extent of men's ailments and present themselves as discovering facts about men's health from watching TTFTBL. Such surprise could be expected given the lack of media attention and public awareness about the signs and symptoms of ailments such as testicular cancer (*cf.* Clarke & Robinson, 1999). As a result of such self-presentation the programme is legitimated as an information source providing important facts and figures (*cf.* Kitzinger, 1999). By emphasising the positive aspects of this programme and the extent and seriousness of various ailments, the men construct a legitimate position from which to question why more coverage of men's health issues is not provided. In other words, participants' assertions that they did not know that men's ailments were such a problem is used to emphasise the need for more attention to be given to men's health issues. This need is also linked to the attention given to women's health issues which has resulted in heightened

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awareness. Briefly, participants emphasise the lack of attention given to men's health and link this to their reluctance to seek assistance. As a result responsibility is shifted from the individual to the health system.

This extract also reflects the agenda-setting process (*cf.* Dearing & Rogers, 1996), where participants work through information provided in TTFTBL and accept the benefits of early detection. However, this is not a passive process on the part of the participants. They present themselves as critical viewers who are aware that one programme will not change anything, and that the public agenda is set over time and through a range of interactions with health coverage (*cf.* Farr, 1995). Participants talk about the positive educational aspects of TTFTBL but also highlight that any immediate influence may be short-lived. They draw on a health promotion explanation to propose that an ongoing campaign is needed in order to encourage men to seek early diagnosis and treatment (*cf.* Tulloch & Lupton, 1997). TTFTBL is interpreted as being a positive step towards encouraging more open public discussion of men's health issues, but other initiatives, such as those used to target women, are considered to be needed if men's awareness is to be improved and their reluctance removed. This functions to shift responsibility for men's reluctance to the health system while participants' identities as self-reliant critical viewers are still preserved.

Although voicing the agenda-setting role of health coverage, participants do not discuss a given ailment solely within the boundaries set by the programme. As is evident in all four focus groups, new information about men's health obtained through an interaction with TTFTBL is negotiated in this group among participants as they reflect on the health communication process and situate various issues within their own lifeworlds. Here, TTFTBL's coverage of testicular cancer is situated within a discussion of the need to encourage men to seek assistance. In particular, Mark uses

the programme's coverage as a catalyst for talking more generally about this ailment with reference to information he has gained through previous interactions with health coverage:

Mark: *It's interesting at the start there with that testicular cancer that this guy, Lance Armstrong, he's a top cyclist, he actually won a world road title, and he was diagnosed with it last year, and every cycling magazine you picked up afterwards, eh, talked about it. And I'd never heard about it until then, and you know.*

All: *Yeah.*

Mark: *And what was the interesting thing is that the hardest hit age group is between 25 and 35. You know, you sort of think that something like that's gonna happen when you're 60 or something, you know, and that these are young guys, and he was like in prime physical fitness, and you know, he caught it at a point where it was early enough. But, you know, if he'd let it go it probably would have killed him, you know, and he's really sort of been an ardent campaigner now for it.*

Ron: *Yeah, well that brings you closer, cos you can relate to that guy, eh.*

Mark: *It does, eh, cos you sort of think, oh it's someone that's unhealthy or someone that's a bit...*

Ron: *Like us.*

Mark: *It just shows it could hit anyone, eh.*

Nick: *Oh, yeah, makes you think about getting a check-up... You know, we probably don't like to admit being sick to others. Not publicly anyway.*

Ron: *We'd rather go out and work, you know, and get a day's work, than go to the doctor. You know, money's all-important, eh...*

Nigel: *Yeah, but see, I suppose if you were more aware of these different things and you thought shit, you know.*

Nick: *Might get it checked out.*

[...]

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Mark: *I think it's a whole education thing, about talking about these type of things as being sort of socially acceptable as well. I mean, you know, there's certain things that a lot of people just put in the closet, you know, and they don't want to talk about it, you know.*

Nick: *It doesn't go away.*

Mark: *Yeah, particularly, you know, male issues like that and I think that's why there's a certain amount of embarrassment there, for guys to go to a doctor, because they think, oh, you know, bloody don't want to talk about this. And, you know, I think the more that comes out into the open and the more it is talked about, particularly through the likes of the media, then I think that it will be more acceptable.*

Nick: *As I said, it's like women are quite happy to go and do their breast checks and stuff like that, I mean that's well publicised, tells you how. You don't get anything else, men's wise, on TV. Not that I've seen...*

The idea that men's health problems affect only older men is a prominent theme in the individual interviews. This idea is rethought in this discussion in relation to TTFTBL's coverage of testicular cancer, an ailment that affects primarily young to middle aged men (*cf.* Clarke & Robinson, 1999). Yet, participants do not just rely on the programme's coverage. This extract also illustrates the ways that participants relate ailments to their own experiences and derive examples from previous media interactions. Health communication information is also derived from peers. In this extract, participants also use a discussion of the importance of health education in building awareness as a transition from a focus on the individual to a focus on influences outside the individual's control. They achieve this transition by talking about the stigma attached to men's illness and link overcoming this stigma to the importance of public discussion in increasing awareness. As is the case in the individual interviews, whether participants present themselves as being willing to seek help depends on their assessment of the seriousness of a problem and whether it justifies the inconvenience and cost involved in going to the doctor. This discussion draws on a cost-

benefit explanation of help-seeking but does not assign responsibility solely to the individual. Participants emphasise the need for information to be made available to men to enable them to assess whether assistance is required. If this information is not made available then responsibility for men's failure to act can be shifted to the system.

Participants talk about the need for men to seek assistance and how this can be facilitated by increased awareness of men's health issues reflects the changing character of medicalization (*cf.* Calnan & Williams, 1992; Crawford, 1980, 1984, 1994; Gabe & Bury, 1996). For instance, the need for awareness among men of possible problems is constructed in a way that links it to individual action in the form of seeking medical assistance. In the process the primacy of the medical approach is preserved. Medical ideas about symptoms and treatment are readily drawn on. The men emphasise the need for information to aid them in conducting self-diagnosis and to aid early detection. However, as is evident in the individual interviews, the reliance on medical explanations does not preclude references to socio-structural considerations. While the men accept the benefits of early detection, they also propose that more needs to be done to help them help themselves. In the process they present themselves as being morally responsible by expressing a willingness to take ailments seriously and by calling for action (*cf.* Blaxter, 1997). However, they are hampered in addressing ailments due to a lack of support, and as a result responsibility for health problems is attributed elsewhere. References to socio-structural influences on men's willingness and ability to access care that are not covered in TTFTBL became more prominent as the discussion progresses. Participants are able to justify their own lack of awareness and reluctance to seek assistance through these means.

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In emphasising the need for more resources to be put into men's health, participants do not focus only on the need for education programmes. They also emphasise the need for increased access to quality medical care and refer to several barriers to men's accessing care that are not covered in TTFTBL, such as medical negligence and financial restraint. In the process, men's health is related to the social system and inequality. Social inequality is suggested even though it is not referred to in TTFTBL. Participants use references to a lack of support as a barrier to men's seeking assistance, in order to raise questions about the ideal image of medical care presented in TTFTBL and to make sense of their situations in life. This image is juxtaposed with participants' experiences of what happens when lower SES men do go to the doctor:

Nigel: *The only other sort of thing I was thinking of when I watched that programme and listening to you guys was like if you did go to the doctor even if it was for, you know, a common sort of a thing, when you're at the doctor getting your flu shot or whatever, you know, if they weren't so fucking lazy they might just ask you a few questions about it or maybe check you over while you are there.*

Ron: *Oh yeah, but you gotta pay.*

Nigel: *But they want to just, yeah, out the door you go, boof.*

Ron: *It's the fuckin' money, mate.*

Nigel: *Next, you know.*

Ron: *A production line.*

Nick: *That's it.*

Nigel: *Like the last time I had to go to a doctor he sort of was too busy wandering around and looking at other people and shit and he said, "Oh yeah". He took my temperature and shit and gave me some antibiotics which would have probably cured 90% of anything what I had. So I don't think he really went in and sort of figured out exactly what I had, just went, "This antibiotic will fix anyone of those. Away you go. Next".*

Nick: *Yeah, well, like he didn't. You'd be lucky if he spent three minutes poking me with anything. He didn't seem to spend a lot of time.*

Ron: *The other thing too is that you've got to have access for men.*

Nigel: *You know, you don't feel like you get your money's worth, eh.*

Nick: *Hours-wise, yeah.*

[...]

Ron: *A lot of men can't afford it so they'll wait until they've got three or four illnesses and then go in to the GP... Most people don't really give a shit about the common man, eh. It's up to each person individually to, you know. We've ascertained that the doctors don't really care unless you're paying for it. It's all right for Selwyn Togood and Storeman Norman [characters depicted in TTFTBL] and everybody else with a few bucks in their pocket, but I'm too busy paying for fuckin' underpants and other bills to go to the doctor. As we've said, 40 percent of our wage packet goes to the Government and that and I think they should institute a free health system or at least free checkups... You know, it needs the whole system to recognise that men have these crippling diseases.*

This extract also highlights the way points raised earlier in a discussion are often built upon as participants develop their views. Here participants describe barriers to care that are not examined in TTFTBL to justify men's reluctance to seek assistance and to preserve their own moral integrity. They propose that, due to the cost and inconvenience of seeking care, men accumulate ailments so that they can get several problems treated at once. This explanation presents an alternative to the emphasis given in TTFTBL on men leaving an ailment for too long because of their masculine attitudes. These participants draw on their group identity as working class men to inform their interpretations of depictions of medical practice (*cf.* Roscoe et al., 1995). TTFTBL's depiction of ideal medical consultations

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appears to encourage participants to draw on their own experiences, to question the validity of such images and, in some respects, doctors' motivation and altruism. However, the benefits of medical care, if properly administered, are taken for granted. Scepticism about the effectiveness of doctors and the quality of care is linked to the practice of medicine as a business, rather than the adequacy of the medical approach.

In sum, this discussion exemplifies the way participants initiate their explorations of various issues in a manner that reflects a programme's perspective. However, as the discussion develops, they introduce a number of additional considerations not explored in the programme and construct a wider frame of reference. The key here is that men's reluctance to seek care is presented as a response to social barriers, rather than solely as the product of masculine attitudes. Participants renegotiate the programme's proposition that men's health problems are due to masculine attitudes by focusing on additional considerations. As a result responsibility for men's failure to seek care is shifted from the individual to contextual influences. Participants fashion masculine self-images that preserve their moral integrity while shifting responsibility to social expectations, the lack of investment in men's health problems, some doctors' attitudes, and financial barriers to care.

9.3 Chapter Discussion

In exploring television reception, this analysis has highlighted the social origins of people's views. It has shown how these views are negotiated through group discussions as participants both voice opposing explanations and work together to make sense of various issues in a mutually supportive manner (*cf.* Billig, 1991, 1997b). This analysis has demonstrated that participants are highly skilled at navigating between various television-mediated and interpersonal sources of information and at using aspects of these to make sense of health, illness, and their own

place in the world. Participants move back and forth between their existing experiences, whether mediated via previous interactions with health coverage or taken from their own lifeworlds, points raised by other participants, and the evidence presented in the programme they have just watched when making sense of various issues.

As a central element of contemporary existence, health coverage provides ready-made stories that function as resources for participants to draw upon when making sense of wider social shifts and exploring options for action (*cf.* Billig, 1997a; Corner, 1999b). By relating the programmes to their own circumstances, participants add further context to various issues and extend the boundaries of their lived experience. A useful way of conceptualising this process is to propose that participants are not interpreting the programme they have just watched as such. Rather, they are exploring issues in relation to a programme's exposition and in relation to each other's views. In this way the research focus is shifted from the simple transmission of information to viewers through programmes to the ways in which issues are worked through in social interactions.

Participants are adept at making sense of often-abstract issues covered in health documentaries and grounding such issues within their own lifeworlds. However, to reiterate a point made throughout this thesis, this does not mean that health coverage has no influence over the scope and shape of participants' views (*cf.* Kitzinger, 1993). It simply implies that any specific interaction between a health documentary and an audience occurs within a continuing dialogue between previous viewing, the programme's perspective, a person's biography, and the views of other audience members. Kitzinger writes:

...it would be wrong to suggest that public understandings are a result of simply viewing a particular set of news reports or a specific programme, as if this occurred in isolation. Every media message interacts, both with the universe of

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other media messages and with the material and social realities of people's lives (1999, pp. 10-11).

Participants use what is made available within the programmes and additional explanations from a range of other sources to infer further connections between events depicted and their own lifeworlds (*cf.* Liebes & Katz, 1990; Philo, 1999; Richardson & Corner, 1986; Tulloch & Lupton, 1997). None of these health documentaries provides a complete account of a given health concern. However, they do provide a focus for the group discussions, from which participants often construct more socially critical accounts that raise a wider set of factors surrounding the issues explored in the programmes. Although influencing participants' interpretations through the framing of evidence, potential meanings are never fully set in a programme (*cf.* Fiske, 1989). Rather, as participants talk about aspects of a health documentary they produce an interpretation that is shared with other participants. The later may incorporate aspects of that interpretation as they construct their own interpretations, which in turn are interpreted by others and so on. At each stage a tangent may be started, new ideas incorporated and the discussion extended.

Any discussion of television's influence on the social construction of lay views is complicated by the fact that socio-cultural explanations and specific examples used by participants within a given discussion are not always distinct from those used in health coverage (*cf.* Lewis, 1991; Livingstone, 1998). For instance, at various points in the focus group discussions, participants voice criticisms of certain depictions. This occurs when the men in focus group four draw on their own experiences to question the positive image of doctors presented in TTFTBL. However, these experiences are not totally distinct from health coverage and are rendered meaningful in relation to previous coverage of medical misadventure that participants have already watched. Such discussions interweave aspects of a specific programme with personal experiences and

explanations derived from previous viewing (*cf.* Kitzinger, 1993). Referring to this process in relation to television generally, Livingstone writes:

Thus it may be more productive to regard the interaction between text and viewer not as a potential clash of knowledge (what the text 'tells us' versus what the viewer knows from elsewhere) but as a negotiation on the appropriate ways of knowing, for epistemological assumptions frame both images in the text and the relevance of viewers' daily experiences to the process of viewing (1999, p. 92).

Such processes bring into question the dichotomy between the explanations drawn on by health coverage and by viewers (*cf.* Hall, 1980). This dichotomy is based on the idea that viewers approach a programme with non-mediated explanations which are independent of health coverage and which they can draw upon to construct oppositional or resistive readings that undermine a programme's perspective (*cf.* Fiske, 1987). Prior knowledge of a topic is presented as enabling viewers to resist the impact of television and to criticise its handling of various issues (Corner & Richardson, 1986; Kitzinger, 1990). This dichotomy has shaped reception research and debate over the possible influence of prior experience and knowledge in the construction of oppositional readings and resistance to media effects. It has been useful in foregrounding the active nature of television viewing, but may no longer be sustainable (Livingstone, 1999).

The analysis presented in this chapter has focused on the processes through which health and illness are socially constructed and how aspects of health coverage are integrated within participants' views (*cf.* Billig, 1997a). It appears that health coverage may not have a direct effect, but it does exert a negotiated influence over the scope and shape of people's views (*cf.* Tulloch & Lupton, 1997). The notion of agenda-setting is supported by the finding that the health documentaries, individual accounts and focus group discussions all draw upon many of the same socio-cultural explanations (*cf.* Dearing & Rogers, 1996; Livingstone & Lunt, 1994;

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Morley, 1999). However, one needs to be careful in assuming a single direction from coverage to viewers (*cf.* Gerbner, 1997) when discussing such salience across forums. Coverage may reflect rather than simply cause 'structures of feeling' such as the pessimism reflected in the participants' discussions of the health reforms (Fiske, 1996). The health documentaries that participants watched were constructed within contemporary New Zealand society and reflect the political and historical agenda already in place (*cf.* Roscoe et al., 1995). As a result, the coverage provided by these programmes appears to re-circulate and amplify existing concerns, rather than to create new ones (*cf.* Gabe & Bury, 1996; Philo, 1999; Tulloch & Lupton, 1997). (Such processes are discussed further in the next chapter.)

To summarise, health coverage is an integrated component of everyday life both affected by and influencing the social construction of health and illness. Engaging with health coverage has become a primary way for people to relate their experiences to wider social concerns and assign meaning to health and illness. As a mediated cultural forum, health coverage helps set the agenda for what people discuss in everyday conversations and the explanations which are seen as pertinent to such discussions. Television viewing is an important event through which explanations are circulated in society, taken up by audience members, elaborated, and used as resources for making sense of health and illness. Yet coverage also draws on lay views that have been influenced by past interactions and as a result both influences and is influenced by public discussion.

Chapter Ten

General Discussion

Previous chapters have outlined the theoretical position adopted in this thesis and have presented substantial discussions linking specific findings to relevant literature. This chapter outlines some wider considerations in relation to the aims of the research and presents more general observations. A number of lessons have been learned from conducting this research. Such lessons and recommendations for future research are also discussed.

10.1 Some General Observations

Within contemporary society, the majority of people are either members of the television audience or regularly interact with television viewers. As a result of its reach throughout society, television health coverage functions as an institutionally mediated cultural forum that assists in the formation of shared ideas about health and illness. In light of the considerable public interest in health concerns and the corresponding media attention, my research into the scope and shape of health coverage and its influence on people's views on health and illness is timely.

Owing to the interdependence between programmes and viewers in the creation of meaning (Curran, 1996; Morley, 1999), this research needs to account for both the influence of health coverage and the relative autonomy of audience members. After all, rather than simply receiving messages, viewers make sense of programmes by negotiating interpretations within the context of their life circumstances, their biographies, the views of others, and the programme's perspective (*cf.*

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Livingstone, 1998). No one social science discipline provides all the necessary conceptual tools for exploring the social construction of people's views, the complexities of health coverage, the role of such coverage within everyday life, and the processes through which aspects of health coverage are integrated into people's views. In order to explore the interrelated nature of these topics and to account for the complexities involved, it was necessary to work eclectically, by drawing on theory and research from several disciplines.

For instance, recent work within health and social psychology provides a stance from which to conceptualise people's views as both socially and individually determined and to explore the interpersonal processes through which these views are constructed (e.g., Billig, 1991, 1997a; Radley, 1999; Stainton Rogers, 1991; Yardley, 1997). Insights from such research are drawn on in this project to inform an exploration of the ways people actively interpret the world and construct their views out of shared socio-structural explanations. Although such research is useful in theorising the social origins of people's views, it does not provide an adequate model of television viewing as an important process through which explanations are circulated in society, taken up by audience members, and used as resources for making sense of health and illness. Media studies theory and research provides insights for theorising the role of television in society and the ways health coverage is interpreted (e.g., Comer, 1995; Livingstone, 1998; Tulloch & Lupton, 1997).

The approach developed for this project reveals the collective ways that people understand health and illness and how these are circulated and renegotiated through the health communication process. As a result, previous research into the relationship between health coverage and the shape and focus of lay views (e.g., Brown et al., 1996; Gabe & Bury, 1996; Calnan & Williams, 1992) has also been extended. For instance, such

previous research goes some way to raising the importance of television health coverage by highlighting overlaps between the changing character of health coverage and the changing character of lay views. However, the interactive processes through which such overlaps are developed have not been adequately explored. Through the combination of research from various social science disciplines this project explores the complexities and contradictions involved in the social construction of people's views within interpersonal and television-mediated interactions. An analysis of health documentaries, individual interviews, and focus group discussions provides information on the complexities of health coverage, the richness of participants' existing views, and the processes through which participants draw on aspects of health coverage and other people's accounts to reconstruct their views on contemporary health concerns.

Analysis of the health documentaries reveals the ways health and illness are constructed on television. Generally, findings from this analysis support those of recent research which has shown that coverage maintains persistent faith in the medical profession despite the development of more complex and potentially critical images (e.g., Brown et al., 1996; Bury & Gabe, 1994; Calnan & Williams, 1992; Chapman & Lupton, 1994; Gabe & Bury, 1996;). My analysis indicates that, although health coverage draws upon multiple explanations to construct thematically complex expositions, there are constraining tendencies within coverage, including an over-reliance on medical and lifestyle explanations (*cf.* Ellis, 1999; Newcomb & Hirsch, 1984). Although socio-structural issues around inequality in access to medical care are raised, no adequate exploration of social inequality as a possible cause of the higher prevalence of illness among lower SES groups is provided within these programmes. Such trends highlight the institutionally constrained nature of health coverage as a cultural forum. However, although health coverage remains medicalized, the raising of socio-structural issues supports the proposition that it is changing to

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accommodate shifts in society and the redrawing of the traditional boundaries of the medical approach. Medicalization has evolved to accommodate an emphasis on prevention, lifestyle, holistic health (*cf.* Crawford, 1980, 1994; Elston, 1991), and equity in resource allocation. Such coverage demonstrates the way medical care can be placed within a socio-structural context while its legitimacy is preserved.

Analysis of the individual interviews reveals the types of assumptions participants draw upon when constructing health and illness. As a result it contributes to knowledge of the shape and focus of the views expressed by people of lower SES and of the influence of wider societal belief systems and values on the construction of these views (*cf.* Blaxter, 1990, 1993, 1997; Popay et al., 1998; Stainton Rogers, 1991; Williams & Calnan, 1996). Findings from the present project show that aspects of medical, lifestyle, and socio-structural explanations are evident when participants make sense of their own health, the health of others, and contemporary health concerns. However, participants do not simply revoice these explanations in predictable ways, but rather draw on them in often idiosyncratic as well as common ways. A key focus of this analysis was on the similarities and differences between the ways various health concerns are constructed in the participants' accounts and the health documentaries. Generally, as health researchers such as Brown and colleagues (1996), Bury and Gabe (1994), Lupton (1997) and Calnan & Williams (1992) have found, people's accounts tend to reflect trends in the construction of health concerns within health coverage. Although there are also some key differences, such as participants greater readiness to link health issues to wider social shifts and inequality, these differences reflect an extension of issues emphasised in health coverage rather than totally distinct topics of discussion. This analysis shows that participants draw upon many of the same explanations as health coverage. The processes through which such overlaps are established are explored in the focus group analysis.

Analysis of the focus group discussions explores the ways that participants interpret and evaluate health documentaries within the context of their own experiences and previous interactions with health coverage. This analysis shows how people's views are renegotiated through group discussions as participants work together to make sense of various issues pertaining to a programme's exposition. This analysis highlights how the meaning of health and illness is neither out there in society nor held solely within the individual. It is the product of social interactions within which people explore issues of concern by drawing on and reworking information from various mediated and interpersonal sources. When constructing their interpretations, participants present themselves as critical viewers who are well aware that these programmes are constructed to communicate a certain perspective on a topic. They draw on knowledge of socio-structural influences not included to identify limitations in that perspective. A common example is the citing of financial barriers to health to exemplify the limited focus of a programme. However, while participants are critical of the lack of focus on socio-structural issues within the programmes, they do not question many assumptions associated with the medical and lifestyle approaches (*cf.* Corner, 1995; Lewis, 1991). For instance, they often associate socio-structural issues with the need for access to medical interventions and lifestyle change.

The processes through which health and illness are socially constructed and the ways aspects of health coverage are integrated within participants' views are explored through these analyses. Health coverage appears to exert a negotiated influence on people's views. Many explanations permeating the health documentaries are also prevalent in the individual interviews and focus group discussions. The existence of these explanations in all three forums supports the idea that health coverage functions as a mediated cultural forum, both drawing on current

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constructions to reinforce and sustain current agendas and helping set new agendas for public discussion over time (*cf.* Dearing & Rogers, 1996; Farr, 1995; Lewis, 1991; Livingstone & Lunt, 1994; Morley, 1999). Although often neutralising critical questions, health coverage is socially valuable in raising a raft of issues and providing resources for viewers to make sense of various health concerns. Participants can exploit aspects of health coverage and extend its socially critical potential. For instance, as yet, health coverage may not adequately investigate issues around social inequality. However, it does place the issue of inequality in access to medical care on the public agenda. Such coverage appears to contribute to participants' willingness to talk not only about problems faced by people such as themselves in gaining access to medical care but also about wider issues around social inequality. In sum, analysis of the programmes, individual interviews, and focus group discussions indicates that health coverage provides symbolic resources for viewers to work through various health issues in relation to their own lifeworlds.

Such findings reflect the recent work of researchers such as Tulloch and Lupton (1997), and Philo (1999), who propose that health coverage functions as part of a mass communication circuit (*cf.* Fiske, 1996; McQuail, 1994). This circuit appears to draw upon, reframe, and recirculate shared explanations of health and illness. The complexity of constructions evident in health coverage both reflects and amplifies current shifts in society, including the changing relationship between lay people and the medical profession (*cf.* Elstad, 1998; Gabe & Bury, 1996; Lupton, 1997; Williams & Calnan, 1996). Within the health documentaries, individual interviews, and focus group discussions, the medical profession is still privileged as a source of expert knowledge and assistance. However, medical explanations are now also supplemented by an array of lifestyle and socio-structural explanations. The range of explanations drawn on within these forums, and overlaps in the use of these explanations across

them reflect current uncertainties about topics such as the provision of medical services and the cause of illness. Commenting on such uncertainty in television generally, Ellis writes:

This I believe to be television's distinctive contribution to the modern age – a relatively safe area in which uncertainty can be entertained (and can be entertaining). As our age is more uncertain than most – or at least more uncertain than that in which I grew up – it seems that television's contribution to our ability to live with uncertainty is crucial (1999, p. 64).

When working through health concerns raised within the programmes, participants are not preoccupied with establishing the exact cause of an ailment. They adopt a probabilistic stance and negotiate provisional views out of aspects of various explanations, which allows them to explore a range of possible contributing factors. Such trends reflect how people can be both reliant upon the medical approach, while also exploring other ways of making sense of illness and dealing with ailments (*cf.* Williams & Calnan, 1996).

To summarise, health researchers have repeatedly referred to the role of health coverage in the development of people's views of health and illness (e.g., Bury & Gabe, 1994; Calnan & Williams, 1992; Lupton, 1994; Parrott, 1996). Supporting the findings of previous research, my analyses indicate that such coverage helps set the public agenda for what are seen as important health concerns (*cf.* Gabe & Bury, 1996; Livingstone & Lunt, 1994; Wallack, 1990). Many of the explanations people draw on in constructing their views are circulated through television health coverage. However, the relationship between people's views and such coverage is complex. As an important influence within the context of people's lifeworlds, health coverage reflects, amplifies, and influences the construction of people's views on health and illness.

10.2 Implications for Research and Practice

Previous investigations of health communication have given considerable attention to public health campaigns (Parrott, 1996; Ratzan, 1998; Wyllie et al., 1997). However, the present study is important because people do not just construct their views on health and illness in relation to official campaigns. In particular, health documentaries provide explanations of the cause of illness and recommendations for action which have influenced the construction of people's views for generations. This project reflects efforts to look further afield by focusing on popular culture forms, which comprise an important part of the symbolic environment within which health promotion occurs (e.g., Brown et al., 1996; Bury & Gabe, 1994; Chapman & Lupton, 1994; Turow & Coe, 1985). Arguments developed throughout this research contribute to the development of a more adequate framework for understanding the health communication process than is often evident in health promotion initiatives. This framework moves beyond a preoccupation with finding the most effective means of communicating health information (*cf.* RUHBC, 1989) and is designed to guide explorations of the ways health coverage is made sense of within social interactions. The integration of programme, audience, and lay views theory and research is not relevant solely to the realm of popular culture. It should contribute to the refinement of health promotion initiatives because it provides a means of tracking the social reconstruction of health and illness across various cultural forums.

Findings from this project provide public health researchers and practitioners with insights into the shape and focus of health coverage; the health and illness explanations drawn on by people of lower SES; the types of interpretations that viewers construct; and the role of health communication in the social construction of health and illness. Analysis of the documentaries has highlighted the complex, changing, and institutionally restrained character of television coverage, in addition to the

processes through which health and illness images are circulated within society. The analysis of the participants' individual accounts has highlighted the common resources drawn on by people of lower SES and the ways health coverage is intertwined within their everyday lives. Additionally, the reception research has shown how television constructions are renegotiated as these people integrate aspects of health coverage into their own views.

The significance of this project also lies in its combination of a concern over growing health inequalities in New Zealand with a focus on health communication to investigate the ways that people of lower SES draw on their existing views when interpreting health coverage. In theorising a socially embedded audience, New Zealanders of lower SES, whose views on health and illness are renegotiated through interactions with health coverage and in showing how this occurs, this project is pertinent for health researchers working in the areas of health inequality and health promotion.

Findings reflecting the ways that people of lower SES make sense of health and illness and their material circumstances are extremely useful in light of the recent emphasis, within health research, that has been placed on the role of human thought as a moderating influence on the health consequences of material deprivation (*cf.* Popay et al., 1998; Wilkinson, 1996). This project is important because the implications of social inequality are not uniformly manifested and are associated with people's views on their situations. Research into the meanings people assign to their circumstances has been identified as a key component to developing knowledge of the relationship between social structures and health inequalities (Bolam et al., 1999; Popay et al., 1998). By linking people's views to various socio-cultural explanations and the stories circulated within society through health coverage, this research develops an understanding of the processes through which these views are produced

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and refined. As a result much-needed insights into the ways that people of lower SES make sense of inequality and related health concerns such as the health care reforms is provided. For instance, if the premise that people's views are important in moderating the impact of material life circumstances (Popay et al., 1998; Wilkinson, 1996) is accepted, then the level of pessimism expressed by participants in relation to their ability to live healthy lives and, if necessary access medical care is a worrying sign.

This project also reveals how the symbolic resources provided by health coverage are put to use by participants in ways that have implications for the focus of some public health campaigns. For instance, the lessons of health promotion appear to have been well learned. Participants know that they should lead a healthy lifestyle, including eating a balanced diet, taking regular exercise, and attending medical screenings. However, they generally do not lead such lifestyles and often cite a range of influences outside their control, such as a lack of resources and adverse life circumstances, when explaining why. Such findings highlight the ways that participants do not simply receive health messages, including those encouraging lifestyle change, but rather contextualise such messages within wider concerns about their situations in life. These findings further support calls for interventions aimed at reducing social inequalities, rather than solely encouraging individual behaviour change, as an appropriate means of addressing health inequalities (e.g., Howden-Chapman & Cram, 1998; Kieger et al., 1993; Lupton, 1994; O'Brien, 1994; Wallack, 1990; Wilkinson, 1996). Health coverage provides a useful forum for placing such initiatives more firmly on the public agenda and working through socially acceptable strategies for action.

When conducting this research I did not focus exclusively on developing a basis for persuading programme-makers to change the shape and scope of health coverage in order to address the omission of issues around social

inequality. Therefore, my findings may not be sufficiently compelling to fully support such an initiative. However, the research framework developed here could be used to gather additional evidence to support such efforts. This is not to propose that health researchers should try and dictate policy to journalists. Such media professionals would more than likely respond negatively to such initiatives. Cooperation between socially-orientated health researchers and journalists, both of whom have similar functions, such as acting as the critical consciousness of society and holding those in positions of power accountable, is needed. As Gripsrud writes, "...the most promising of strategies here is one which aims to forge some kind of alliance between the intellectuals within education and research, on the one hand, and the newer class of media intellectuals (journalists etc.), on the other, based on the commonalities of ethos..." (1999a, pp. 51-52). When attempting to work with journalists, we need to realise that, like much contemporary academic research, the products of journalists' labour are not influenced solely by professional norms. The increasingly market-orientated institutions within which journalists work can influence the shape and scope of the perspectives broadcast. However, these restraints can be used as a basis for positive collaboration between socially-orientated health researchers and journalists. Media researchers such as Leadbeater (1996) and Roscoe (in press) propose that a reduction in funding for detailed research means that journalists have to rely increasingly on official sources and melodramatic plot lines that juxtapose various points of view. If this is true then, by forging relationships with media professionals and making ourselves available to provide alternative viewpoints and to raise critical questions, we may have a bearing on the scope and focus of health coverage.

10.3 Moving On: Lessons Learned and Future Research

It should be acknowledged that the themes brought to prominence in the writing of this thesis were a product of my journey through the research

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process. For instance, guiding me through the initial design and data collection was the assumption that health coverage had one set of ideas that were then accepted, partially accepted or rejected by viewers, who drew on a separate set of ideas (*cf.* Hall, 1980). As the research progressed, I became increasingly aware that this was a difficult assumption to sustain because health coverage is a source of explanations from which people construct their views. Explanations evident within health coverage are reworked and integrated into the construction of people's views over time. Aspects of a programme watched last week become part of the symbolic resources a viewer draws on when interpreting a programme today. As a result more emphasis was placed on exploring the processes through which lay views were renegotiated within social interactions following television viewing. Health communication was explored as an interactive process, within which people draw on aspects of coverage to work through health concerns and to adjust their views accordingly.

Although this thesis presents an analysis of four health documentaries which fit the investigative report category, it is also informed by an engagement with a much larger set of programmes and styles. This larger corpus included 'Reality TV' shows such as *Hospital* and *Middlemore*, which function as real life medical soap operas celebrating the wonders of modern medicine through story lines played out over several weeks. These programmes were collected and preliminary analyses conducted on them. However, they were not drawn on in Chapter Seven due to practical restraints of time and space and the need to focus in adequate depth on the four programmes that the participants watched. The key point here is that the complexity of health documentary extends outside the points made in this thesis and should be explored further.

In hindsight, it would also have been useful to explore different audience groups' interpretations of the same programmes. This would have allowed the comparison of interpretations constructed across various demographic categories. However, I decided to explore general trends across several programmes. This decision was guided by the need to explore a few cases in order to gain some depth of analysis and to highlight general processes that could be explored further in future research.

It also needs to be emphasised that the interactions explored in this research are indicative of an ongoing societal dialogue out of which people's views on health and illness are formulated and revised. As part of everyday life, people interact with health coverage and one another and, in the process, draw on their evolving views to make sense of health and illness. Although such processes are theorised and explored, in part, within this thesis, it was impossible to capture them fully. Additional, larger scale research is needed to explore further the complexities involved in this ongoing dialogue and to develop further our understanding of the integration of health information, from a range of sources, within peoples' views. As part of such work, it would be interesting to trace the social negotiation of lay views over an extended period of time in relation to coverage of specific health concerns. Such future work would benefit from a design that allowed the construction of health concerns to be traced across a range of media forms (e.g., various television programmes, radio shows, and print stories). A longitudinal study might also collect responses from a range of audiences using various data collection techniques (e.g., semi-structured interviews, focus group discussions, diaries, audiotapes of talkback radio conversations, and ethnographic observations). Among other things, data obtained from these sources could be used in a complementary fashion to draw out additional complexities, including the construction of health and illness in 'naturally occurring' contexts such as talkback radio conversations. Briefly, future work could further elaborate

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findings from this thesis and explore the ways health coverage is socially negotiated across a range of media and audience forums.

To conclude, this research does not provide the definitive word on the health communication process. What it does is provide insights and conceptual tools for investigating the social construction of health and illness. It contributes to knowledge of the social mediation of lay views and the ways people come to know about medical procedures, their own place in the world, and a raft of health concerns through social interactions. This research has demonstrated that many of the symbolic resources from which people construct their accounts and identities are derived from sources other than face-to-face interactions. It has contributed to research on the social origins of the ideas shaping people's views by exploring the function of television-mediated stories in the social construction of health and illness.

References

- Abercrombie, N. (1996). *Television and society*. Cambridge, England: Polity Press.
- Abraham, C., & Hampson, S. E. (1996). A social cognition approach to health psychology: Philosophical and methodological issues. *Journal of Health Psychology, 11*, 223-241.
- Adorno, T. W., & Horkheimer, M. (1979). *Dialectic of enlightenment* (J. Cumming, Trans.). London: Verso.
- Althusser, L. (1971). *Lenin and philosophy and other essays* (B. Brewster, Trans.). New York: Monthly Review Press.
- Ang, I. (1985). *Watching Dallas: Soap opera and the melodramatic imagination*. London: Methuen.
- Ang, I. (1988). Understanding television audiencehood. In H. Newcomb (Ed.), *Television: The critical views* (5th ed., pp. 367-386). New York: Oxford University Press.
- Ang, I. (1990). *Desperately seeking the audience*. London: Routledge.
- Angus, I. (1994). Democracy and the constitution of audiences. In J. Cruz, & J. Lewis (Eds.), *Viewing, reading, listening: Audience and cultural reception* (pp. 233-252). Boulder, CO: Westview Press.
- Armstrong, D. (1993). From clinical gaze to regime of total health. In A. Beattie, M. Gott, L. Jones, & M. Sidell (Eds.), *Health and wellbeing: A reader* (pp. 55-67). London: Macmillan.
- Aron, D. (1998). Towards a link between production and reception in television documentary. *48th Annual Conference of the International Communication Association* (Mass Communication Division), July 20-24, Jerusalem, Israel.
- Ashton, T. (1995). From evolution to revolution: Restructuring the New Zealand health system. In D. Seedhouse (Ed.), *Reforming health care: The philosophical and practice of international health reform* (pp. 85-94). New York: John Wiley & Sons.

References

- Atkin, C. K. (1981). Mass communication research principles for health education. In M. Meyer (Ed.), *Health education by television and radio* (pp. 41-55). Munich: Saur.
- Atkin, C., & Wallack, L. (Eds.). (1990). *Mass communication and public health: Complexities and conflicts*. London: Sage.
- Auckland – New X-ray Machine. (1958). *Pictorial Parade*, New Zealand.
- Barnett, J. R., Barnett, P., & Kearns, R. A. (1998). Declining professional dominance?: Trends in the proletarianisation of primary care in New Zealand. *Social Science and Medicine*, 46, 193-207.
- Barsam, R. M. (1992). *Non-fiction film: A critical history (revised and expanded)*. Bloomington: Indiana University Press.
- Beaglehole, R., & Bonita, R. (1994). Cardiovascular diseases. In J. Spicer, A. Trlin, & J. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives* (pp. 55-66). Palmerston North, New Zealand: Dunmore Press.
- Beaglehole, R., & Bonita, R. (1997). *Public health at the crossroads: Achievements and prospects*. Cambridge, New York: Cambridge University Press
- Becker, H. (1993). Theory: The necessary evil. In D. J. Flinders, & G. E. Mills (Eds.), *Theory and concepts in qualitative research: Perspectives from the field* (pp. 218-229). New York: Teachers College Press.
- Bennett, P., & Murphy, S. (1997). *Psychology and health promotion*. Buckingham, England: Open University Press.
- Berg, B. L. (1995). *Qualitative research methods for the social sciences* (2nd ed.). Boston: Allyn & Bacon.
- Berger, P., & Luckman, T. (1967). *The social construction of reality*. Harmondsworth: Penguin.
- Berliner, H. S., & Salmon, J. W. (1980). The holistic alternative to scientific medicine: History and analysis. *International Journal of Health Services*, 10, 133-147.
- Bhaskar, R. (1989). *Reclaiming reality: A critical introduction to contemporary philosophy*. London: Verso.

- Big Crowd Supports Fight for Hospital. (1995, May 8). *New Zealand Herald*, p. 14.
- Billig, M. (1991). *Ideology and opinions: Studies in rhetorical psychology*. London: Sage.
- Billig, M. (1997a). From codes to utterances: Cultural studies, discourse and psychology. In M. Ferguson, & P. Golding (Eds.), *Cultural studies in question* (pp. 205-226). London: Sage.
- Billig, M. (1997b). Discursive, rhetorical, and ideological messages. In C. McGarty, & S. A. Haslam (Eds.), *The message of social psychology: Perspectives on mind in society* (pp. 37-53). Oxford: Blackwell.
- Biocca, F. (Ed.). (1991). *Television and political advertising: Value / psychological processes*. Hillsdale, NJ: Erlbaum Associates.
- Blaxter, M. (1990). *Health and lifestyles*. London: Routledge.
- Blaxter, M. (1993). Why do the victims blame themselves? In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 124-142). London: Routledge.
- Blaxter, M. (1997). Whose fault is it? People's own conceptions of the reasons for health inequalities. *Social Science and Medicine*, 44, 747-756.
- Blaxter, M., & Paterson, E. (1982). *Mothers and daughters*. London: Heinemann Educational Books.
- Bolam, B. L., Murphy, S., Gleeson, K., & Hodgetts, D. (1999). Conceptualising structural and behavioural explanations of health inequalities: The role of lay accounts. *Reconstructing Health Psychology: Critical and Qualitative Approaches*, 29-31 July 1999, St Johns, Newfoundland, Canada.
- Bondebjerg, I. (1996). Public discourse / private fascination: Hybridization in 'true-life-story' genres. *Media, Culture and Society*, 18, 27-45.
- Bordwell, D. (1989). Historical poetics of cinema. In R. B. Palmer (Ed.), *The Cinematic text: Methods and approaches* (pp. 369-398). New York: AMS Press.
- Bordwell, D. (1996). Contemporary film studies and the vicissitudes of grand theory. In D. Bordwell, & N. Carroll (Eds.), *Post-theory: Reconstructing film studies* (pp. 3-36). Madison: University of Wisconsin Press.

References

- Bordwell, D., & Thompson, K. (1997). *Film art: An introduction* (5th ed.). New York: McGraw-Hill.
- Bourdieu, P. (1984). *Distinction: A social critique of the judgment of taste* (R. Nice, Trans.). Cambridge, MA: Harvard University Press.
- Bowie, R. (1992). Uncovering the health expenditure myth. In L. Keene (Ed.), *Health reforms a second opinion* (p. 10). Wellington, New Zealand: Wellington Health Action Committee.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Brown, J., Chapman, S., & Lupton, D. (1996). Infinitesimal risk as public health crisis: News media coverage of a doctor-patient HIV contact tracing investigation. *Social Science and Medicine*, 43, 1685-1695.
- Brunsdon, C., & Morley, D. (1978). *Everyday television: 'Nationwide'*. London: British Film Institute.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Bury, M. (1997). *Health and illness in a changing society*. New York: Routledge.
- Bury, M., & Gabe, J. (1990). Hooked? Media responses to tranquillizer dependence. In P. Abbott, & G. Payne (Eds.), *New directions in the sociology of health* (Exploration in Sociology, 36, pp. 87-103). London: Falmer Press.
- Bury, M., & Gabe, J. (1994). Television and medicine: Medical dominance or trial by media? In J. Gabe, D. Kelleher, & G. Williams (Eds.), *Challenging Medicine* (pp. 65-83). London: Routledge.
- Busse, E. W. (1989). The myth, history, and science of aging. In E. W. Busse (Ed.), *Geriatric psychiatry* (pp. 3-34). Washington D.C., WA: American Psychiatric Press.
- Calnan, M. (1987). *Health and illness: The lay perspective*. London: Tavistock.
- Calnan, M., & Williams, S. (1992). Images of scientific medicine. *Sociology of Health and Illness*, 14, 232-254.
- Campbell, R. (1991). *60 minutes and the news: A mythology for middle America*. Urbana, IL: University of Illinois Press.

- Carey, J. W. (1975). Communication and Culture. *Communication Research*, 2, 173-191.
- Carroll, N. (1996). Nonfiction film and postmodern. In D. Bordwell, & N. Carroll (Eds.), *Introduction post-theory: Reconstructing film studies* (pp. 37-68). Madison: University of Wisconsin Press.
- Carroll, D., Bennett, P., & Smith, G. D. (1993). Socio-economic health inequalities: Their origins and implications. *Psychology and Health*, 8, 295-316.
- Cartwright, F. F. (1968). *The development of modern surgery*. New York: T. Y. Crowell Company.
- Catterall, M., & Maclaran, P. (1997). Focus group data and qualitative analysis of programs: Coding the moving picture as well as the snapshots. *Sociological Research Online*, 2 (1), <http://www.socresonline.org.uk/socresonline/2/1/6.html>, 22 March 1998.
- Chamberlain, K. (1997). Socio-economic health differentials: From structure to experience. *Journal of Health Psychology: An Interdisciplinary, International Journal*, 2, 399-411.
- Chapman, S., & Lupton, D. (1994). Freaks, moral tales and medical marvels: Health and medical stories on Australian television. *Media Information Australia*, 72, 94-103.
- Cheyne, C., O'Brien, M., & Belgrave, M. (1997). *Social policy in Aotearoa New Zealand: A critical introduction*. Auckland, New Zealand: Oxford University Press.
- Chisholm, B. (1991). Difficult viewing: The pleasures of complex screen narratives. *Critical Studies in Mass Communication*, 8, 389-403.
- Clarke, J. (1991). Media portrayal of disease from the medial, political economy, and lifestyle perspectives. *Qualitative Health Research*, 1, 287-308.
- Clarke, J., & Robinson, J. (1999). Testicular cancer: Medicine and machismo in the media (1980-1994). *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 3, 263-282.
- Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. London: Sage.

References

- Comstock, G., Chaffee, S., Katzman, N., McCombs, M., & Roberts, D. (1978). *Television and human behavior*. New York: Columbia University Press.
- Conrad, P., & Schneider, J. W. (1980). Looking at levels of medicalization: A comment on Strong's critique of the thesis of medical imperialism. *Social Science and Medicine*, 14A, 75-79.
- Corner, J. (1995). *Television form and public address*. London: Edward Arnold.
- Corner, J. (1996). *The art of record: A critical introduction to documentary*. Manchester: Manchester University Press.
- Corner, J. (1997). Television in theory. *Media, Culture and Society*, 19, 247-262.
- Corner, J. (1999a). Documentary: The transformation of a social aesthetic. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 173-184). London: Routledge.
- Corner, J. (1999b). *Critical ideas in television studies*. Oxford: Clarendon Press.
- Corner, J., & Richardson, K. (1986). Documentary meanings and the discourse of interpretation. In J. Corner (Ed.), *Documentary and the mass media* (pp. 141-160) (Stratford-Upon-Avon Studies, 2nd Series). London: Edward Arnold.
- Corner, J., Richardson, K., & Fenton, N. (1990). *Nuclear reactions: Forms and response in 'public issue' television*. London: John Libbey.
- Comwell, J. (1984). *Hard-earned lives: Accounts of health and illness from East London*. London: Tavistock.
- Coward, R. (1993). The myth of alternative health. In A. Beattie, M. Gott, L. Jones, & M. Sidell (Eds.), *Health and wellbeing: A reader* (pp. 94-101). London: Macmillan.
- Crawford, R. (1977). You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services*, 7, 663-680.
- Crawford, (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 19, 365-388.

- Crawford, R. (1984). A cultural account of "health": Control, release and the social body. In J. B. McKinlay (Ed.), *Issues in the political economy of health care* (pp. 60-103). London: Tavistock.
- Crawford, R. (1994). The boundaries of the self and the unhealthy other: Reflections on health, culture and AIDS. *Social Science and Medicine*, 38, 1347-1365.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW, Australia: Allen & Unwin.
- Cruz, J., & Lewis, J. (1994), Introduction. In J. Cruz, & J. Lewis (Eds.). (1994). *Viewing, reading, listening: Audience and cultural reception* (pp. 1-18). Boulder, CO: Westview Press.
- Curran, J. (1990). The new revisionism in mass communication research: A reappraisal. *European Journal of Communication*, 5, 135-164.
- Curran, J. (1996). Rethinking mass communications. In J. Curran, D. Morley, & V. Walkerdine (Eds.), *Cultural studies and communications* (pp. 119-165). London: Arnold.
- Curtis, S., & Taket, A. (1996). *Health and society: Changing perspectives*. London: Arnold.
- Davey Smith, G., & Morris, J. (1994). Increasing inequalities in the health of the nation, *British Medical Journal*, 309, 1453-1454.
- Davis, A., & George, J. (1988). *States of health: Health and illness in Australia*. Sydney, NSW, Australia: Harper & Row.
- Davis, P., Howden-Chapman, P., & McLeod, K. (1996). The New Zealand socioeconomic index: A Census-based occupational scale of socioeconomic status. In P. Crampton, & P. Howden-Chapman (Eds.), *Socioeconomic inequalities and health: Proceedings of the socioeconomic inequalities and health conference* (pp. 131-148), Wellington, 9-10 December, 1996.
- Davis, R. H., & Davis, J. A. (1985). *TV'S images of the elderly: A practical guide for change*. MA: Lexington Books.
- Davison, C., Frankel, S., & Smith, G. D. (1992). The limits of lifestyle: Re-assessing 'fatalism' in the popular culture of illness prevention. *Social Science and Medicine*, 34, 675-685.

References

- Dayan, D., & Katz, E. (1992). *Media events: The live broadcasting history*. Cambridge, MA: Harvard University Press.
- Dearing, J. W., & Rogers, E. M. (1996). *Agenda-setting*. Thousand Oaks, CA: Sage.
- Desbarats, P. (1994). The media and the dissemination of research. In E. V. Dunn, P. G. Norton, M. Stewart, & F. Tudiver (Eds.), *Disseminating research: Changing practice* (pp. 76-86). Thousand Oaks, CA: Sage.
- Durie, M. (1985). A Maori perspective of health. *Social Science and Medicine*, 20, 483-485.
- Durie, M. (1995). *Diverse Maori realities*. Wellington, New Zealand: Ministry of Health.
- Easton, B. (1994). 'How did the health reforms blitzkrieg fail?'. *Political Science*, 46, 215-233.
- Edwards, D., & Potter, J. (1992). *Discursive Psychology*. London: Sage.
- Elliott, P. (1974). Uses and gratifications research: A critique and sociological alternative. In J. G. Blumler, & E. Katz (Eds.), *The uses of mass communication: Current perspectives on gratifications research* (pp. 248-268). Beverly Hills, CA: Sage.
- Ellis, J. C. (1989). *The documentary idea: A critical history of English-language documentary film and video*. Englewood Cliffs, NJ: Prentice Hall.
- Ellis, J. (1999). Television as working-through. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 55-70). London: Routledge.
- Elstad, J. I. (1998). The psycho-social perspective on social inequalities in health. In M. Bartley, D. Blane, & G. Davey Smith (Eds.), *The sociology of health inequalities* (pp. 39-58). Oxford: Blackwell.
- Elston, M.A. (1991). The politics of professional power: Medicine in the changing health services. In J. Gabe, M. Calnan, & M. Bury (Eds.), *The sociology of the health service* (pp. 58-59). London: Routledge.
- Engels, F. (1844). Health: 1844. In B. Davey, A. Gray, & C. Seale (Eds.), *Health and disease: A reader* (2nd ed., pp. 129-134). Buckingham, England: Open University Press.

- Engels, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129-136.
- Enough to Make You Sick. (1995, 29 March). *Inside New Zealand*, Television Three, New Zealand.
- Entman, R. M. (1993). Framing: Toward clarification of a fractured paradigm. *Journal of Communication*, 43, 51-58.
- Farr, R. M. (1995). Representations of health, illness and handicap in the mass media of communication: A theoretical overview. In I. Markova, & R. M. Farr (Eds.), *Representations of health, illness and handicap* (pp. 3-30). Singapore: Harwood Academic.
- Farr, R. M. (1996). *The roots of modern social psychology*. Oxford, United Kingdom: Blackwell.
- Farr, R. M., & Markova, L. (1995). Professional and lay representations of health, illness and handicap: A theoretical overview. In I. Markova, & R. M. Farr (Eds.), *Representations of health, illness and handicap* (pp. 93-110). Singapore: Harwood Academic.
- Featherstone, M. (1987). Leisure, symbolic power and the life course. In J. Home, D. Jary, & A. Tomlinson (Eds.), *Sports, leisure and social relations* (pp. 113-138). London: Routledge.
- Finlayson, M. (1996). *An analysis of the implementation of health policy in New Zealand 1991-1996*. Unpublished doctoral thesis. Department of Social Policy, University of Waikato, Hamilton, New Zealand.
- Fiske, J. (1987). *Television culture*. London: Methuen.
- Fiske, J. (1989). *Understanding popular culture*. London: Routledge.
- Fiske, J. (1993). *Power plays power works*. London: Verso.
- Fiske, J. (1994). Audiencing: Cultural practice and cultural studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 189-199). London: Sage.
- Fiske, J. (1996). *Media matters: Race and gender in US politics* (Rev. ed.). Minneapolis, MN: University of Minnesota Press.
- Fougere, G. (1994). The state and health-care reform. In A. Sharp (Ed.), *Leap into the dark: The changing role of the state in New Zealand since 1984* (pp. 107-124). Auckland, New Zealand: Auckland University Press.

References

- Fox, N, J. (1993). *Postmodernism, sociology and health*. Buckingham, England: Open University Press.
- Fry, M. (1996). *A servant to many masters: A history of the national film unit*. Unpublished masters thesis. Department of History, Victoria University. Wellington, New Zealand.
- Gabe, J., & Bury, M. (1996). Risking tranquillizer use: Cultural and lay dimensions. In S. J. Williams & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences* (pp. 74-93). London: UCL Press.
- Gerbner, G. (1997). Gender and age in prime-time television. In S. Kirschner, & D. A. Kirschner (Eds.), *Perspectives on psychology and the media* (pp. 69-94). Washington D.C., WA: American Psychological Society.
- Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1986). Living with television: The dynamics of the cultivation process. In J. Bryant, & D. Zillmann (Eds.), *Perspectives on media effects* (pp. 17-40). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Gergen, K. J. (1976). Social psychology as history. *Journal of Personality and Social Psychology*, 26, 309-320.
- Gergen, K. J. (1982). *Toward transformation in social knowledge*. New York: Springer.
- Gergen, K. J. (1985). The social construction movement in modern psychology. *American Psychologist*, 40, 266-275.
- Gergen, K. J. (1997). Social psychology and social constructs: The emerging vision. In G. McGarty, & S. A. Haslam (Eds.), *The message of social psychology: Perspectives on mind in society* (pp. 113-128). Oxford: Blackwell.
- Giddens, A. (1991). *Modernity and self-identity*. Cambridge, England: Polity Press.
- Giddens, A. (1994). *Beyond left and right*. Cambridge, England: Polity Press.
- Glassner, B. (1989). Fitness and the postmodern self. *Journal of Health and Social Behaviour*, 30, 180-191.

- Golden Oldies. (1996, 10 October). *Assignment*. Television One, New Zealand.
- Gray, A. (1992). Good health care is everybody's business. In L. Keene (Ed.), *Health reforms a second opinion* (p. 12). Wellington, New Zealand: Wellington Health Action Committee.
- Greco, M. (1993). Psychosomatic subjects and the 'duty to be well': Personal agency within medical rationality. *Economy and Society*, 22, 357-372.
- Grey Power to Protest Against Health Reforms. (1996, February 8). *Dominion*, p. 2.
- Gripsrud, J. (1999). Scholars, journalism, television: Notes on some conditions for mediation and intervention. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 34-52). London: Routledge.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). London: Sage.
- Hall, S. (1980). Encoding and decoding. In S. Hall, D. Hobson, A. Lowe, & P. Willis (Eds.), *Culture, media, language* (pp. 128-138). London: Hutchinson.
- Hall, S. (1994). Reflections upon the Encoding/Decoding Model: An interview with Stuart Hall. In J. Cruz, & J. Lewis (Eds.), *Viewing, reading, listening: Audience and cultural reception* (pp. 233-252). Boulder, CO: Westview Press.
- Harper, D.J. (1996). Accounting for poverty: From attribution to discourse. *Journal of Community and Applied Psychology*, 6, 249-265.
- Harré, R. (1979). *Social being: A theory of social psychology*. Oxford: Blackwell.
- Harré, R. (1997). An outline of the main methods of social psychology. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 17-37). East Sussex, United Kingdom: Psychology Press.
- Harris, R. J. (1994). *A cognitive psychology of mass communication* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

References

- Haworth, N. (1994). Neo-liberalism, economic internationalization and the contemporary state in New Zealand. In A. Sharp (Ed.), *Leap into the dark: The changing role of the state in New Zealand since 1984* (pp 19-40). Auckland, New Zealand: Auckland University Press.
- Hay, I. (1989). *The caring commodity: The provision of health care in New Zealand*. Auckland, New Zealand: Oxford University Press.
- Health and Wealth. (1996, 12 September). *Assignment*. Television One, New Zealand.
- Herman, E., & Chomsky, N. (1988). *Manufacturing consent: The political economy of mass media* (1st ed.). New York: Pantheon Books.
- Herzlich, C. (1973). *Health and illness*. London: Academic Press.
- Herzlich, C., & Pierret, J. (1987). *Illness and self in society* (E. Forster, Trans.). Baltimore, MB: John Hopkins University Press.
- Hospital*. (1997, 29 January to 16 April). Television Three, New Zealand.
- Howden-Chapman, P., & Cram, F. (1998). *Social, economic and cultural determinants of health* (Background paper No. 1). National Health Committee: Health Determinants Programme.
- Hunter, D. J. (1994). From tribalism to corporatism: The managerial challenge to medical dominance. In J. Gabe, D. Kelleher, & G. Williams (Eds.), *Challenging medicine* (pp. 1-22). London: Routledge.
- Inkster, W. (1996). Confronting the mythology of public perceptions about our health system. *Health Manager*, 3, 15-17.
- Jacobs, L. (Ed.). (1979). *The documentary tradition* (2nd ed.). New York: W.W. Norton.
- Jensen, K. B. (1988). News as social resource: A qualitative empirical study of the reception of Danish television news. *European Journal of Communication*, 3, 275-301.
- Juhasz, A. (1993). Knowing AIDS through the televised science documentary. In C. Squire (Ed.), *Women and AIDS: Psychological perspectives* (pp. 150-164). London: Sage.
- Kalisch, P. A. (1983). *Images of nurses on television*. New York: Springer Publishing.

- Karpf, A. (1988). *Doctoring the media*. London: Routledge.
- Katz, E. (1959). Mass communications research and the study of popular culture. *Studies in Public Communication*, 2, 1-6.
- Katz, E., Blumler, J., & Gurevitch, M. (1974). Utilisation of mass communication by the individual. In J. Blumler, & E. Katz (Eds.), *The uses of mass communications: Current perspectives on gratifications research* (pp. 19-32). London: Sage.
- Katz, E., & Lazarsfeld, P. (1955). *Personal influence*. Glencoe, IL: Free Press.
- Kearns, R., & Barnett, J. R. (1997). Consumerist ideology and the symbolic landscapes of private medicine. *Health and Place*, 3, 171-180.
- Kelleher, D., Gabe, J., & Williams, G. (1994). Understanding medical dominance in the modern world. In J. Gabe, D. Kelleher, & G. Williams (Eds.), *Challenging medicine* (pp. xi-xxix). London: Routledge.
- Kelsey, J. (1995). *The New Zealand experiment: A world model for structural adjustment*. Auckland, New Zealand: Auckland University Press.
- Kieger, N., Rowley, D. L., Herman, A. A., Avery, B. A., & Phillips, M. T. (1993). Racism, sexism, and social class: Implications for studies of health, disease, and well-being. *American Journal of Preventative Medicine*, 9, 82-122.
- Kilbom, R. (1996). New contexts for documentary production in Britain. *Media, Culture and Society*, 18, 141-150.
- Kirkwood, W. G., & Brown, D. (1995). Public communication about the causes of disease: The rhetoric of responsibility. *Journal of Communication*, 45, 55-76.
- Kitzinger, J. (1990). Audience understandings of AIDS media messages: A discussion of methods. *Sociology of Health and Illness*, 12, 319-335.
- Kitzinger, J. (1993). Understanding AIDS: Researching audience perceptions of acquired immune deficiency syndrome. In J. Eldridge (Ed.), *Getting the message: News, truth and power* (pp. 271-304). London: Routledge.

References

- Kitzinger, J. (1995). The face of AIDS. In I. Markova, & R. M. Farr (Eds.), *Representations of health, illness and handicap* (pp. 49-66). Singapore: Harwood Academic.
- Kitzinger, J. (1999). A sociology of media power: Key issues in audience reception research. In G. Philo (Ed.), *Message received: Glasgow media group research 1993-1998* (pp. 3-20). New York: Longman.
- Krueger, R. A. (1988). *Focus groups: A practical guide for applied research*. London: Sage.
- Laugesen, M., & Salmond, G. (1994). New Zealand health care: A background. In G. Salmond, G. Mooney, & M. Laugesen (Eds.), *Health Policy* (Vol. 29, Special issue: Health care reform in New Zealand) (pp. 11-23). Ireland: Elsevier.
- Leadbeater, C. (1997). Panordrama (BBC's current affairs programme, Panorama). *New Statesman*, 126, 28-29.
- Lembo, R. (1994). Is there culture after cultural studies? In J. Cruz, & J. Lewis (Eds.), *Viewing, reading, listening: Audience and cultural reception* (pp. 33-54). Boulder, CO: Westview Press.
- Lewis, J. (1991). *The ideological octopus: An exploration of television and its audience*. New York: Routledge.
- Liebes, T., & Katz, E. (1990). *The exporting of meaning: Cross-cultural readings of Dallas*. New York: Oxford University Press.
- Lievrouw, L. A. (1994). Health communication research reconsidered: Reading the signs. *Journal of Communication*, 44, 90-99.
- Livingstone, S. M. (1990). *Making sense of television: The psychology of audience interpretation* (1st ed.). Oxford, England: Pergamon Press.
- Livingstone, S. M. (1993). The rise and fall of audience research: An old story with a new ending. *Journal of Communication*, 43, 5-12.
- Livingstone, S. (1998). *Making sense of television: The psychology of audience interpretation* (2nd ed.). New York: Routledge.
- Livingstone, S. (1999). Mediated knowledge: Recognition of the familiar, discovery of the new. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 91-107). London: Routledge.
- Livingstone, S., & Lunt, P. (1994). *Talk on television: Audience participation and public debate*. London: Routledge.

- Loewy, E. H. (1995). Of markets, technology, patients and profits. In D. Seedhouse (Ed.), *Reforming health care: The philosophical and practice of international health reform* (pp. 149-160). Chichester: John Wiley & Sons.
- Lost Youth Lost Hope. (1995, 17 August). *Assignment*, Television One, New Zealand.
- Lull, J. (1990). *Inside family viewing: Ethnographic research on television's audiences*. London: Routledge.
- Lupton, D. (1994). *Medicine as culture: Illness, disease and the body in western societies*. London: Sage.
- Lupton, D. (1995). *The imperative of health: Public health and the regulated body*. London: Sage.
- Lupton, D. (1997). Consumerism, reflexivity and the medical encounter. *Social Science and Medicine*, 45, 373-381.
- Macintyre, C. (1997). The Black Report and beyond what are the issues? *Social Science and Medicine*, 44, 723-745.
- Malcolm, L. (1996). Inequalities in access to and utilisation of primary medical care services for Maori and low income New Zealanders. *New Zealand Medical Journal*, 109, 356-358.
- Malcolm, L., & Barnett, P. (1994). New Zealand providers in an emerging market. In G. Salmond, G. Mooney, & M. Laugesen (Eds.), *Health Policy* (Vol. 29, Special issue: Health care reform in New Zealand) (pp. 85-100). Ireland: Elsevier.
- Martin, J. (1994). The role of the state in administration. In Sharp, A. (Ed.), *Leap into the dark: The changing role of the state in New Zealand since 1984* (pp. 41-67). Auckland, New Zealand: Auckland University Press.
- Martin, J., & Thompson, J. (1997). Between scientism and relativism: Phenomenology, hermeneutics and the new realism in psychology. *Theory and Psychology*, 7, 629-652.
- Mathieson, C.M. (1999) Interviewing the ill and the healthy. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 117-132). London: Sage.
- McCombs, M. E., & Shaw, D. L. (1972). The agenda-setting function of the press. *Public Opinion Quarterly*, 36, 176-187.

References

- McGee, R., & Elwood, M. (1994). Cancer. In J. Spicer, A. Trlin, & J. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives* (pp. 67-82). Palmerston North, New Zealand: Dunmore Press.
- McQuail, D. (1991). Reflections on uses and gratifications research. In R. K. Avery, & D. Eason (Eds.), *Critical perspectives on media and society* (pp. 9-27). London: Guilford.
- McQuail, D. (1994). *Mass communication theory: An introduction* (3rd ed.). London: Sage.
- Mechanic, D. (1995). Emerging trends in the application of the social sciences to health and medicine. *Social Science and Medicine*, 40, 1491-1496.
- Medhurst, M. J. (1989). Propaganda techniques in documentary film and television: AIM vs. PBS. In G. Burns, & R. J. Thompson (Eds.), *Television studies: Textual analysis* (pp. 183-204). New York: Praeger.
- Medical Practitioners Act. (1867). *New Zealand Statutes 1867* (p. 407). Wellington, New Zealand: New Zealand Government Print.
- Middlemore*. (1997, 6 February to 31 July). Television Two, New Zealand.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Mooney, G., & Salmond, G. (1994). A reflection on the New Zealand health care reforms. In G. Salmond, G. Mooney, & M. Laugesen (Eds.), *Health Policy* (Vol. 29, Special issue: Health care reform in New Zealand) (pp. 173-182). Ireland: Elsevier.
- Morgan, M. (1989). Television and democracy. In I. Angus, & S. Jhally (Eds.), *Cultural politics in contemporary America* (pp. 240-253). New York: Routledge.
- Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed., Vol. 16). Thousand Oaks, CA: Sage.
- Morley, D. (1980). *The 'Nationwide' audience: Structure and decoding*. London: British Film Institute.
- Morley, D. (1981). *Family television: Cultural power and domestic leisure*. London: Comedia.

- Morley, D. (1983). Cultural transformations: The politics of resistance. In H. Davis, & P. Walton (Eds.), *Language, image, media* (pp. 104-117). Oxford: Blackwell.
- Morley, D. (1986). *Family television: Cultural power and domestic leisure*. London: Comedia.
- Morley, D. (1991). 'Changing paradigms in audience studies'. In E. Seiter, H. Borchers, G. Kreutzner, & E. Warth (Eds.), *Remote control: Television, audience, and cultural power* (pp. 16-43). London: Routledge.
- Morley, D. (1992). *Television audience and cultural studies*. London: Routledge.
- Morley, D. (1993). Active audience theory: Pendulums and pitfalls. *Journal of Communication*, 43, 13-19.
- Morley, D. (1996). Populism, revisionism and the 'new' audience research. In J. Curran, D. Morley, & V. Walkerdine (Eds.), *Cultural studies and communications* (pp. 279-293). London: Arnold.
- Morley, D. (1997). Theoretical orthodoxies: Textualism, constructivism and the 'new ethnography' in cultural studies. In M. Ferguson, & P. Golding (Eds.), *Cultural studies in question* (pp. 121-137). London: Sage.
- Morley, D. (1998). So-called cultural studies: Dead ends and reinvented wheels. *Cultural Studies*, 12, 476-497.
- Morley, D. (1999). Finding out about the world from television news. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 136-158). London: Routledge.
- Morse, J. M. (1994). "Emerging from the data": The cognitive processes of analysis of qualitative inquiry. In D. S. Foster (Ed.), *Critical issues in qualitative research methods* (pp. 23-43). Thousand Oaks, CA: Sage.
- Moscovici, S. (1994). Social representations and pragmatic communication. *Social Science Information*, 33, 163-177.
- Muller, J. H., & Koenig, B. A. (1988). On the boundary of life and death: The definition of dying by medical residents. In M. Lock, & E. Gordon (Eds.), *Biomedicine examined* (pp. 351-374). Dordrecht: Kluwer Academic.

References

- Murdock, G. (1999). Rights and reservations: Public discourse and cultural citizenship. In J. Gripsrud (Ed.), *Television and common knowledge* (pp. 7-17). London: Routledge.
- National Health Advisory Committee on Health and Disability. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington, New Zealand: National Advisory Committee on Health and Disability.
- Newcomb, H. (1984). On the dialogic aspects of mass communication. *Critical Studies in Mass Communication*, 1, 34-50.
- Newcomb, H. M. (1988). One night of prime time: An analysis of television's multiple voices. In J. W. Carey (Ed.), *Media, myths, and narratives: Television and the press* (Vol. 15, Sage annual reviews of communication research, pp. 88-112). London: Sage.
- Newcomb, H. (1994). Television and the present climate of criticism. In H. Newcomb (Ed.), *Television: The critical views* (5th ed., pp. 3-13). New York: Oxford University Press.
- Newcomb, H., & Hirsch, P. (1984). Television as a cultural forum: Implications for research. In W. D. Rowland, & B. Watkins (Eds.), *Interpreting television: Current research perspectives* (pp. 58-73). Beverly Hills, CA: Sage.
- Nichols, B. (1988). The voice of documentary. In A. Rosenthal (Ed.), *New challenges for documentary* (pp. 48-63). Berkeley, CA: University of California Press.
- Nichols, B. (1991). *Representing reality: Issues and concepts in documentary*. Bloomington, IN: Indiana University Press.
- Nichols, B. (1994). *Blurred boundaries: Questions of meaning in contemporary culture*. Bloomington, In: Indiana University Press.
- Nightingale, V. (1996). *Studying audiences: The shock of the real*. London: Routledge.
- Novak, M. (1997). *Issues in aging: An introduction to gerontology*. New York: Longman.
- O'Brien, M. (1994). The managed heart revisited: Health and social control. *The Sociological Review*, 42, 393-413.
- Operating at Risk. (1995, 15 June). *Assignment*, Television One, New Zealand.

- Parker, I. (1989). *The crisis in modern social psychology and how to end it*. London: Routledge.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Parker, I. (1997). Discursive psychology. In D. Fox, & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 284-298). London: Sage.
- Parkin, F. (1971). *Class inequality and political order: Social stratification in capitalist and communist societies*. New York: Praeger.
- Parrott, R. (1996). Advocate or adversary?: The self-reflexive roles of media messages for health. *Critical Studies in Mass Communication*, 13, 266-278.
- Paul, C. (1999). Changes in health: What role for society. In *A decade of change: Consequences for health* (Health Research Council Conference Report, pp. 8-12). Auckland, New Zealand: Health Research Council of New Zealand.
- Perry, N. (1994). *The dominion of signs: Television, advertising, and other New Zealand fictions*. Auckland, New Zealand: Auckland University Press.
- Peterson, A., & Lupton, D. (1996). *The new public health: Health and self in the age of risk*. St Leonards, NSW, Australia: Allen & Unwin.
- Philo, G. (1999). Introduction: A critical media studies. In G. Philo (Ed.), *Message received: Glasgow media group research 1993-1998* (pp. viii-xvii). New York: Longman.
- Pierret, J. (1993). Constructing discourses about health and their social determinants. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 9-26). London: Routledge.
- Pill, R., & Stott, N. (1985). Choice or chance: Further evidence on ideas of illness and responsibility for health. *Social Science and Medicine*, 20, 981-991.
- Plantinga, C. (1996). Moving pictures and the rhetoric of nonfiction: Two approaches. In D. Bordwell, & N. Carroll (Eds.), *Introduction post-theory: Reconstructing film studies* (pp. 307-325). Madison, WI: University of Wisconsin Press.

References

- Pollock, K. (1993). Attitude of mind as a means of resisting illness. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 49-70). London: Routledge.
- Popay, J., & Williams, G. (1996). Public health research and lay knowledge. *Social Science and Medicine*, 42, 759-768.
- Popay, J., Williams, G., Thomas, C., & Gatrell, A. (1998). Theorising inequalities in health: The place of lay knowledge. In M. Bartley, D. Blane, & G. Davey Smith (Eds.), *The sociology of health inequalities* (pp. 59-83). Oxford: Blackwell.
- Porter, R. (Ed.). (1985). *Patients and practitioners: Lay perceptions of medicine in pre-industrial society*. Cambridge, New York: Cambridge University Press.
- Porter, R. (Ed.). (1996). *The Cambridge illustrated history of medicine*. Cambridge, New York: Cambridge University Press.
- Potter, J. (1996). *Representing reality*. London: Sage.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Powell, I. (1992). A conflict of cultures. In L. Keene (Ed.), *Health reforms a second opinion* (p. 39). Wellington, New Zealand: Wellington Health Action Committee.
- Putnis, P. (1994). *Displaced re-cut and recycled: File-tape in television news*. Gold Coast, QLD, Australia: Bond University Press.
- Qualitative Solutions & Research. (1994). *Q.S.R NUD*IST qualitative data analysis software for research professionals*. La Trobe University, Bundoora Campus, Victoria, Australia.
- Radley, A. (1993). The role of metaphor in adjustment to chronic illness. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 109-123). London: Routledge.
- Radley, A. (1994). *Making sense of illness: The social psychology of health and disease*. London: Sage.

- Radley, A. (1996). The critical moment: Time, information and medical expertise in the experience of patients receiving coronary bypass surgery. In S. J. Williams, & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences* (pp. 118-138). London: UCL Press.
- Radley, A. (1999). Social realms and the qualities of illness experience. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 16-30). London: Sage.
- Radley, A., & Billig, M. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health and Illness*, 18, 220-240.
- Ratzan, S. C. (1998). Strategies for attaining public health. In S. C. Ratzan (Ed.), *The mad cow crisis: Health and the public good* (pp. 182-208). New York: New York University Press.
- Renckstorf, K., & McQuail, D. (1996). Social action perspectives in mass communication research: An introduction. In K. Renckstorf, & D. McQuail (Eds.), *Media use as social action: A European approach to audience studies* (pp. 1-17). London: John Libbey.
- Research Unit in Health and Behavioural Change University of Edinburgh. (1989). *Changing the public health*. Chichester: John Wiley & Sons.
- Richardson, K., & Corner, J. (1986). Reading reception: Mediation and transparency in viewers' accounts of a TV programme. *Media, Culture, and Society*, 8, 485-508.
- Roscoe, J. (in press). Documenting the immigrant nation: Tensions and contradictions in the representation of immigrant communities in a New Zealand television documentary series. *Media, Culture, and Society*.
- Roscoe, J., Marshall, H., & Gleeson, K. (1995). The television audience: A reconsideration of the taken-for-granted terms 'active', 'social' and 'critical'. *The European Journal of Communication*, 10, 87-109.
- Rosenthal, A. (1988). General introduction. In A. Rosenthal (Ed.), *New challenges for documentary* (pp. 1-7). Los Angeles: University of California.
- Ross, J. (1997). *The semantics of media: Studies in linguistics and philosophy*. London: Kluwer Academic.

References

- Rubin, A. M., & Perse, E. M. (1987). Audience activity and TV news gratifications. *Communication Research*, 14, 58-85.
- Saks, M. (1994). The alternatives to medicine. In J. Gabe, D. Kelleher, & G. Williams (Eds.), *Challenging medicine* (pp. 84-103). London: Routledge.
- Salmond, G. (1992). A community left behind. In L. Keene (Ed.), *Health reforms a second opinion* (p. 11). Wellington, New Zealand: Wellington Health Action Committee.
- Salmond, G., Mooney, G., & Laugesen, M. (1994). Introduction to health care reform in New Zealand. In G. Salmond, G. Mooney, & M. Laugesen (Eds.), *Health Policy* (Vol. 29, Special issue: Health care reform in New Zealand) (pp. 1-3). Ireland: Elsevier.
- Sampson, E. E. (1983). *Justice and the critique of pure psychology*. New York: Plenum.
- Saunders, P. (1996). Do inequalities in income cause inequalities in health? In P. Crampton, & P. Howden-Chapman (Eds.), *Socioeconomic inequalities and health: Proceedings of the socioeconomic inequalities and health conference* (pp. 9-36), Wellington, 9-10 December, 1996.
- Sayer, A. (1992). *Method in social science: A realist approach* (2nd ed.). London: Routledge.
- Scott, C. D. (1994). Reform of the New Zealand health care system. In G. Salmond, G. Mooney, & M. Laugesen (Eds.), *Health Policy* (Vol. 29, Special issue: Health care reform in New Zealand) (pp. 25-40). Ireland: Elsevier.
- Seiter, E. (1998). *Television and new media audiences*. New York: Clarendon Press.
- Semin, G. R., & Gergen, K. J. (Eds.). (1990). *Everyday understanding: Social and scientific implications*. London: Sage.
- Sharma, U. (1996). Using complementary therapies: A challenge to orthodox medicine? In S. J. Williams, & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences* (pp. 230-255). London: UCL Press.
- Sharp, A. (Ed.). (1994). *Leap into the dark: The changing role of the state in New Zealand since 1984*. Auckland, New Zealand: Auckland University Press.

- Signorielli, N. (1990). Television and health: Images and impact. In C. Atkin, & L. Wallack (Eds.), *Mass communication and public health: Complexities and conflicts* (pp. 96-113). Newbury Park, CA: Sage.
- Signorielli, N., Gerbner, G., & Morgan, M. (1995). Violence on television: The cultural indicators project. *Journal of Broadcasting and Electronic Media, 39*, 278-283.
- Silverstone, R. (1994). *Television and everyday life*. London: Routledge.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harré, & L.V. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). London: Sage.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261-271.
- Smith, J., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 218-240). London: Sage.
- Smythe, D. W. (1954). Reality as presented by television. *Public Opinion Quarterly, 18*, 143-156.
- Sontag, S. (1978). *Illness as metaphor*. New York: Farrar, Straus and Giroux.
- Spicer, J., Trlin, A., & Walton, J. (Eds.). (1994). *Social dimensions of health and disease: New Zealand perspectives*. Palmerston North, New Zealand: Dunmore Press.
- Stanton Rogers, W. (1991). *Explaining health and illness: An exploration of diversity*. London: Harvester Wheatsheaf.
- Stanton Rogers, W. (1996). Critical approaches to health psychology. *Journal of Health Psychology, 1*, 65-78.
- Stephens, R., & Waldegrave, C. (1997). Measuring poverty in New Zealand. In P. Crampton, & P. Howden-Chapman (Eds.), *Socioeconomic inequalities and health: Proceedings of the socioeconomic inequalities and health conference* (pp. 105-120), Wellington, 9-10 December, 1996.

References

- Stevens, L. (1993). Reflexivity: recognizing subjectivity in research. In D. Colquhoun, & A. Kellehear (Eds.), *Health research in practice: Political, ethical, and methodological issues* (pp. 152-170). London: Chapman & Hall.
- St John, P. (1996). Clinical benefits of new booking system murky. *New Zealand Doctor*, 16 October 1996, p. 7.
- St John, S. (1994). The state and welfare. In A. Sharp (Ed.), *Leap into the dark: The changing role of the state in New Zealand since 1984* (pp. 89-106). Auckland, New Zealand: Auckland University Press.
- Strasburger, V. C. (1995). *Adolescents and the media: Medical and psychological impact*. Thousand Oaks, CA: Sage.
- The Great Kiwi Health Lottery. (1995, July 20). *Assignment*. Television One, New Zealand.
- The Kiwi Killing Fields. (1995, 5 July). *Inside New Zealand*, Television Three, New Zealand.
- The Lifestyle of the Ostrich. (1997, 17 June). The Problem with Men (Part One). *Tuesday Documentary*, Television One, New Zealand.
- The Poisoning of New Zealand. (1995, 13 September). *Inside New Zealand*, Television Three, New Zealand.
- The Tell Tale Genes. (1995, 29 June). *Assignment*, Television One, New Zealand.
- The Thing from the Black Lagoon. (1997, 24 June). The Problem with Men (Part Two). *Tuesday Documentary*, Television One, New Zealand.
- Thousands Protest Cuts. (1997, September 20). *Otago Daily Times*, p. 1.
- Tones, K. (1996). The anatomy and ideology of health promotion: empowerment in context. In A. Scriven, & J. Orme (Eds.), *Health promotion: Professional perspectives* (pp. 9-21). London: Macmillan.
- Tulloch, J., & Lupton, D. (1997). *Television, AIDS and risk: A cultural studies approach to health communication*. St Leonards, NSW, Australia: Allen & Unwin.

- Tully, J. (1996). Piercing the veil of health reporting. In J. McGregor (Ed.), *Dangerous democracy? News media politics in New Zealand* (pp. 156-165). Palmerston North, New Zealand: Dunmore Press.
- Tully, J., & Fountain, B. (1993). *The news tourniquet*. Christchurch, New Zealand: Journalism Department, University of Canterbury.
- Turow, J. (1989). *Playing doctor: Television, storytelling, and medical power*. New York: Oxford University Press.
- Turow, J., & Coe, L. (1985). Curing television's ills: The portrayal of health care. *Journal of Communication*, 35, 36-51.
- Upton, S. (1991). *Your health and the public health: A statement of government health policy*. Wellington, New Zealand: New Zealand Department of Health.
- Van Zoon, L. (1994). *Feminist media studies*. London: British Film Institute.
- Vaughan, D. (1988). Television documentary usage. In A. Rosenthal (Ed.), *New challenges for documentary* (pp. 34-47). Los Angeles: University of California Press.
- Vitamin Industry...New Products from Cook Strait. (1944). *Weekly Review*, New Zealand.
- Waitzkin, H. (1979). Medicine, superstructure and micro politics. *Social Science and Medicine*, 13A, 601-609.
- Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behaviour*, 30, 220-239.
- Walkerdine, V. (1996). Subject to change without notice: Psychology, postmodernity and the popular. In J. Curran, D. Morley, & V. Walkerdine (Eds.), *Cultural studies and communications* (pp. 96-118). London: Arnold.
- Wallack, L. (1990). Mass media and health promotion: Promise, problem, and challenge. In C. Atkin, & L. Wallack (Eds.), *Mass communication and public health: Complexities and conflicts* (pp. 41- 51). Newbury Park, CA: Sage.
- Wallack, L., & Dorfman, L. (1992). Television news, hegemony, and health. *American Journal of Public Health*, 82, 125-126.

References

- Wear, A. (Ed). (1992). *Medicine in society: Historical essays*. Cambridge, New York: Cambridge University Press.
- White, K. (1994). Social construction of medicine and health. In J. Spicer, A. Trlin, & J. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives* (pp. 240-256). Palmerston North, New Zealand: Dunmore Press.
- Wilkinson, R. (1996). *Unhealthy societies: The afflictions of inequality*. London: Routledge.
- Wilkinson, S. (1998). Focus groups in health research: Exploring the meaning of health and illness. *Journal of Health Psychology, 3*, 329-348.
- Williams, G., & Popay, J. (1994). Lay knowledge and the privilege of experience. In J. Gabe, D. Kelleher, & G. Williams (Eds.), *Challenging medicine* (pp. 118-139). London: Routledge.
- Williams, R. (1990). *A Protestant legacy: Attitudes to death and illness among older Aberdonians*. Oxford: Clarendon Press.
- Williams, R. (1993). Religion and illness. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 71-91). London: Routledge.
- Williams, S. (1995). Theorising class, health and lifestyles: Can Bourdieu help us? *Sociology of health and illness, 17*, 577-604.
- Williams, S. J., & Calnan, M. (1996). Modern medicine and the lay populace: Theoretical perspectives and methodological issues. In S. J. Williams, & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences* (pp. 2-25). London: UCL Press.
- Winston, B. (1995). *Claiming the real: The Griersonian documentary and its legitimations*. London: British Film Institute.
- Woodward, A., & Kawachi, I. (1998, March). *Why should we reduce health inequalities? Reasons for acting on the social, cultural and economic factors that cause ill-health* (Background paper No. 2). National Health Committee: Health Determinants Programme.
- Wyllie, A., Holibar, F., Casswell, S., Fuamatu, N., Aiolupatea, K., Moewaka Barnes, H., & Panapa, A. (1997). A qualitative investigation of responses to television alcohol advertisements. *Contemporary Drug Problems, 24*, 103-132.

References

Yardley, L. (Ed.). (1997). *Material discourses of health and illness*. London: Routledge.

Yardley, L. (1999) Understanding embodied experience. In M. Murray, & K. Chamberlain (Eds.), *Qualitative health psychology: Theories and methods* (pp. 31-46). London: Sage.

Zeman, F. D. (1967). Some little known classics of old-age medicine. *The Journal of the American Medical Association*, 200, 150-152

Zola, I. (1972). Medicine as an institution of social control. *Sociological Review*, 20, 487-504.

Appendix A

Programme Synopses

The Great Kiwi Health Lottery [TGKHL] (1995)

TGKHL presents an investigation of the New Zealand health care reforms. The perspective adopted in TGKHL is that these reforms are failing and consequently having a negative impact on the provision of medical care to and prompt treatment of patients of lower SES. The coverage is structured around a conflict between bureaucratic attempts to introduce tighter fiscal controls and the autonomy of the medical profession. After the host's introduction, which briefly reviews the reforms, evidence is presented to demonstrate how treatment-rationing decisions are made. This is followed by a debate, juxtaposing bureaucrats and doctors, over whether people are able to gain adequate access to care and who is responsible for inadequacies in the health system. An exploration of how the system is structured, how funding decisions are made, and the conflict between medical ethics and fiscal restraint is then presented. This includes an exploration of the possibility of alternative funding arrangements, such as having a list of ailments and subdividing it into conditions that will be treated at the public's expense and those that will not. It is proposed that such strategies would remove the burden of denying care from doctors. Correspondingly, patients are presented primarily as either victims of public waiting lists or benefactors of private care. Attention is given to the private provision of care, illustrated through depictions of patients who are provided with prompt access to the wonders of medical science. This establishes the summary proposition that, in the current social climate,

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access to health care is increasingly inequitable and a matter of one's ability to pay.

Health and Wealth [H&W] (1996)

H & W builds on coverage of the health care reforms provided in TGKHL and focuses on the shift from publicly to privately funded health care. It is proposed that increases in private spending on medical care are the result of problems in the ailing public system and the government's agenda to privatise public services. A key question investigated is whether private care is becoming a necessity to fill the void left by inadequacies in the public system. Politicians are depicted stating that the growth in private medicine is not at the expense of the public system, even though the programme's rhetorical framing indicates that it is. The issue of 'queue jumping' or private patients being treated in public hospitals without having to wait like those on the public waiting lists is also explored. Specific attention is given to the increasing cost of medical care. These rising costs are linked to private surgeon's fees. Surgical private practices are presented as profit-orientated businesses, attracting professionals from the inadequately funded public system. This shift is attributed to disparities in pay between public and private doctors and the unrealistic work pressures imposed on practitioners in the public system. An important proposition developed in these sequences is that the public system is not providing adequate care and therefore the private system is profiting. It is not only doctors who are depicted leaving the public system. Examples of patients on the public waiting lists who have been forced to obtain treatment in the private system are also presented to highlight the extent of the problem. In the closing sequences, prompt access to medical treatment is presented as a basic right. The programme ends with the proposition that an adequately resourced public health system is necessary to ensure health for all. Questions about just how that system will be funded are left unanswered.

Golden Oldies [GO] (1996)

GO investigates issues relating to New Zealand's aging population, including the ramifications of the need of an increasing number of aged persons to access health care resources. The overall perspective is that, although the elderly are living longer more active lives owing to lifestyle changes, society needs to become more senior-friendly and adapt services to ensure dignity and health in old age. This programme works through the issue of whether the increase in life expectancy is going to result in an increase in the financial burden placed on the working population for providing care for the elderly: a proposition supported by a discussion of age-related health conditions such as Alzheimer's disease. Next, renewed attention is given to the active elderly. It is proposed that the elderly have changed, from being inactive to being more physically active and spritely. Lifestyle factors, including diet and exercise, are presented as the key to a long and healthy life for the individual and thus as the means of alleviating the financial burden on the taxpayer. Additionally, scientific research into extending people's life expectancies and revitalising the elderly is covered. It is proposed that the cure for degenerative conditions, such as Alzheimer's disease, is linked to the cure for aging. Subsequent sequences focus on making society more senior-friendly in response to the increasing number of elderly consumers. Trends such as resurfacing to eradicate wrinkles, employment later in life, retirement villages, the need for increased geriatric care, and home shopping are briefly explored. Concluding sequences outline the need for a system of pensions which cares for the elderly and provides dignity in old age. What is left unresolved is whether these pensions will be paid for through a tax-based or private insurance system.

The Thing from the Black Lagoon [TTFTBL] (1997)

TTFTBL is the second instalment of a two-part series entitled 'The Problem with Men'. This programme is an example of a public health initiative which

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provides medicalized information intended to influence men's health-related decision-making. Synopses of both episodes of 'The Problem with Men' are presented here in order to set the context for my analysis of the second episode (TTFTBL), which was screened for the fourth focus group.

The first episode of 'The Problem with Men', 'The Lifestyle of the Ostrich' [TLOTO] (1997), begins by depicting John Clark, a well-known New Zealand comedian, and another man in a sitting room watching television and having a light-hearted discussion about men not looking after themselves and ignoring health problems. The programme travels to various Western countries and establishes general trends, such as men dying significantly earlier than women. Evidence is presented to support the proposition that the shorter life expectancy for men is due to their ignoring the symptoms of health problems and living unhealthy lifestyles. The need for vigilance is explored through the presenter and several men undertaking medical examinations. Each man's efforts to address the health problems identified in these examinations is then depicted four months later. Progress is shown to be virtually non-existent and only minor behavioural changes are reported. The lack of change is used to emphasise the proposition that it is men's reluctance to change their ways that is the key factor in the onset of serious illness and premature death. This leads to coverage of a men's health night: a new initiative aimed at providing men with health information in a relaxed atmosphere so they can take responsibility for their health. The issue of men's need for support when dealing with health issues is inherent in these sequences and leads to an emphasis on group initiatives. Attention is given to three over-weight men in Auckland who have formed a support group to try and lose weight together. Emotive accounts of the dangers involved in an unhealthy lifestyle are emphasised by the presenter announcing that one of the men died soon after the filming of the programme. The final sequence includes a follow-up after four months with the men who attended the men's health night. The

audience is informed that many of these men are attempting to change their ways, but like the men who visited the GP only minor behavioural changes have occurred. The programme ends with a return to the two men talking as they watch television. This discussion functions to introduce issues that will be explored in the second episode (TTFTBL).

Extending several themes from TOTO, TTFTBL presents the overall perspective that there is a need for men to face their health problems because ignoring an ailment can lead to life-threatening complications. Men need to adopt a healthy lifestyle in order to prevent illness, but if an ailment develops effective medical treatments with minimal side-effects are available. TTFTBL begins with a continuation of the discussion between the two men. This time the subject is the inability of men to talk about testicular cancer, impotence, and prostate cancer. The following sequences deal with testicular cancer, emphasising how this ailment is treatable if caught early enough. Attention is given to the need for men to know the symptoms and how to conduct self-examinations, as an aid to early detection and treatment. The following sequences explore men's treatment experiences and the benefits of prompt medical intervention. The focus then shifts to impotence, its symptoms, patient's experiences of it, various treatments for it, and how men try to hide such problems. This is followed by an investigation of prostate cancer. Once again men who have first-hand experience recount the need for early diagnosis and the effectiveness of medical treatments. Attention is given to the men's concerns about the possibility of incontinence and having to live with side effects after surgery. The focus then turns to patients who have successfully undergone treatment with only limited side-effects. A summary sequence focuses once again on men's health-seeking behaviour and is used to inform the audience that it is now their turn to act. Additional information is offered in the form of a support telephone number at the end of the programme.

Appendix B

Audience Interpretations of Health Coverage

Information Sheet

Who is conducting this research?

This research is being run by Darrin Hodgetts, a Graduate Student in Psychology, under the supervision of Kerry Chamberlain a Senior Lecturer in Psychology Department and Keith Beattie a Lecturer in the History Department, at Massey University.

What is this study about?

The aim of this study is to find out about people's health and illness ideas. I am interested in talking to people about health and illness and how they view a particular health related television documentary.

What would I have to do?

The study is in two parts. **Firstly**, if you agree to take part, you would be asked to participate in an interview with the researcher lasting approximately 30 to 60 minutes. The interview would take place at a time and place that is convenient for you. You would be asked to talk about your general ideas of health and illness and media use. An audiotape will be used so that all of the information you provide is recorded accurately.

Appendix B

Secondly, you will be involved in a group viewing and discussion of a health documentary. The group viewing and discussion will also be sound recorded. It is estimated that the viewing will take from 30 to 60 minutes and the discussion about 90 minutes to complete. In the discussion you will be asked to speak about your interpretations of the television programme. This is a very informal encounter and refreshments will be provided. In total your participation will involve no more than four hours.

What is in it for me?

- A forum in which you can have your say.
- You will receive some refreshments during the group session.
- The organisation you are affiliated with will receive a small donation and a research report.
- In the long term the results of studies like this one may contribute to an improved understanding of how health and illness is communicated by the media.

What can I expect from the researcher?

If you take part in the study, you have the right to:

- Refuse to answer any particular questions, and to withdraw from the study at any time.
- Have the right to ask for the tape to be turned off at any point during the interview.
- Ask any further questions about the study that occur to you during your participation.
- Contact the researcher at any time to discuss aspects of the study.
- Provide information on the understanding that it is completely confidential to the researcher. All records are identified by code number, and are seen only by the researcher. The audiotape recording of your comments will be destroyed at the completion of the research.

Bona Fide

To whom it may concern, this declaration is to certify that Darrin Hodgetts is a researcher from Massey University. This project is not connected with health organisations or the media in any way. If you have any questions about this study please contact Dr Keith Beattie (History, extension 4246).

Supervisor:

Name:

Signature:

Date:

If you have questions, you are welcome to telephone Massey University.

Phone: Keith Beattie (06) 356 9099 (extension) 4246

Phone: Darrin Hodgetts (06) 356 9099 (extension) 7316
Hamilton (07) 847 7063

Appendix C

Audience Interpretations of Health Coverage Consent Form

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I have the right to ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, and to decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that it is completely confidential. I also agree to the interviews being tape recorded and I understand that I have the right to ask for the tape recorder to be turned off at any time during the interviews.

I also agree that:

The researcher may use brief direct quotations from the verbal material I produce during the study in his reports of the research, provided these do not identify me in any way.

YES

NO (please circle)

I wish to participate in this study under the conditions set out on the Information Sheet.

PARTICIPANT

RESEARCHER

Signed:

Signed:

Name:

Name.....

Date:

Date:.....

Appendix D

Individual Interview Protocol

Fourth Research Group

Introduction

Talk with participants and break the ice:

- Relax this is an informal discussion
- When talking try to think of examples

1. Think of someone you know who is sick?

- Who are you thinking of?
- Can you talk about them?
- What makes you call them sick?
- How do you know if someone else is sick?

2. Can you think back to when you have been ill and describe the experience for me?

- What does being sick mean to you?
- Is there a part of being sick that you would like to avoid the most?
- Do you have any ailments at the moment? Talk about them?

3. What sort of things would you seek help for?

- Where would you go?
- Is it hard to ask for help?
- How much faith do you have in doctors?
- What things would you deal with yourself? How?

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4. How do you feel about hospitals?

- What about going there yourself?

5. Do you think about your health?

- Do you discuss it with other people? If so, with who?

6. Are you a healthy person?

- Do you do any particular things for the sake of your health?
- Do you do things that you know are not healthy?
- What is the biggest threat to your health?
- Can you think of any health issues specifically relating to men?

7. Where do you usually obtain health and illness information from?

- Where are health issues usually discussed?
- What health issues are not discussed in the media that should be?
- What do you think of how health and illness is presented on television?
- How much television do you watch?
- What programmes do you watch?

8. Summarise the main points from the interview and encourage further input from the participant.

- In relation to what we have been talking about is there anything that you would like to bring up or thought should have been discussed?
- Do you have any questions for me?

Thank the participant and discuss an appropriate time for the focus group discussion.

Appendix E

Focus Group Guide

First Research Group

Introduction

I am interested in discussing issues relating to this television programme, 'The Great Kiwi Health Lottery'. The purpose of this group is to create the opportunity for us to discuss this programme and issues it presents. I would like to audiotape this discussion so I can get an accurate record of the conversation and concentrate on what is said and not on taking notes. Before beginning I have got a few points that I would like you to keep in mind:

- There are no right or wrong answers
- When making a point think about including examples
- Be honest, I am interested in what you think
- If you have any questions feel free to ask them at any time
- Feel free to respond to others but try not to interrupt
- It would be appreciated if no-one discusses what others say outside the context of the group session

Prompts:

1. What did you think of the programme?
2. What do you think most people would consider to be the main issues dealt with in the programme?
What do you think was most important?

Appendix E

What do you think the main viewpoint expressed in the programme was?

3. Do you feel this programme handled the health reforms well? why?

4. There appeared to be a lot of discussion about access to hospitals and surgical care.

What do you think about the way this was handled?

Do you think there are any alternatives?

5. Can you relate to what the patients were talking about?

6. Out of the people that appear in the programme:

- Whose account did you agree with the most, and why?
- Whose account did you agree with the least, and why?
- How did the reporter come across?
- What can you say about how the doctors came across?

Conclusion:

Summarise the main points from the discussion and encourage further input from participants.

1. Has anyone got any other points they would like to raise?

2. How did you find the session?

3. Do you have any questions for me?

Secondary Prompts:

1. Who else has had a similar experience?

2. What do you think about that idea?

3. Can you talk about this a little more?

Thank the Participants